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Individual High Risk Pools: A Case Study of the Minnesota Comprehensive Health Association

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Prepared by
Donna L. Spencer and Lynn Blewett
University of Minnesota

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About the Report

The paper is intended to provide national policymakers with insight about the administrative structure, effects, and implementation challenges of insurance coverage market reforms in Minnesota. It also provides lessons about program reform administration and implementation for New York State policymakers.

About the Rockefeller Institute and the New York State Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The New York State Health Policy Research Center (HPRC) is a program of the Rockefeller Institute. HPRC provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

About the State Health Access Data Assistance Center (SHADAC)

The State Health Access Data Assistance Center (SHADAC) is a health policy research center and a health data resource providing targeted policy research and technical expertise on the collection, analysis, and use of policy-relevant data on health services, including insurance coverage, access to care, and utilization. Housed within the University of Minnesota's School of Public Health and led by Lynn Blewett, Ph.D., SHADAC's researchers, staff, and faculty advisors maintain an ongoing research agenda related to issues of health insurance coverage, data collection methods, and state health policy. SHADAC's experts in health policy analysis, survey design, sampling, and data analysis specialize in the application of national and state data resources for health policy decisions and strive to make health care data more accessible, improve the quality of data at the state and national levels, and increase its use for making informed policy decisions related to health care coverage and access. SHADAC's goal is to serve as a bridge between state and federal agencies and between data and policy. SHADAC is largely supported by the Robert Wood Johnson Foundation.

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Executive Summary

Overview

Minnesota is one of 35 states that operate a high risk pool, which is designed to remove high cost cases from the individual market for the purpose of lowering the cost of insurance for the people who remain in the pool, and to assure access to insurance for people who might otherwise be uninsured. Minnesota's high risk pool, known as the Minnesota Comprehensive Health Association (MCHA), was implemented in 1977 and currently enrolls approximately 30,000 people. It provides comprehensive major medical plans for people who have existing health conditions, do not have access to a large or small employer-based health plan, and who have not been able to secure affordable coverage in the individual market. The program is among the largest and most expensive state high risk pools in the nation, but it is also viewed as a possible model for providing health insurance coverage for a segment of the population that would otherwise be uninsured, and as a mechanism for potentially mitigating premium cost increases in Minnesota's individual market.

Administration

MCHA is a not-for-profit corporation that became operational in 1977. The Minnesota Department of Commerce regulates MCHA, and the association is governed by a board of directors. The commissioner of commerce is responsible for creating policies related to the pool, approving the carrier to administer the pool, selecting or approving board members, and responding to appeals from plan enrollees. The governing board includes 11 members. MCHA's day-to-day operations are handled by an insurance carrier in the state.

Eligibility

To be eligible for MCHA, an applicant must be a state resident. MCHA's five eligibility categories include: loss of group coverage, federal Health Coverage Tax Credit (HCTC) program eligibility, ineligibility for the federal Medicare program, health-related insurance coverage rejection, and the existence of a pre-existing condition. In a recent survey, the majority of enrollees indicated that being turned down for an individual policy due to a pre-existing condition was a reason for applying to MCHA. Approximately 23 percent report that they applied to MCHA because their Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits terminated, they could not afford COBRA, or COBRA was not available to them at the time of job termination.

Effects of Reforms on Private Insurance Coverage

Approximately 30,000 people participate in MCHA, making it the largest high risk pool in the country and an important safety net for its enrollees. Enrollment has fluctuated, but even so, MCHA makes up less that 3 percent of the state's total enrollees in public health programs and overall, it supports less than 1 percent of the state's population. Effects of the high risk pool on decreasing costs in the individual market are difficult to measure with precision, although generally it has been viewed as a relatively small but important component of Minnesota's health care system and a safety net for the "uninsurable."

Lessons

Stakeholder involvement augments program success – MCHA's private/nonprofit health plan structure with public oversight and a liberal policyholder appeal process has resulted in a strong, flexible, and

efficient design for Minnesota. Inherent in this approach is the involvement and "balance of power" among key stakeholders, including the Department of Commerce, insurance companies, board members, and plan enrollees. While the Department of Commerce oversees and regulates the pool, it established committees early on to give stakeholders (health care providers, hospitals, carriers) the opportunity to provide input and participate in the implementation of the pool, particularly the development of the operating rules.

There is room to improve care management – Because there is no employer or agency to push for change or to promote managed or preventive care, there has been little incentive for MCHA to innovate or become a market leader. MCHA is one of the few fee-for-service health plans left in Minnesota. With its current writing carrier, MCHA uses disease management services covering multiple conditions, and the pool recently began incentive-based health and wellness programs for all members.

High risk pools help to stabilize the market – By directing residents with serious (and costly) health problems to MCHA, Minnesota's high risk pool has helped stabilize the private individual market in the state. Further, MCHA eligibility rules, underwriting practices, and dependent/spouse inclusions also have stabilized the high risk pool by allowing the entrance of relatively healthy individuals into the pool.

Increases in general health care costs challenge high risk pools – A prominent concern with MCHA pertains to growth in costs, and this concern is not unique to Minnesota's pool. MCHA has been supported primarily through enrollee premiums and insurer assessments. In recent years, the pool has required additional funding from the state legislature. Legislators have considered increasing the premium range used for MCHA. In addition, given that MCHA helps to address both fully-insured and self-insured market failures, some believe that the MCHA insurer assessment financing mechanism should be broader, with insurer assessments based not just on fully-insured plans (consisting of many small businesses and individuals) but also self-insured plans (typically large employers). (ERISA legislation currently prohibits assessments on the self-insured plans.) Compounding this concern is the recent growth in self-funded plans (representing 59.6 percent in the state's private market in 2005) and the ramifications for the overall size of MCHA's assessment base. Some legislators and policy analysts have considered alternative mechanisms to building health care resources, such as third party administrator assessments similar to those implemented in Maine, and provider taxes.

The role of state funding continues to be debated – State appropriations have been used irregularly to offset MCHA losses during the pool's 31 years of existence. During the first few years of MCHA, tax write-offs were used to subsidize insurer assessments. Since then, the state appropriated funds to offset pool losses for three years, for a total of $45 million. Some believe there is a need for more regular state funding for MCHA. A concern related to state funding, however, is its consistency and stability. Some believe that relying on annual state budgets may make pool funding more uncertain. In this context, insurer assessments have been viewed by some as more predictable.

Affordability of high risk pools for individuals is a concern – While Minnesota's high risk pool premiums are relatively low (capped at 125 percent of the private individual market average), many enrollees still cannot afford the premiums (and may not reach the deductible, especially in the case of the high-deductible plans). One feature MCHA has used to enhance its affordability for enrollees is a split deductible — one for medical services and a separate deductible for prescription drugs. Excluding preventive care from the required deductible is another example of an affordability option that has been considered. Additionally, the state has utilized federal grant funding to support low-income subsidies several times in recent years.

