



Policy Short Takes: Minnesota Comprehensive Health Association

A STATE-BASED HIGH-RISK POOL

This policy short take outlines the history, costs and policy challenges associated with the implementation of the Minnesota Comprehensive Health Association (MCHA), Minnesota's high-risk health insurance pool that existed from 1976 to 2014.

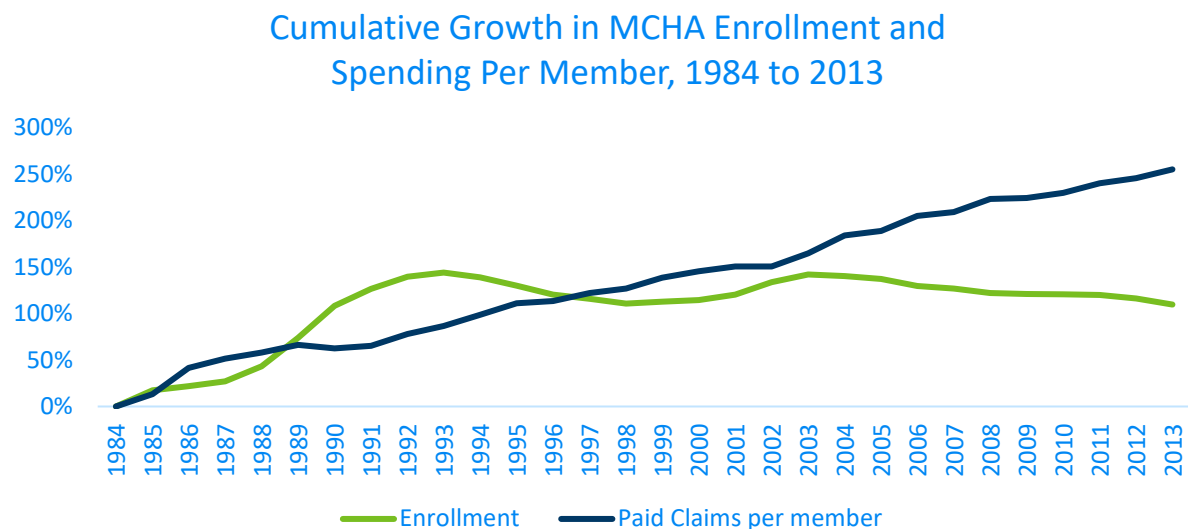
What was the Minnesota Comprehensive Health Association?

- The Minnesota Comprehensive Health Association (MCHA) was created in 1976 by the state legislature to provide access to health insurance for Minnesota residents who did not have other coverage options. At its end, MCHA was the country's oldest and second-largest state-based high-risk pool.
- MCHA was governed through a nonprofit board model controlled by the insurance industry, with input from stakeholders. Peak enrollment was in 1993 with just over 35,000 (the annual average was around 20,000).
- The need for MCHA ended when the Affordable Care Act (ACA) took effect in January 2014 (namely, guaranteed issue and renewability). No longer forced out of the individual market, MCHA enrollees were able to access coverage in the private, unsubsidized insurance market or transitioned to Medicaid, MinnesotaCare, and MNsure (Minnesota's state health exchange).
- Enrollees paid significant premiums (in 2013, 24,975 enrollees paid \$121.05 million in premiums), but premiums did not fully fund the program. For example, claims losses totaled \$175 million in 2013.
- Premiums were set between 101 percent and 125 percent of comparable market rates. Monthly premiums could range from less than \$100 to more than \$800, depending on the size of required cost sharing. There was a \$5 million lifetime maximum per person.
- When MCHA was in place, MinnesotaCare was available for certain individuals with incomes up to 275 percent of the poverty line. Today, MinnesotaCare eligibility extends only to 200 percent of the poverty line. Therefore, restoring MCHA today, absent other public program changes, means the number of Minnesotans potentially eligible for the program could be much greater than when the program ended. Additionally, new enrollees with lower incomes would be less likely to afford MCHA premiums.

What were the Costs and Policy Impacts of Minnesota's High-Risk Pool?

- MCHA did not “fix” the individual market. Although premiums rose fairly modestly year over year, the comprehensiveness of benefits eroded through increasing deductibles and cost-sharing.

