

***Minnesota Comprehensive Health Association (MCHA):***

***Field Research Report***

*Prepared for:*

Rockefeller Institute of Government and New York State Health Foundation

*By:*

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***Introduction***

This report was prepared as part of a state health policy research project led by the Rockefeller Institute of Government's New York State Health Policy Research Center (HPRC) and funded by the New York State Health Foundation. The purpose of the project, "Small Group Market Reforms in the States," is to inform legislative efforts in New York State to increase health insurance coverage in the state's individual and small group markets. HPRC contracted with researchers to generate in-depth information about the small group market contexts in three other states (Maine, Minnesota, and New Jersey) and select policy approaches used by these states to broaden access to health insurance coverage. This report's focus is the state of Minnesota. The report provides information on Minnesota's small group market and one particular program in place within the state to expand coverage to the uninsured: the state's high risk pool, the Minnesota Comprehensive Health Association (MCHA). 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.

## **Report Approach**

In preparing this report, we obtained information from several sources. First, we compiled readily available data, reports, and other information on health insurance coverage in Minnesota, the small group market in the state, and Minnesota's high risk pool. Regarding the latter, we relied on MCHA, the Minnesota Department of Commerce, the Research Department of the Minnesota House of Representatives, and key resources on state high risk pools such as the *Comprehensive Health Insurance for High Risk Individuals: A State-by-State Analysis*, the most recent version (2007/2008) of which was published by the National Association of State Comprehensive Health Insurance Plans (NASCHIP).<sup>1</sup>

In March and April 2008, we also spoke with key informants about MCHA. These included representatives from MCHA, the Minnesota Department of Commerce, Research Department of the Minnesota House of Representatives, and the Health Economics Program housed within the Minnesota Department of Health. All of the individuals have long-term familiarity with MCHA. Finally, we obtained additional reports and data on MCHA from these individuals, including monthly carrier reports to MCHA and MCHA reports to the Department of Commerce.

## **Organization of Report**

The balance of this report is organized into three sections. First, we provide important contextual information for Minnesota: We present an overview of health insurance coverage and health care financing in Minnesota, introduce the small group market in the state, and summarize key state legislation related to the regulation of the state's small group market. The next section of the report provides an in-depth summary of Minnesota's high risk pool, including its

legislative history, organization and management, plan and benefit options, eligibility criteria, and financing. Finally, we highlight some of the key challenges, successes, and issues associated with MCHA.

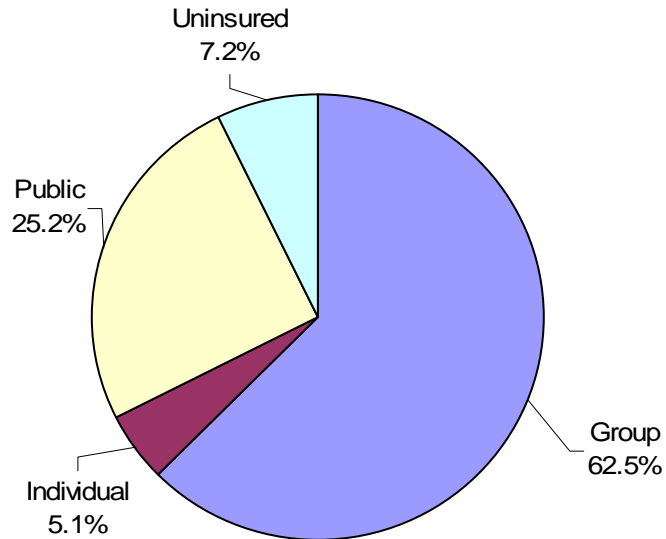
## ***Minnesota Context***

### **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% for 2005/2006, lower than the national uninsurance rate of 15.5%. (During the same time, New York's uninsurance rate fell in between at 13.5%.)<sup>2</sup> A very recent state survey on health insurance coverage in Minnesota found that the uninsurance rate in 2007 was 7.2% (see Figure 1 on following page), which remained statistically unchanged from 2004 (7.7%), when the state survey was last conducted. According to the 2007 survey, 71.3% of uninsured Minnesotans are employed<sup>3</sup>, and the percentage of these working for small businesses is 44.1%.<sup>4</sup>