I. Introduction

State governments create high risk pools to provide coverage to a specific segment of their health insurance market — "uninsurables" — or individuals who have existing health conditions yet do not have access to a large or small employer-based health plan, and who have not been able to secure affordable coverage in the individual market. Many of these individuals have been denied coverage in the private market or offered a plan with an excessively high premium. High risk pools typically serve the self-employed, workers of employers that do not provide health insurance as an employee benefit, individuals who are in between jobs or changing jobs and have lost group coverage, or young adults transitioning off of a parent's health insurance plan. Currently, 35 states have a high risk pooling mechanism in place.[1]

This report provides information on Minnesota's high risk pool, the Minnesota Comprehensive Health Association (MCHA), and is intended to provide information and insights to legislators in New York State considering options for expanding insurance coverage in the state's individual and small group markets. Implemented in 1977, MCHA is one of the longest-running state high risk pools, and with current enrollment just under 30,000 and a total funding level above $235 million, it is also among the largest and most expensive state high risk pools in the nation. This report begins with an overview of state individual high risk pools in general and then presents more detailed information about MCHA, including the plans and benefits it offers, its eligibility rules and enrollment levels, its management and administration, and its expenditures and financing. We conclude with several lessons learned from MCHA and a broader discussion of high risk pools as a mechanism states can use to manage risk (i.e., high health care costs) in their health insurance markets.

II. Overview of High Risk Pools

Currently, 35 states have implemented an individual high risk pool. The 15 states without such a pool include New York, Arizona, Delaware, Georgia, Hawaii, Maine, Massachusetts, Michigan, Nevada, New Jersey, Ohio, Pennsylvania, Rhode Island, Vermont, and Virginia.[2]

State high risk pools serve several main functions:

- **High risk pools provide guaranteed coverage in the individual market.** An important function of a state high risk pool is to address a key area of vulnerability in the private individual health insurance market: the lack of statutorily guaranteed coverage. Whereas large and small employer health insurance plans are required by federal law to provide guaranteed issue coverage to employees (i.e., not restrict access based on health status), the individual market is not regulated in this way, and most states have not mandated guaranteed issue in their individual market. "Underwriting of new applicants for individual insurance is allowed in most states. Those with pre-existing conditions may be declined, or rated up to higher premiums, or offered more limited coverage."[3] State high risk pools offer a last resort to high risk individuals who are unable to obtain affordable coverage in the private market.

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[1] National Association of State Comprehensive Health Insurance Plans (NASCHIP), 2007.
[2] Ibid. Some states, including New York (i.e., the Healthy New York program), have implemented pooling and reinsurance mechanisms for small businesses. This report, however, focuses on individual pools.
[3] Communicating for Agriculture and the Self-Employed (CA), 2005, p. 13.

- **High risk pools meet federal requirements for guaranteed availability for people converting from group to individual coverage.** The federal Health Insurance Portability and Affordability Act (HIPAA) of 1996 requires that all states have guaranteed portability and renewability for policy holders transitioning from group to individual coverage. States have flexibility in meeting this requirement, with a high risk pool being one mechanism approved by the federal government. Several of the states that have *not* established a high risk pool to date (e.g., New York, Maine, New Jersey, Vermont) have mandated guaranteed issue in their individual markets.

- **High risk pools help spread and stabilize risk in the individual market.** States use multiple approaches for managing risk (i.e., costs of coverage for people with more expensive health issues) in the individual health insurance market. High risk pools represent one approach. Other approaches include guaranteed issue mandates, rating schemes, and reinsurance. Through financing from industry members (e.g., via carrier assessments), government, and enrollees, high risk pools provide a means for sharing and spreading the costs associated with individuals with expensive health problems. By pooling these high risk individuals, the rest of the individual market has a lower risk, on average.

- **High risk pools serve as a mechanism for providing coverage for individuals eligible for the Federal Health Coverage Tax Credit (HCTC).** Under the HCTC, early retirees receiving payments from the Pension Benefit Guaranty Corporation (PBGC) and displaced workers due to foreign trade are eligible for a tax credit amounting to 65 percent of the individual's health premium. High risk pools are one of the mechanisms states can use as part of their HCTC acceptance program. Twenty states utilize their high risk pool for this reason.[4]

State high risk pools tend to be similar in terms of their key design features. The National Association of Insurance Commissioners (NAIC) has produced a model for state high risk pool legislation to facilitate uniformity across states. As previously mentioned, federal HIPAA regulations consider a high risk pool an acceptable mechanism for states to address the required guaranteed portability and renewability for individuals transitioning from the group to individual market. "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 premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Act."[5]

Key features of high risk pools, however, do vary to some extent across states. Key design features include:

- **Enrollee eligibility criteria**: Some of the criteria typically used by pools to determine a person's eligibility for participation include state residency, proof of rejection(s) or certain rate increase by insurer, proof of pre-existing condition, and federal eligibility under HIPAA. Some states have a list of presumptive/pre-existing conditions that automatically establishes eligibility into the pool (e.g., HIV/AIDS).

[4] NASCHIP, 2007.
[5] Ibid., p. 8.

- **Plan types and benefits:** Medical benefits under high risk pools are comprehensive and tend to resemble coverage offered by individual or group health plans in a state. Because of the statewide nature of high risk pools (and therefore the need to provide coverage in both rural and urban areas), many high risk pools offer preferred provider organization (PPO) or fee-for-service benefit plans[6]. Deductibles vary; states usually offer multiple levels of deductible-based plans, and some include a Health Savings Account (HSA) high-deductible plan. Annual and lifetime maximums also vary. Medicare Supplement plans are available through some state high risk pools.

- **Reinsurance:** Traditional state high risk pools have their own health insurance benefit plans, rates, and management, and a pool may contract plan administration out to a writing carrier, as is the case in Minnesota. In contrast, state individual high risk reinsurance pools are plans offered directly by carriers in the state, yet reinsured by the pool. An example of an individual reinsurance pool is the Idaho Individual High Risk Reinsurance Pool.

- **Financing:** Given the population high risk pools are intended to serve, risk pools "inherently lose money." [7] About half of total pool costs usually are financed by enrollee premiums. Most states supplement premium revenue with some form of mandated assessment on insurers within the state. Less common is an assessment on providers, as is the case in Maryland and West Virginia.[8] State funding for high risk pools can include general revenue appropriations or tax expenditures (e.g., tax credits to insurers to offset assessments). "In actual practice, states use different combinations of these funding sources from one year to the next…. How states manage to raise the … required funding is an ongoing struggle for each high risk pool and an ongoing debate within each state legislature."[9]

- **Premium rates:** Typically, states set high risk pool premiums based on the standard risk rate; that is, the average rate in the individual market within the state. High risk pool premiums usually range from 125 percent to 200 percent of this rate, although Florida's law currently allows up to 250 percent.[10]

- **Premium subsidy or discount programs**: To improve affordability for individuals, some states have adopted premium discount programs to assist low-income participants. Federal grants (under the Trade Adjustment Assistance Reform Act of 2002 and State High-Risk Pool Funding Extension Act of 2006) have been available to states to assist with these efforts. And while Minnesota's high risk pool does not have a low-income subsidy component on a regular basis, it has taken advantage of these federal grants to subsidize lower-income members in some recent years.