Figure 1: High Costs to Consumers - Spending Per Member Rose Faster than Enrollment



Source: Minnesota Department of Health Analysis of MCHA Writing Carrier Reports

- MCHA was not affordable for many. Premiums were expensive for individuals by any standard (and to the system). Not all high-risk individuals likely signed up to get the coverage they needed.¹
- While there was a premium subsidy available, it was limited in scope (only 1,590 people, or about 6 percent of enrollees, received a subsidy in 2013).
- Even some who signed up could not afford care, given cost-sharing provisions. Over one in four MCHA enrollees did not get needed medical care due to cost in 2012 – 9 percent were MA eligible, another 37 percent were between 138 percent and 200 percent of poverty.²
- Across all states with high-risk pools, the high costs and limited benefits associated with high-risk pool coverage resulted in delayed or forgone care and adverse outcomes for enrollees. Many patients also accrued medical debt despite having insurance.³

Effects on Quality and Access

- By concentrating insurance risk, high-risk pools also concentrate costs. This tends to result in greater expenses to administrators and consumers, driving plans to impose severe coverage limits that often negate the benefit of insurance.

- MCHA may have actually reduced the incentive to manage care better for the most costly patients (e.g., through care coordination, delivery of social supports, prescription drug management, etc.) since risk was borne across state insurers (and ultimately premium payers) in the fully insured market, not by individual carriers or the plan administrator.
- Pronounced adverse selection is common in high-risk pools because only the sickest and most expensive individuals are willing to pay the high premiums for coverage. This increases administrative costs even more.