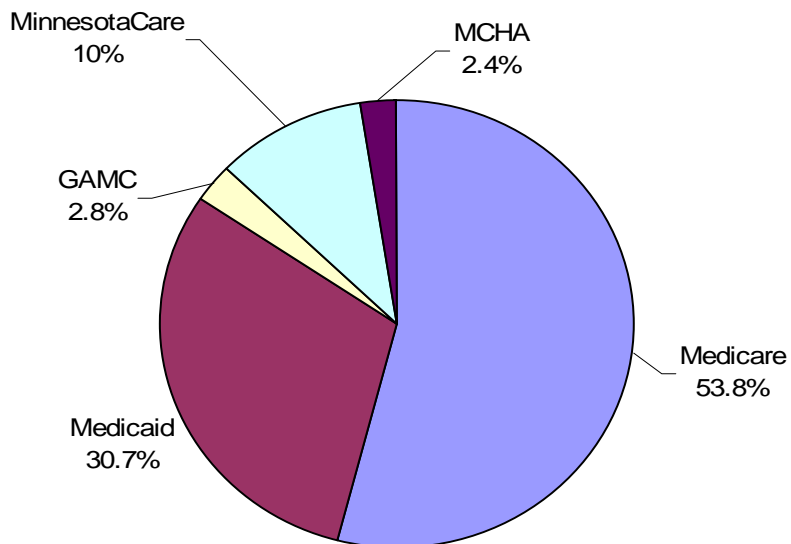
Public programs provide health insurance coverage to 25.2% of Minnesota's total population (Figure 1). As shown in Figure 2, Medicare and Medicaid combined were the source of coverage for approximately 85.0% of those enrolled in public programs in 2005 (representing 21.2% of Minnesota's total population, data not shown<sup>5</sup>). MinnesotaCare, a reduced-cost program for low-income uninsured residents including adults without children, makes up 10.4% of those with public coverage, followed by Minnesota's General Assistance Medical Care (GAMC, a free state health care program for very low-income adults and children who are not eligible for other programs), and the state's high risk pool (MCHA), both of which make up less than 3.0% of public health plan enrollees. Taking into consideration the entire state population, MCHA supports less than 1% of the population overall (data not shown).<sup>6</sup>

**Figure 1. Sources of Insurance Coverage in Minnesota (2007)**



Source: Minnesota Department of Health and University of Minnesota School of Public Health (2008).  
Based on the state's total population.

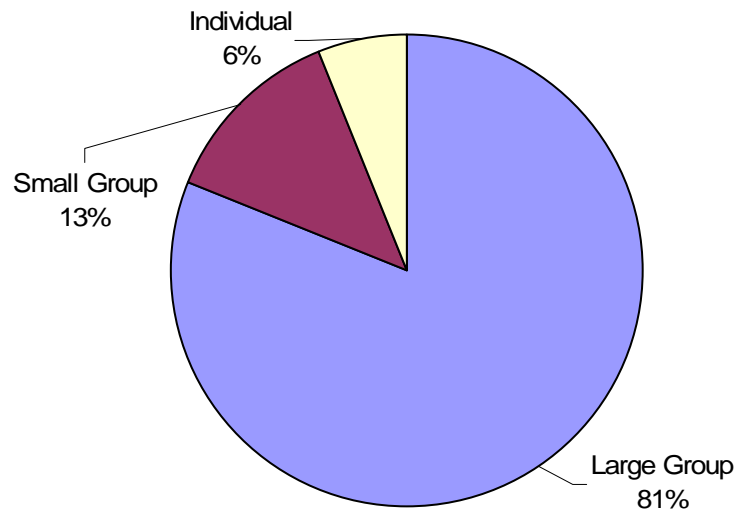
**Figure 2. Composition of Public Health Insurance Coverage in Minnesota (2005)**



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

The majority of Minnesotans get their health insurance coverage in the private market (67.6% in 2007, see Figure 1 above). Of those privately insured, the overwhelming majority (94%) are insured in the group market, with only 6% having coverage from the individual market (see Figure 3). In Minnesota, 81.0% of the private market is enrolled have large group health plans (plans with greater than 50 employees), and 13% have coverage through a small group plan (2-50 employees). In 2005, an estimated 40.4% 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% were self-insured (usually large companies that elect to bear the risks themselves but may have an insurance company manage the plan).<sup>7</sup>