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[6] NASCHIP, 2007.
[7] CA, 2005, p. 14.
[8] NASCHIP, 2007.
[9] Ibid. p. 11.
[10] Ibid.

III. Minnesota Comprehensive Health Association (MCHA)

MCHA was created by the Minnesota Legislature in 1976 to make health insurance available to state residents who are considered medically uninsurable. These residents have either reached the lifetime maximums of their group or other insurance benefits, do not have access to a group insurance plan and have been denied private individual coverage, can only obtain limited coverage, or are assessed higher premiums due to pre-existing medical conditions. MCHA is a not-for-profit corporation that became operational in 1977, and is regulated by the Minnesota Department of Commerce. The mission of MCHA is "to offer health coverage, through a statewide nonprofit Minnesota corporation, to Minnesota residents who cannot obtain coverage in the private market due to existing health conditions; to offer our members educational healthcare resources, and to develop initiatives to help our members manage their chronic diseases and achieve optimum health."[11]

MCHA Plans and Benefits

MCHA offers six non-Medicare individual plans and a Medicare supplement plan.[12] Table 1 summarizes the various non-Medicare deductible plan options.

Table 1. MCHA Individual Deductible Plan Offerings

Plan Type	Medical Deductible	Prescription Drug Deductible	Out of Pocket Maximum	Co-Insurance Rate (for in-network)
$500 deductible	$400	$100	$3,000	80/20%
$1,000 deductible	$800	$200	$3,000	80/20%
$2,000 deductible	$1,600	$400	$3,000	80/20%
$5,000 deductible	$4,000	$1,000	$5,000	80/20%
$10,000 deductible	$8,000	$2,000	$10,000	80/20%
High-Deductible Health Plan (health savings account)	Individual deductible = $3,000 Family deductible = $6,000		Same as deductible	100%

Source: MCHA (2007a). Note: Once out of pocket maximum is met, $500-$10,000 deductible plans pay 100 percent of expenses.

MCHA benefit plans are comprehensive major medical plans and generally cover the services listed in Table 2, including hospital care, physician care, prescription drugs, select forms of long-term care, mental health and substance abuse services, and other types of services. The lifetime maximum amount payable per covered person is $5 million. MCHA does not cover vision or dental services.[13] Additionally, although MCHA does not cover all preventive services, the pool does provide cancer screening, pediatric preventive services, child immunizations, and flu vaccinations for adults. Additionally, routine adult physicals are covered as of July 2008.[14]

[11] Minnesota Comprehensive Health Association (MCHA), 2000, p. 4.
[12] MCHA, 2007a; MCHA, 2006.
[13] CA, 2005.
[14] MCHA, 2007b.

Table 2. Services Covered Under MCHA Individual Deductible Plans

Hospital/Inpatient Care
Physician Services
Chiropractor Services
Routine Cancer Screening Procedures
Prescription Drugs (Except Basic Medicare Supplement Plan)
Skilled Nursing Facility
Hospice Care
Home Health
Outpatient Rehabilitation Services
Mental Health and Substance Abuse Services
Reconstructive and Restorative Services
Ambulance
Infertility Services
Transplant Services
Durable Medical Equipment and Prosthetics

Source: MCHA (2007a).

The MCHA Basic Medicare Supplement Plan provides limited coverage for Medicare Part A and B co-payments but covers neither Part A and B deductibles nor prescription drugs. For Medicare Part A (hospitalization and skilled nursing), the Basic Medicare Supplement Plan pays for the Part A coinsurance and all eligible hospitalization expenses not covered by Medicare. For Medicare Part B (physician and other services), the MCHA plan pays for the share of Medicare's approved amount for covered services not paid for by Medicare. Through optional riders, the Basic Medicare Supplement Plan may be extended to cover Part A and B deductibles as well as 80 percent of usual and customary charges exceeding Medicare-approved costs for Part B services. The Medicare Supplement Plan also provides coverage for substance abuse, outpatient mental health, cancer screening, immunizations, reconstructive and restorative surgery, and other services/devices.

MCHA Eligibility

To be eligible for participation in MCHA, state residency is required. There are several eligibility avenues available for state residents when applying for MCHA coverage. The five eligibility categories include loss of group coverage, federal Health Coverage Tax Credit (HCTC) program eligibility, ineligibility for the federal Medicare program, health-related rejection, and the existence of a pre-existing condition. Table 3 summarizes the requirements under each of these eligibility categories.

Table 3. Eligibility Categories for MCHA

1. Loss of Group Coverage - State resident as of date of application - Lost group coverage - Eligible individual under HIPAA	**4. Health Related Rejection** - State resident for at least 6 months prior to date of application - Due to health reason(s), rejected for individual health coverage from MN carrier or rejected from health insurance agent in last 6 months
2. Health Coverage Tax Credit (HCTC) Program - State resident as of date of application - Deemed eligible by federal HCTC program	**5. Presumptive Condition(s)** - State resident for at least 6 months prior to date of application - Treated within last 3 years for a special medical pre-existing condition (e.g., AIDS/HIV, chemical dependency, and others)
3. Ineligible for Medicare Program - State resident for at least 6 months prior to date of application - 65 years of age or older - Deemed ineligible by federal Medicare program	

Source: MCHA website, available at: www.mchamn.com/html/eligibility.html.

For all eligible persons, MCHA provides dependent coverage for spouses up to age 65, unmarried children through the age of 25, children for whom the applicant or spouse is a legal guardian or has a Qualified Medical Support Order, dependents with a disability or mental illness or disorder, and newborn grandchildren who are financially dependent on the applicant.[15]

In the fall of 2004, MCHA surveyed a random sample of its enrollees.[16] The majority (68.7 percent) of respondents (1,640 Medicare and deductible plan members) indicated that being turned down for an individual policy due to a pre-existing condition was a reason for applying to MCHA. Approximately 23.0 percent reported that they applied to MCHA because their COBRA benefits had terminated, they could not afford COBRA, or COBRA was not available to them at the time of job termination. Approximately 8.0 percent indicated that a reason for applying was that their employer did not offer health insurance. A much smaller percentage, 3.3 percent, reported that they qualified for MCHA under HIPAA.

Those who applied to MCHA because of a pre-existing condition were asked about the condition that prevented them from obtaining health insurance. Weight condition (13.6 percent), cardiovascular condition (12.5 percent), diabetes or other endocrine disorder (12.4 percent), hypertension (11.4 percent), and mental health (9.0 percent) were the top five conditions reported.