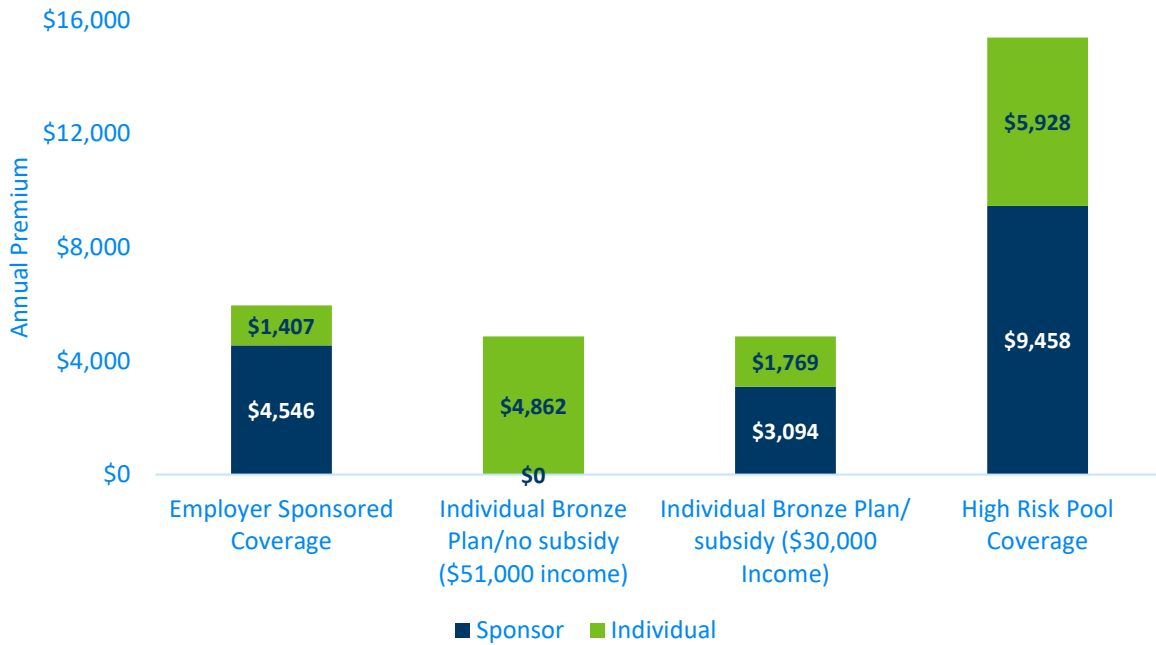
State Funding and Bailouts

- Funding was a challenge for MCHA and all high-risk pools. Because MCHA covered people with some of the greatest medical needs, premiums covered approximately 43 percent of the health care claims filed by MCHA enrollees. The remaining 57 percent of claims expense was paid by an assessment on the health insurance industry.
- The health insurance industry built the assessment into their premiums purchased in the fully insured market – the individual, small group, and large-group insured markets’ policies, as well as the stop loss market.⁴
- Because the assessment had a narrow base, it had a measurable impact on the cost of policies, raising premiums in the commercial market by an estimated 2 percent.⁵
- In total, claims losses—health care spending not covered by premiums—amounted to nearly \$176 million in 2013 or an assessment of \$28 per \$1,000 in premiums.
- The Minnesota Legislature also appropriated state funds of \$15 million to cover MCHA losses in 1998, 1999, and 2001. These funds came from various sources, including the Workers Compensation assigned risk plan and the General Fund.
- Additionally, MCHA received \$70 million from the Blue Cross Blue Shield tobacco settlement in 2002 to offset the 2003 losses. In 1997, \$30 million from the Health Care Access Fund was used to subsidize MCHA for a two-year period.⁶

Cost Estimates for MCHA in 2017

- Had MCHA remained a risk pool for high-risk enrollees and continued at the previous trajectory, it would have remained an expensive program.
- In 2017, the estimated average annual premium of MCHA policies with deductibles would be approximately \$5,928, just over \$1000 per year more than the cost of the current bronze plan policy for a 40-year-old in Morris, Minnesota and over four times as much as the average premium paid by employees for employer-sponsored coverage.
- However, that premium by itself would likely cover only 38 percent of the average claims costs, requiring an average subsidy of \$9,458 per enrollee funded through an assessment or another funding mechanism (Figure 2).

Figure 2: Comparison of 2017 Annual Premiums by Source of Coverage and Income, 40-year-old in Morris, Minn.



Source: MDH/Health Economics analysis of data from the Medical Expenditure Panel Survey – Insurance Component, rate filing data in the individual market (Stevens County/Rating Area 6, selected because premiums are similar to the state average) and average projected MCHA premium data. Subsidies are income-based Advanced Premium Tax Credits, available through MNSure; High-Risk Pool is based on Minnesota Comprehensive Health Association (MCHA) Costs

End Notes

¹ MCHA enrollees represented about 10 percent of non-group market enrollment in 2011, but an estimated 27 percent of all adults under the age of 65 have health conditions that render them uninsurable. K. Pollitz, “High-Risk Pools for Uninsurable Individuals” KFF.org Issue Brief, February 2017. Available at: <http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>

² 2012 MCHA survey (SHADAC) <http://www.shadac.org/publications/minnesota-comprehensive-health-association-enrollee-survey-assessing-results-chartbook>

³ J. P. Hall and J. M. Moore, “Does High-Risk Pool Coverage Meet the Needs of a Population at Risk for Disability?” Inquiry, Fall 2008 45(3):340–52; J. P. Hall, S. L. Carroll, and J. M. Moore, “Health Care Behaviors and Decision-Making Processes Among Enrollees in a State High-Risk Insurance Pool: Focus Group Findings,” American Journal of Health Promotion, May–June 2010 24(5):304–10; and J. P. Hall, J. M. Moore, and G. W. Welch, “Preventing Disability Among Working Participants in Kansas’ High-Risk Insurance Pool: Implications for Health Reform,” Journal of Vocational Rehabilitation, 2011 34(2):119–28.

⁴ Stop loss insurance limits protects employers with self-funded health plans when employees or their dependents experience catastrophic illness or accident. It also protects self-funded employers when their total group medical costs are higher than anticipated.

⁵ L. Blewett, "State High-Risk Pools: An Update on the Minnesota Comprehensive Health Association" American Journal of Public Health, February 2011 101(2): 231-237, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3020190/>

⁶ The health care access fund (HCAF) was created to increase access to health care, contain health care costs, and improve the quality of health care services in Minnesota. Revenues to the fund come from a 2 percent tax on providers; a 1 percent gross premium tax; MinnesotaCare enrollee premiums; investment income earned on the balance of the fund; and federal match on administrative costs. HCAF provides funding to MinnesotaCare and Medical Assistance.

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