**Figure 3. Composition of Private Health Insurance Market in Minnesota (2005)**



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

### **Small Group Health Insurance Market in Minnesota**

In line with the Health Insurance Portability and Affordability Act (HIPAA) of 1996, Minnesota defines “small group” as employers with 2 to 50 employees.<sup>8</sup> Although, as noted above, only 13% of the private health insurance market in Minnesota was enrolled in small group

health plans in 2005, approximately 91% of private-sector employers in Minnesota during the same year had fewer than 50 employees. Enrollment in fully-insured small group health plans consistently increased in Minnesota between the mid 1990s and early 2000s and amounted to over 438,644 people in 2006.<sup>9</sup>

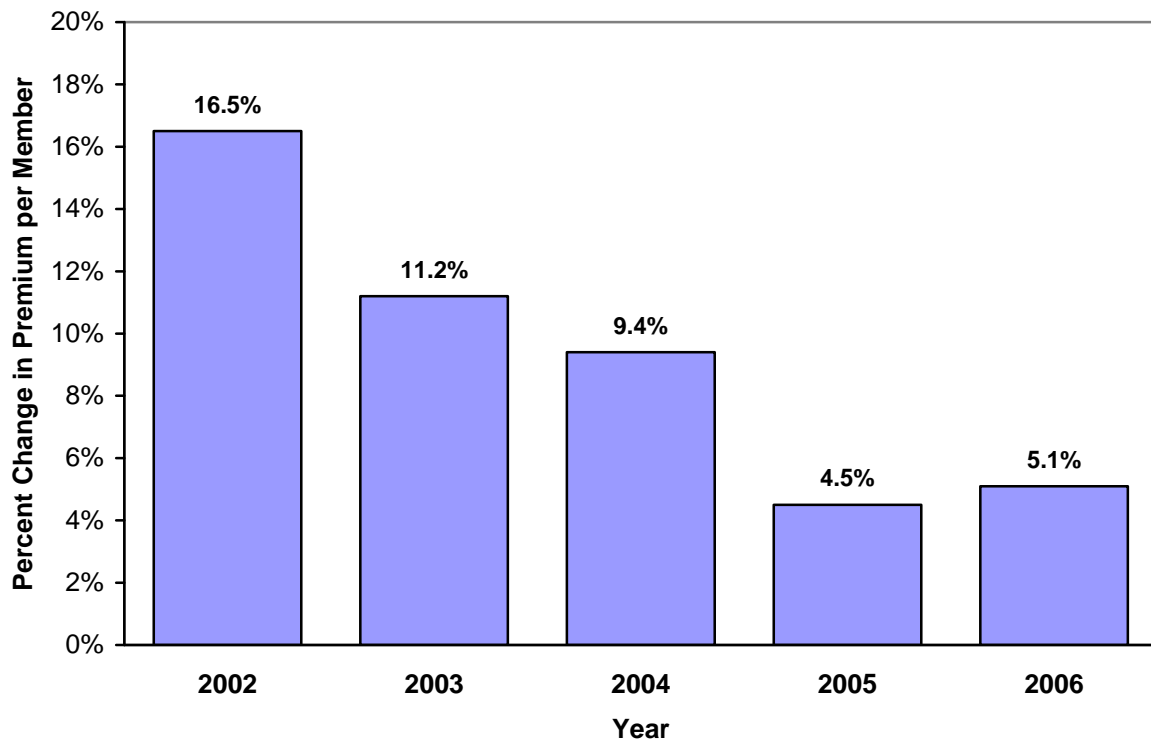
*Small Employer-Sponsored Health Insurance Offer and Take-Up Rates.*<sup>10</sup> Similar to private employers in the U.S. overall, 54.3% of private firms in Minnesota offered health insurance to their employees in 2005. The majority (99.0%) of all private establishments in the state with at least 50 employees offered insurance, compared to only 41.3% of private firms with fewer than 50 employees. This pattern is similar to that found at a national level, where 95.7% of large private firms and 43.4% of small private firms provided insurance coverage. For very small-sized private establishments in Minnesota (i.e., those with fewer than 10 employees), the offer rate in 2005 was particularly low at 31.8%.