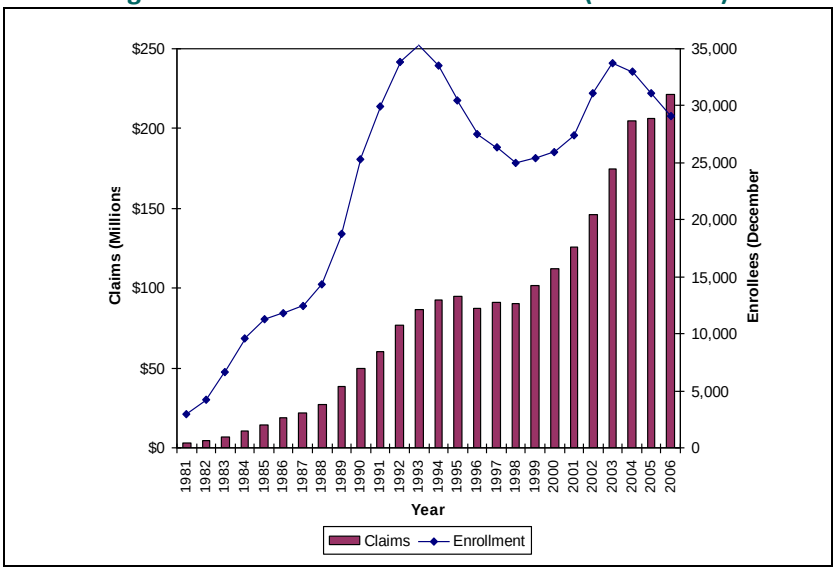
Enrollment and Claims

With approximately 30,000 enrollees participating at the end of 2006, Minnesota's MCHA program is the largest state high risk pool in the country.[17] Even so, MCHA makes up less than 3.0 percent of the state's total enrollees in public health programs. Taking into consideration the entire state population, MCHA supports less than 1 percent of the population overall (see Appendix for more information on health care coverage in Minnesota).

[15] MCHA, 2007a.
[16] Betzner et al., 2005.
[17] NACHIP, 2007.

Of course, MCHA enrollment has not always been this high (see Figure 1). Enrollment in MCHA grew consistently between 1981 (2,918 plan participants) and 1993 (35,296 participants). Between 1994 and 1998, enrollment decreased by 25.5 percent to 24,954 members in 1998. Since then, enrollment has fluctuated, but overall has increased by 16.6 percent to 29,089 participants in 2006. At the end of 2006, 4.8 percent of participants were enrolled in the Basic Medicare Supplement Plan, with 95.2 percent of the enrollees spread across the six deductible plans as follows: $500 (18.7 percent); $1,000 (27.5 percent); $2,000 (28.9 percent); $5,000 (9.2 percent); $10,000 (5.1 percent); and high deductible health plan (5.8 percent).

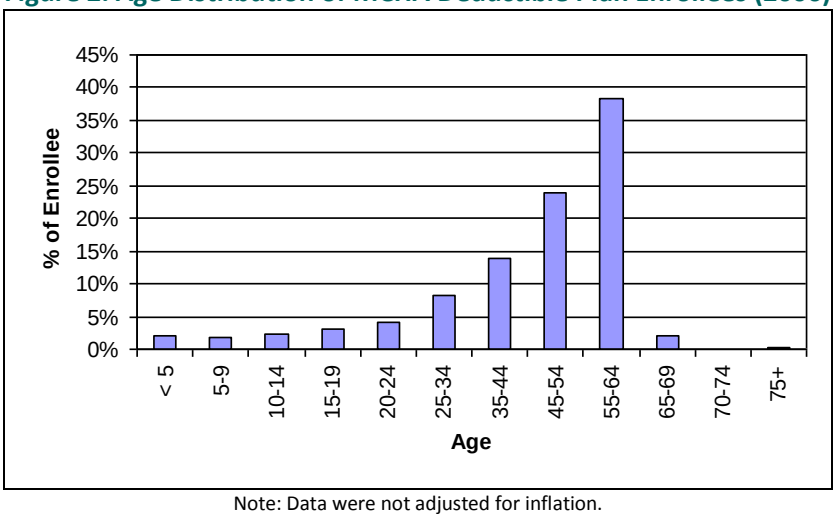
Figure 1. MCHA Claims and Enrollment (1981-2006)



Note: Data were not adjusted for inflation. Sources: CA (2005) and NASCHIP (2007).

Figure 2 shows enrollment by age group for MCHA participants in the individual deductible plans. In 2006, the majority (62.0 percent) of these enrollees were between 45 and 64 years of age, and another quarter (26.4 percent) were 20-44 years. Fewer enrollees were below 20 years of age (9.2 percent) or 65 and above (2.3 percent). Overall, just over half (53.8 percent) of the enrollees were female.

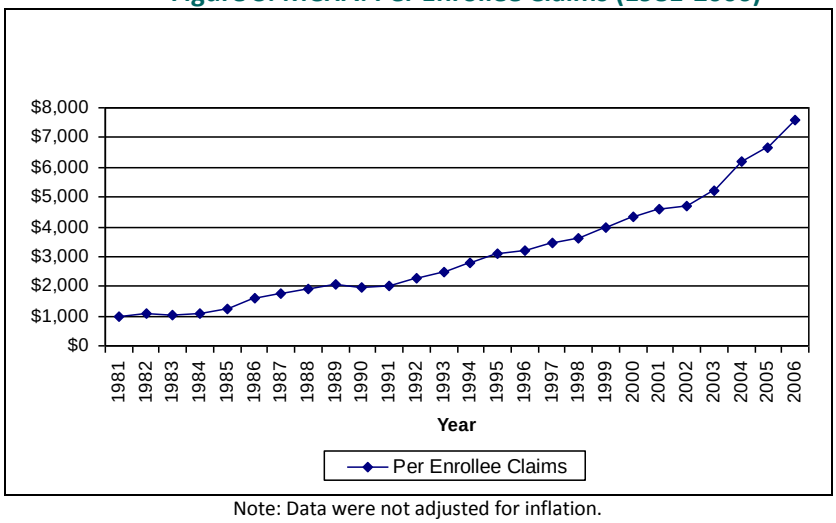
Figure 2. Age Distribution of MCHA Deductible Plan Enrollees (2006)



Note: Data were not adjusted for inflation.
Source: Gruber (2008).

In addition to showing trends in enrollment, Figure 1 presents total claims for all MCHA (both deductible and Medicare supplement) enrollees from 1981 to 2006. With the exception of the late 1990s, when total claims decreased slightly, total claims increased consistently between 1981 ($2.9 million) and 2006 ($221.2 million). Figure 3 presents medical expenditures expressed as total claims per enrollee at the end of each year, revealing a similar steady growth in claims. In 1981, total claims per enrollee amounted to under $1,000; in 2006, that amount was $7,605.

Figure 3. MCHA: Per Enrollee Claims (1981-2006)

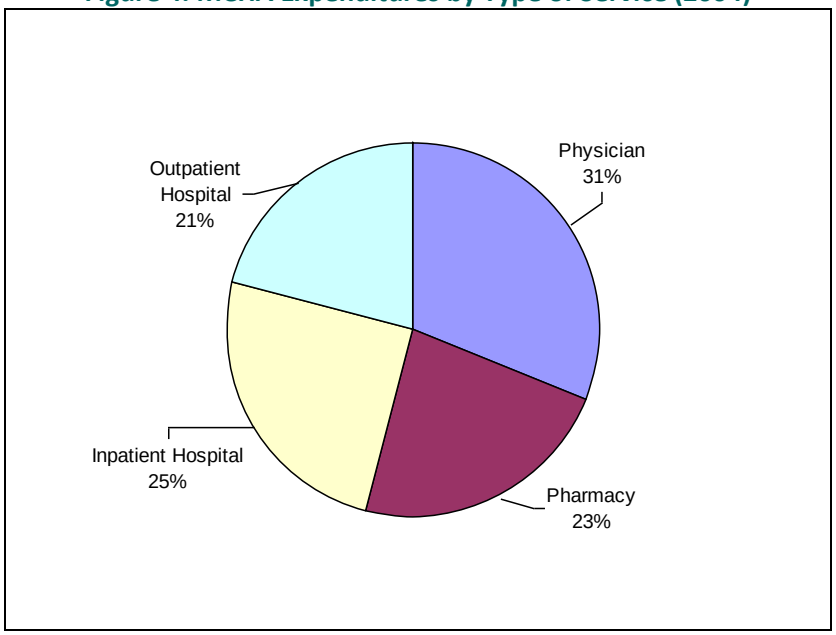


Note: Data were not adjusted for inflation.
Sources: CA (2005) and NASCHIP (2007). Value represents total claims divided by number of enrollees at end of year.

MCHA's 2004 Annual Report[18] provides information on service utilization and expenditures for four categories: physician, pharmacy, inpatient hospital, and outpatient hospital. Figure 4 summarizes the distribution of expenditures for both individual deductible and Medicare supplement plan enrollees combined by type of service for claims during calendar year 2004. A third of all costs were attributable to physician services, followed by inpatient hospital, pharmacy, and outpatient hospital services. For the individual deductible plan enrollees, the top diagnostic categories in terms of costs were cardiovascular, neoplasms, and musculoskeletal (together representing 39.1 percent of costs). For the Medicare supplement enrollees, the top two diagnostic categories, comprising 31.7 percent of costs, were cardiovascular and genitourinary. While only representing 2.1 percent of total MCHA enrollment, catastrophic cases (cases in which claim payments exceeded $50,000 in a year) contributed 34 percent to total expenditures during 2004.

[18] MCHA, 2005.

Figure 4. MCHA Expenditures by Type of Service (2004)



Source: MCHA (2005).

MCHA Organization

The Minnesota Legislature established MCHA as a nonprofit corporation in 1976. Chapter 317A of Minnesota law provides the organizing framework for MCHA as a nonprofit corporation. Chapter 62E of the state law outlines the operations and administration of MCHA, qualified plans, as well as member eligibility, benefits, and premiums. Per Chapter 297I (Section 15, Subdivision 7), MCHA is exempt from the state insurance taxes imposed under this chapter. In accordance with its originating legislation, the Minnesota Department of Commerce regulates MCHA, and the association is governed by a board of directors. The commissioner of commerce is responsible for creating policies related to the pool, approving the carrier to administer the pool, selecting or approving board members, and responding to appeals from plan enrollees.

Board

Historically, MCHA was governed by a nine-member board of directors, including five members representing industry and four public members selected by the commissioner of the Department of Commerce. Under the original arrangement, at least two of the public members were required to be MCHA plan enrollees.

In 2004, the Minnesota Legislature revised the required board composition to include 11 board members. Six members are now selected from contributing health plan carriers. One of these members must be a health actuary, and all private members must be approved by the commissioner. The other five members are public members and are selected by the commissioner. Of the five public members, at least two must be MCHA plan enrollees (as was the case originally), two must represent employers whose insurance premiums are included in the MCHA rate assessment base, one is required to be a

licensed insurance agent, and at least two must reside outside the seven-county metropolitan area in the state.[19]

MCHA Operations

MCHA's everyday insurance operations (including enrollment, premium billing, claims payments, and customer support) are handled by a carrier in the state. Minnesota law allows MCHA to accept bids from state carriers to administer the plan as the writing carrier. Selection must be based on board-established and commissioner-approved criteria. Since 2003, Medica Health Plans has fulfilled the administrative function. The history of MCHA administration (which includes three writing carriers since 1977) is summarized in Table 4.

Table 4. History of MCHA Administration

Years	Writing Carrier
1977 – 1982	Northwestern National Life Insurance Company
1983 – 2003	Blue Cross and Blue Shield of Minnesota
2003 – present	Medica Health Plans

Sources: MCHA (2000) and CA (2005).

MCHA Financing

Since its inception, MCHA has been supported by two main sources of funding: enrollee premiums and annual assessments on insurers selling in the individual and group health insurance markets within the state of Minnesota. (Due to the federal Employee Retirement Income Security Act (ERISA) of 1974, self-insured employer plans are protected from these assessments.) In addition, state general fund appropriations have helped to support the pool at a few points in time in MCHA's history.[20]

Typically, about half of the program's total funding has come from enrollee premiums.[21] In 2005, premiums totaled $113.3 million, about 51 percent of total funds. State law requires MCHA premiums to fall between 101 to 125 percent of the average premium for a comparable individual plan in the commercial market. Currently, MCHA's premium rates, which are set by the commissioner, are at approximately 119 percent of the market (MCHA, 2007b). Since 2004, there have been two premium rates: a tobacco-user premium rate and a standard premium rate (for nonusers). Table 5 shows the standard and tobacco-user rates currently in effect for the six deductible plans.

[19] A list of the current board members is available at www.mchamn.com/html/board.html.
[20] CA, 2005; NASCHIP, 2007.
[21] MCHA, 2005.

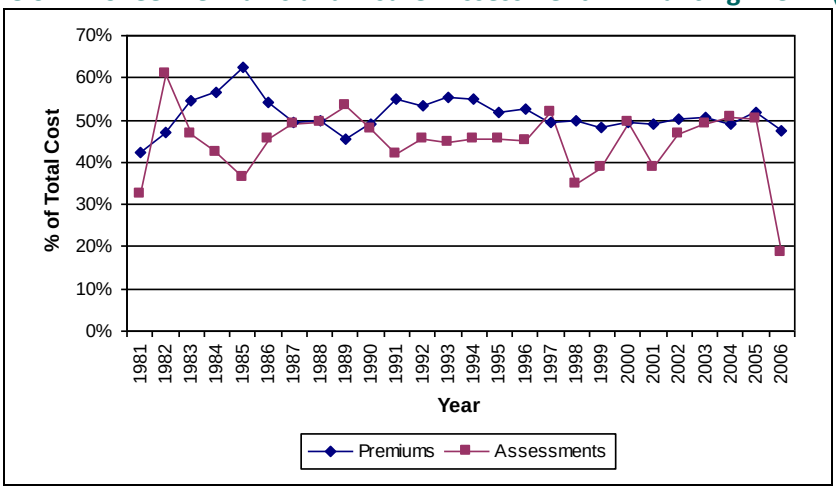
Table 5. MCHA Standard and Tobacco-User Monthly Premium Rates (July 2007-June 2008)

Age	$500 Deductible		$1,000 Deductible		$,2000 Deductible		High Deductible		$5,000 Deductible		$10,000 Deductible	
	S	T	S	T	S	T	S	T	S	T	S	T
< 15	$252	$315	$187	$234	$153	$191	$148	$184	$113	$142	$77	$96
15-29	$260	$325	$191	$239	$157	$196	$152	$190	$117	$147	$80	$100
30-34	$288	$360	$210	$263	$172	$215	$165	$206	$130	$163	$89	$111
35-39	$303	$378	$222	$278	$183	$229	$175	$219	$135	$169	$92	$115
40-44	$338	$422	$249	$311	$205	$256	$197	$246	$150	$188	$103	$129
45-49	$413	$517	$305	$381	$250	$313	$242	$303	$186	$232	$127	$159
50-54	$539	$674	$397	$496	$326	$407	$312	$389	$242	$303	$166	$208
55-59	$685	$857	$510	$637	$409	$512	$389	$486	$306	$383	$209	$261
60-64	$755	$944	$559	$698	$456	$570	$439	$549	$340	$425	$230	$288
65+	$756	$944	$560	$699	$457	$572	$441	$551	$340	$425	$230	$288
1 Child	$222	$222	$156	$156	$117	$117	$111	$111	$94	$94	$68	$68
2 Children	$443	$443	$312	$312	$235	$235	$221	$221	$188	$188	$136	$136

Source: MCHA (2007c). S= Standard; T= Tobacco-user. Rates are rounded to nearest dollar.