In terms of employee take-up of employer-sponsored insurance (ESI), 78.3% of Minnesota's private-sector employees who were eligible for coverage from their employer enrolled in coverage in 2005, which is similar to the national private ESI take-up rate of 79.6%. For private firms in Minnesota with fewer than 50 employees, the take-up rate was 80.2%. For the state's larger private establishments, the rate was 77.9%.

*Premiums.* Health plans in Minnesota's fully-insured small group market generated \$1.5 billion in total premium volume in 2006.<sup>11</sup> It is important to highlight the concentrated nature of the state's small group market: Three providers in the state comprise over 90% of the small group market shares and include Blue Cross and Blue Shield (BCBS) of Minnesota (44.3%), Medica (30.7%), and HealthPartners (17.5%).<sup>12</sup> Minnesota is not alone in terms of its small group market: other states have highly consolidated small group markets as well.<sup>13</sup>

In 2006, the average small market monthly premium in Minnesota was \$324 (for single coverage) and \$849 (for coverage for a family of four), both of which fell higher than the national average.<sup>14</sup> Not surprisingly, small group market premiums in Minnesota have increased consistently in recent years (see Figure 4). The percent change in premium amount per member was particularly high in 2002, 2003 and 2004 (ranging from 9.4% to 16.5%). In 2005 and 2006, the percent increase in small group market premiums was about 5.0%.

**Figure 4. Premium Increases in Minnesota’s Small Group Market (2002-2006)**



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

### **Small Group Regulation in Minnesota**

Federal laws – including the Employee Retirement Income Security Act (ERISA) of 1974 and three amendments to ERISA, the Consolidated Omnibus Budget Reconciliation Act

(COBRA) of 1986, the Mental Health Parity Act (MPHA) of 1996, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 – provide a foundation for more recent health insurance regulation at the state level. States’ small group markets typically are “fully-insured”<sup>15</sup> – that is, the employer pays an insurance company to bear the financial risk. While most group health insurance plans must meet certain federal standards, fully-insured group health plans also are subject to state benefit regulation and rating rules.<sup>16</sup> In line with HIPAA on the federal level, Minnesota defines “small group” as employers with 2 to 50 employees.<sup>17</sup> Minnesota does not have special rules for groups of one (i.e., self-employed individuals).<sup>18</sup>

Here, we discuss guaranteed issue and renewal requirements, pre-existing condition exclusion rules, service coverage requirements, rating approaches, continuation and conversion coverage, and other efforts to regulate small group health insurance in Minnesota. As summarized in Table 1 below, in some cases, the state does not regulate its small group market beyond what is required by federal law; in others, Minnesota augments federal law to reach the small group health insurance market.

**Table 1. Summary of Small Group Health Insurance Market Regulation in Minnesota**

<b>Area of Regulation</b>	<b>Meets Federal Standard</b>	<b>Exceeds/Augments Federal Standard</b>	<b>MN Additions</b>
Definition of Small Group (2-50 individuals)	X		
Guaranteed Issue	X		
Guaranteed Renewal	X		
Pre-Existing Condition Exclusion Rules	X		
Service Coverage Requirements		X	Additional mandated benefits
Mental Health Parity		X	Required parity goes beyond annual/lifetime limits
State Continuation Coverage		X	Expands COBRA to smaller businesses
Conversion Coverage		X	Mandates coverage for fully-insured and limits rates

*Guaranteed Issue and Renewal.* In compliance with HIPAA, Minnesota requires guaranteed issue for all small group market products. That is, an employer with 2-50 employees cannot be turned down for a small group insurance plan by an insurer due to the characteristics (e.g., health status) of the employers' workers. Likewise, an insurer may not refuse to renew coverage for a small group due to group characteristics.

*Pre-Existing Condition Exclusion Rules.* HIPAA limits the pre-existing conditions that can be excluded from coverage by a group plan. Minnesota's laws do not exceed this federal standard.<sup>19</sup> Per HIPAA, the maximum look-back period is 6 months in Minnesota, and the maximum exclusion period under the new coverage is 12 months. Group plans are required to give credit for prior "creditable" coverage, and in calculating this coverage, the maximum lapse period in coverage allowed is 63 days.