The annual insurer assessments are determined by MCHA, approved by the commissioner of commerce, and based on the proportion of each insurer's volume of premium revenue to the total premium revenue generated by all relevant insurers in Minnesota. In 2005, insurer assessments totaled $102.9 million (or 49 percent of total pool funds). It has been estimated that the assessments result in a 2 percent increase in commercial health insurance premiums.[22] Figure 5 shows the relative role of enrollee premiums and insurer assessments in MCHA funding each year between 1981 and 2006. The drop observed in 2006 insurer assessments pertains to another source of funds (tobacco settlement funds) secured during that year.

Figure 5. Role of Enrollee Premiums and Insurer Assessment in Financing MCHA (1981-2006)



Source: Calculations based on information from CA (2005) and NASCHIP (2007).
Value represents total premiums (or total insurer assessments) divided by total costs. Premium and assessment contributions may not total 100 percent in a given year. In some years, state appropriations or tobacco settlement funds supplemented premiums and insurer assessments.

[22] MCHA, 2007b.

As mentioned previously, state funds have been leveraged to subsidize MCHA costs and offset losses at several times during the program's history.[23] First, until 1987, the state subsidized contributing insurers by granting them a 100 percent income and premium tax offset against the MCHA assessments. This part of the law was repealed in 1987, and the tax offset has since been discontinued. Then, during its 1997 session, the Minnesota Legislature appropriated $30 million to MCHA for a two-year period (1998 and 1999) from the state's Health Care Access Fund (HCAF). Because the HCAF is funded by a hospital and provider tax, which is allowed to be passed-through to payers including self-funded purchasers, self-funded plans indirectly contributed to MCHA during these two years. Later, $15 million was appropriated to cover MCHA's losses in 2001. These monies came out of a surplus from the Minnesota's Workers Compensation assigned risk plan.[24]

Finally, one other source of revenue has supported MCHA: 1998 tobacco settlement funds paid to Blue Cross and Blue Shield of Minnesota. Approximately $73.9 million were disbursed to MCHA to offset losses/insurer assessments in 2006.[25]

IV. Key Lessons for New York

MCHA is a stable, mature, and well-managed high risk pool that has been viewed as a relatively small but important component of Minnesota's health care system and safety net option for the uninsurable. There are several issues and insights from MCHA for New York (and other states) to take into account when considering the inclusion and design of an individual high risk pool.

Implementation and Organization of a High Risk Pool

Overall, the private/non-profit health plan arrangement with public oversight and a liberal policyholder appeal process has resulted in a strong, flexible, and efficient design for Minnesota. Inherent in this approach is the involvement and a "balance of power" among key stakeholders, including the Department of Commerce, insurance companies, board members, and plan enrollees. In 1989, policyholders also established a nonprofit "to represent the interests of MCHA policyholders before the MCHA governing board, the Minnesota Legislature, public officials, and the public at large" (Association of MCHA Policyholders, 2008).

One related success associated with the implementation of MCHA is the involvement of multiple stakeholder perspectives. While the Department of Commerce oversees and regulates the pool, it established committees early on to give opportunities for stakeholders (health care providers, hospitals, carriers) to provide input and participate in the implementation of the pool, particularly the development of the operating rules. The statute creating the pool provided parameters for design and implementation, but flexibility was built into the language, allowing Department of Commerce and stakeholder input.

High Risk Pool Administration/Management

Because there is no employer or agency to push for change or for better managed or preventive care, there has been little incentive for MCHA to innovate or to be a market leader. Indeed, MCHA is one of the few fee-for-service health plans left in Minnesota. With its current writing carrier, MCHA uses

[23] See, for example, MCHA, 2005; CA, 2005; and NASCHIP, 2007.
[24] CA, 2005.
[25] NASCHIP, 2007.

Medica's disease management services, covering approximately 60 different conditions. Also, it has started an incentive-based health and wellness program for all members, available via the Internet.[26] Otherwise, MCHA enrollee service utilization is managed largely through co-payments and deductibles.

Market Issues

By directing residents with serious (and costly) health problems to MCHA, Minnesota's high risk pool has helped to stabilize the private individual market in the state. Further, MCHA eligibility rules, underwriting practices, and dependent/spouse inclusions also have stabilized the high risk pool by allowing relatively healthy individuals into the pool, as well. The average cost per enrollee has been comparatively low due to the number of healthy individuals.

In 2004, the Department of Commerce, in collaboration with MCHA, studied the eligibility criteria used for pre-existing conditions.[27] The study compared MCHA with other state high risk pools and examined the underwriting practices of the health care market. MCHA, along with a subset of other state pools, automatically accepts an applicant into the pool if the applicant has one of the pre-existing conditions (even if the applicant does not have proof of insurance rejection). Some believe that there is little oversight of the underwriting practices in the individual market and that some people are underwritten too easily. This study found that the underwriting practices of carriers would not likely insure anyone with one of the major health conditions, but concluded that additional market regulations would render the market more vulnerable and there should be no changes to MCHA.

Related to underwriting in the state, a House bill (HF3991) recently was proposed during the 2008 legislative session for the Department of Commerce to convene a risk adjustment advisory council (comprised of representatives from the insurance industry, MCHA board, safety net providers, and consumers). The bill proposed that the council conduct a study of MCHA financing and review "whether the affordability needs of persons with health problems can be addressed through guaranteed issue, with no premium penalty for health history and not allowing pre-existing condition limitations." The bill did not pass.

High Risk Pool Expenditures and Cost Control

A prominent concern with MCHA pertains to growth in costs, and this concern is not unique to Minnesota's pool. "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."[28]

Historically, enrollment caps have not been used to control costs in Minnesota; instead, other mechanisms have been considered. For example, MCHA involves a large network of providers and enrollees generally are satisfied with MCHA benefits. However, to make MCHA more affordable in the future, some consideration has been given to limiting the provider network or establishing network tiers to reduce costs.

[26] Ibid.
[27] Minnesota Department of Commerce and MCHA, 2005.
[28] NASCHIP, 2007, p. 11.

High Risk Pool Financing

"All state risk pools inherently lose money and need to be subsidized."[29] As previously mentioned, MCHA has been supported primarily through enrollee premiums and insurer assessments, with occasional support from the state. Minnesota's high risk pool premium rate level (up to 125 percent of the standard risk rate) falls at the lower end of rate limit levels used in other states. In most states, the maximum is at least 150 percent and, in a handful of states, it is 200 percent.[30] Legislators have considered increasing the premium range used for MCHA.

Given that MCHA helps to address both fully-insured and self-insured market failures, some believe that the MCHA insurer assessment financing mechanism should be broader, with insurer assessments based on not just fully-insured plans (consisting of many small businesses and individuals) but also self-insured plans (typically large employers). ERISA legislation currently prohibits assessments on the self-insured plans. Compounding this concern is recent growth in self-funded plans (representing 59.6 percent in the state's private market in 2005) and the ramifications for the overall size of MCHA's assessment base. Some legislators and policy analysts have considered alternative mechanisms to building health care resources, such as third party administrator assessments similar to those implemented in Maine, and provider taxes.

Finally, regarding public subsidies, state appropriations have been used irregularly to offset MCHA losses during the pool's 31 years of existence. During the first few years of MCHA, tax write-offs were used to subsidize insurer assessments. Since then, the state appropriated funds to offset pool losses for three years, for a total of $45 million. Some believe that there is a need for more regular state funding for MCHA. A concern related to state funding, however, is its consistency and stability. Some believe that relying on annual state budgets may make pool funding more uncertain. In this context, insurer assessments have been viewed by some as more predictable.

Affordability of High Risk Pools for Individuals

While Minnesota's high risk pool premiums are relatively low (capped at 125 percent of the private individual market average), many enrollees still cannot afford the premiums (and may not reach the deductible, especially in the case of the high-deductible plans). One feature MCHA has used to enhance its affordability for enrollees is a split deductible — one for medical services and a separate deductible for prescription drugs. Excluding preventive care from the required deductible is another example of an affordability option that has been considered.

Additionally, subsidies for low-income MCHA enrollees have been available four times in the pool's history: 1998, 2005, 2006, and 2007.[31] Federal grant funds supported these subsidies. In 2007, 2,422 MCHA beneficiaries below 200 percent of the federal poverty level received subsidy checks.

[29] Minnesota Department of Commerce and MCHA, 2005.
[30] NASCHIP, 2007.
[31] Ripley, Brodsho, and Nwoke, 2007.

V. High Risk Pool as One Option for a State's Management of Risk

A final consideration pertains to high risk pools in the context of a state's broader range of options for managing risk (i.e., high health care costs). Private health insurance pools manage risk across people; the larger the group, the better ability to manage or spread the risk. If an individual in the group has a catastrophic health event, the entire risk of the group increases, which leads to increases in premiums. Adverse selection occurs when a group experiences a disproportionate enrollment of individuals with high medical costs.[32]

There are two key concerns with health risk from a state policy perspective. One is to assist those with health needs in gaining access to affordable coverage. The other is helping carriers and small employers provide affordable coverage by alleviating concerns for adverse selection. States have employed several methods to manage risk. Each uses different financing mechanisms and state regulations to achieve affordable coverage in the private market.

High Risk Pools

The majority of states have established high risk pools that offer health insurance coverage to "uninsurable" residents – individuals with health problems who private insurers have turned down or for whom insurers have dramatically increased premium rates. For these individuals, high risk pools offer an important (often the only) source of available coverage. In the case of Minnesota, the primary financing mechanisms are enrollee premiums and an assessment on the fully-insured products offered in the private market. By pooling these high risk individuals, the rest of the individual (and small group) market has a lower risk on average.

The advantage of a high risk pool is that states have provided an opportunity for coverage for the uninsurable. The disadvantage is that even with the premiums capped at 125 percent of the average individual market premium, the premiums are still fairly expensive. There also is little evidence that high risk pools have increased small employer offerings. In addition, direct general fund subsidy may be required if costs are such that the fully-insured market cannot afford the assessments or if the fully-insured market declines in terms of covered lives.

Reinsurance

Reinsurance is an insurance product for insurance companies. The idea is that, especially for the individual and small group markets, if a group experiences costs above a certain threshold, the government will pick up the costs. These programs are designed to help insurers better predict costs and lower premiums, helping make coverage more affordable for individuals, small employers, and their employees. These programs typically are financed from general fund dollars and tied directly to the individual and small group health insurance markets (as in the case of the Healthy New York program). There is evidence that generous publicly-subsidized reinsurance can significantly reduce premiums.[33]

Reinsurance is a mechanism to help private carriers to offer affordable products in the individual and small group markets. However, the state general fund subsidy must be fairly large to affect premiums. For many states, general fund financing is not an option.

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[32] Swartz, 2005.
[33] Bovbjerg et al., 2008.

Community Rating

State insurance regulation provides some protection to individuals and small employers in regulating how much premiums can increase in a given year, and also limits the amount of risk rating associated with such factors as age, gender, and location. These rules are called “rate bands.” With community rating, insurance companies are required to charge the same premium to everyone regardless of age, gender, or health status. This is in contrast to experience rating, where insurers charge different premiums to various groups of people based on age, gender, and other factors associated with expected health care costs. Underwriting is the mechanism used by insurers to collect information from individuals to help project expected costs, which are translated into premiums. Community rating guarantees that individuals with health conditions or older people are not charged more than other members of the group.

The key concern with community rating is that insurers that face high risk in their plans (adverse selection) may not be able to cover the costs of providing health insurance. Insurers may opt to leave the market entirely to avoid ongoing losses due to community rating requirements. Community rating may work when pools are large enough to spread the risk across a large number of individuals.

Guaranteed Issue

State insurance regulation can require insurers to accept applicants for coverage without regard to their health status or previous claims experience. States must provide a guaranteed-issue product for federally eligible individuals as part of the HIPAA regulations, and most states use their high risk pool as their guaranteed issue product. A more comprehensive guaranteed issue approach (which is not required by federal law and therefore voluntary for states) is to require all insurers to take on anyone or any employer that applies. Separate provisions address how groups can be rated for premium levels.

Guaranteed issue does not address the affordability of premiums. It provides access to coverage but this coverage, especially if individually rated, may still be unaffordable. Guaranteed issue can be coupled with rating requirements but, again, this may force some carriers into unsustainable losses.

Overall, each state must address the unique characteristics of its population, the public program environment, and insurance regulation as a means to increase access and coverage for its population. For some states, general fund financing or subsidy is not an option due to a poor economy or general low tax rates. Community rating and guaranteed issue without some additional relief for private insurance carriers may only work in large populated markets. High risk pools are one option for states to pursue using enrollment caps to keep costs down or to assist in affordability through direct government subsidy or reinsurance of the costs of the pool.

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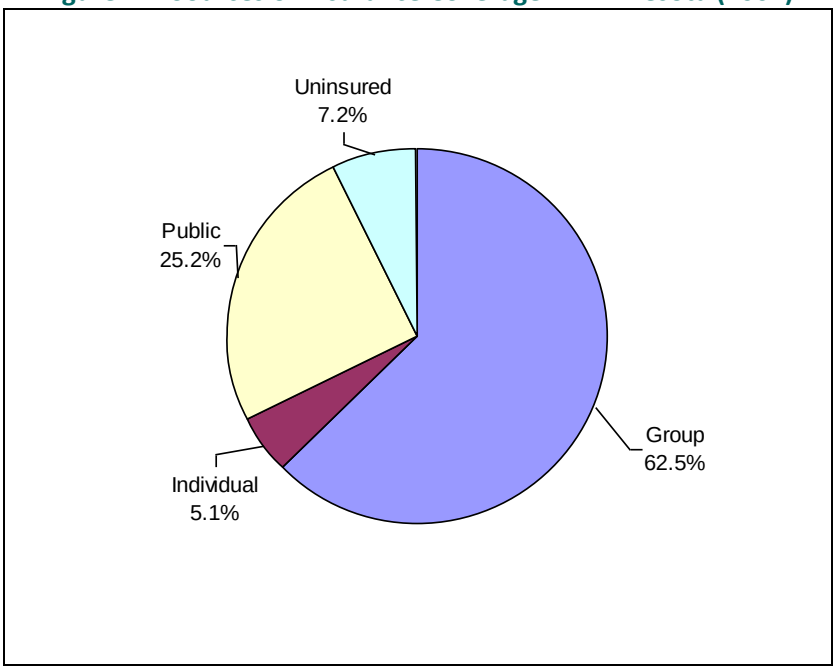
Appendix: Overview of Health Care Financing and Health Insurance Coverage in Minnesota

According to data from the March Supplement of the Current Population Survey, Minnesota's rate of uninsurance was 8.6 percent for 2005/2006, lower than the national uninsurance rate of 15.5 percent. (During the same time, New York's uninsurance rate fell in between at 13.5 percent.)[34] A very recent state survey on health insurance coverage in Minnesota found that the uninsurance rate in 2007 was 7.2 percent (see Figure A1 below), which remained statistically unchanged from 2004 (7.7 percent), when the state survey was last conducted. According to the 2007 survey, 71.3 percent of uninsured Minnesotans are employed,[35] and the percentage of these working for small businesses is 44.1 percent.[36]

Public programs provide health insurance coverage to 25.2 percent of Minnesota's total population (Figure A1). As shown in Figure A2 on the following page, the state's high risk pool (MCHA) makes up less than 3.0 percent of public health plan enrollees. Taking into consideration the entire state population, MCHA supports less than 1 percent of the population overall.[37]

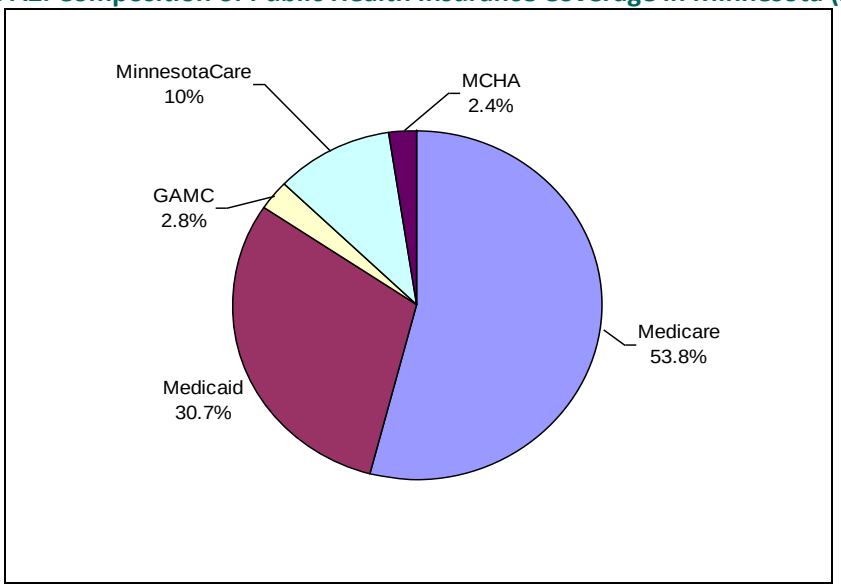
Figure A1. Sources of Insurance Coverage in Minnesota (2007)



Source: Minnesota Department of Health and University of Minnesota School of Public Health (2008). Based on all age groups.

[34] Based on analyses of 2006 and 2007 Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC) data. Estimates include all age groups.
[35] For uninsured children, the employment characteristic refers to a parent.
[36] Minnesota Department of Health and University of Minnesota School of Public Health, 2008.
[37] Data not shown. Minnesota Department of Health, Health Economics Program, 2007b.

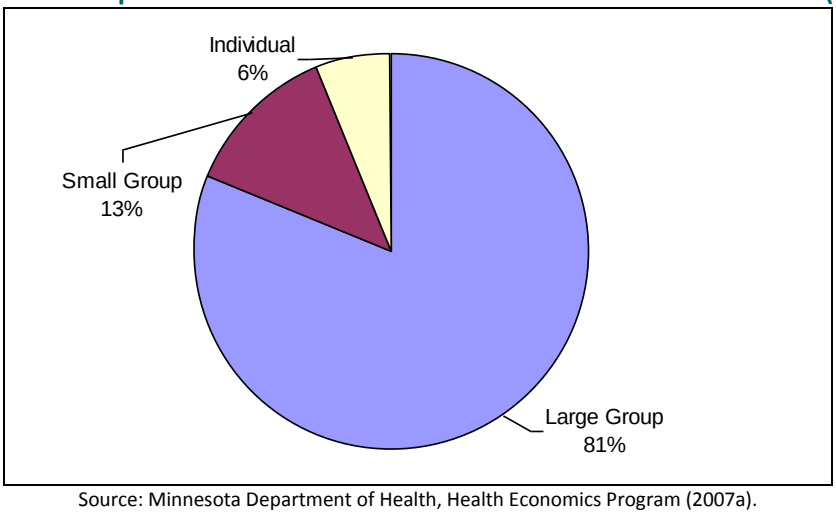
Figure A2. Composition of Public Health Insurance Coverage in Minnesota (2005)



Source: Minnesota Department of Health, Health Economics Program (2007b).

The majority of Minnesotans get their health insurance coverage in the private market (67.6 percent in 2007, see Figure A1). Of those privately insured, the overwhelming majority (94 percent) are insured in the group market, with only 6 percent having coverage from the individual market (see Figure A3). In Minnesota, 81.0 percent of the private market is enrolled in large group health plans (plans with greater than 50 employees), and 13 percent have coverage through a small group plan (2-50 employees). In 2005, an estimated 40.4 percent of the private market was fully insured (that is, employers pay insurers to bear the risk associated with employees' health care costs), and 59.6 percent were self-insured (usually large companies that elect to bear the risks themselves but may have an insurance company manage the plan).[38]

Figure A3. Composition of Private Health Insurance Market in Minnesota (2005)



Source: Minnesota Department of Health, Health Economics Program (2007a).

[38] Data not shown. Derived from data presented in Minnesota Department of Health, Health Economics Program (2007b).