*Service Coverage Requirements.* Federal law does not require that health insurance plans cover a minimum set of services. Instead, mandates are implemented at a state level for fully-insured plans, and all states have mandated at least some benefits.<sup>20</sup> Mandated benefits in Minnesota include maternity care, preventive well-baby care, emergency care, cancer screening, hearing aids for children younger than 18 years, certain diabetes-related services, mental health parity (more below) and many other health care services.<sup>21</sup> In addition to traditional plans, all insurers participating in the small group market in Minnesota must offer at least two types of plans (a deductible-type plan and a copayment-type plan) covering a list of minimal benefits prescribed by state statute. As of 2005, small employers in Minnesota may also offer "flexible benefits" plans. These benefit plans must include maternity benefits and meet federal requirements, but do not have to include the otherwise mandated benefits.<sup>22</sup>

Regarding mental health coverage, group health plans that offer mental health benefits are not allowed to have lower annual or lifetime limits for mental health benefits (not including substance abuse or chemical dependency) than limits for medical/surgical benefits. This requirement is in accordance with the federal MHPA of 1996.<sup>23</sup> Additionally, Minnesota exceeds this federal law by also mandating that managed care organizations give parity to both mental illness and substance abuse in terms of other coverage limits such as deductibles, co-payments, and maximum number of office visits.<sup>24</sup> This law only pertains to fully-insured plans.

*Rating Restrictions.* Minnesota places limits on rating for the small group market and uses premium rate bands to restrict rates in the state.<sup>25</sup> Minnesota Statute 62L.07, Subdivision 2 states that “each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage.” Further, the percent increase in a small employer plan rate for a new period is restricted. As of 2002, the state allows carriers to charge new rates upon filing to the Minnesota Department of Commerce as opposed to waiting until the Commissioner’s approval.<sup>26</sup>

*Continuation and Conversion Coverage.* Continuation coverage refers to a short-term extension of group coverage for an individual whose eligibility for that coverage has ended (e.g., termination of employment). In 1986, the U.S. passed COBRA requiring many group health plans to provide access to such continuation coverage. Should a policy holder elect to continue coverage, s/he is responsible for the entire premium amount (including the employer’s share) during the extension period. The federal law only impacts group plans offered by employers with at least 20 employees. As of 2007, 40 states (including Minnesota) have legislation in place requiring access to continuation coverage for group plans held by employers with fewer than 20

employees.<sup>27</sup> COBRA typically provides continuation coverage for up to 18 months (although it can be extended to a total of 36 months for individuals who qualify), and COBRA costs are capped to 102% of the existing group plan premium plus an additional 2% for administrative costs.<sup>28</sup> Minnesota's continuation coverage for small businesses protects policy holders up to 36 months and, as with COBRA, caps the premium rate at 102% of the original group coverage.<sup>29</sup>

Following termination of either COBRA or state continuation coverage, fully-insured group plans are mandated to offer a conversion policy (from group to individual) in Minnesota. The conversion policy may cover standard health benefits similar to the state's high risk pool or be a reduced-premium policy covering fewer benefits. Minnesota law limits the rates insurers may charge for a conversion policy: Premiums for a standard conversion policy may not exceed 90% of the premiums charged by the MCHA for similar coverage.<sup>30</sup>

### ***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 reached the lifetime maximums of their group or other insurance benefits or 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 organization regulated by the Minnesota Department of Commerce and became operational in 1977. 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.”<sup>31</sup>

## MCHA Plans and Benefits

MCHA offers six non-Medicare individual plans and a Medicare supplement plan.<sup>32</sup>

Table 2 summarizes the various non-Medicare deductible plan options.

**Table 2. 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% of expenses.

MCHA benefit plans are comprehensive major medical plans and generally cover the services listed in Table 3. The lifetime maximum amount payable per covered person is \$5 million. MCHA does not cover vision or dental services.<sup>33</sup> 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 will be a covered service as of July 2008.<sup>34</sup>

**Table 3. 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 coverage for 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 that is 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% 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 for state residents in 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 presumptive condition. Table 4 below summarizes the requirements under each of these eligibility categories.

For all eligible persons, MCHA provides dependent coverage for spouses up to age 65 years, unmarried children through the age of 25 years, 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.<sup>35</sup>

**Table 4. Eligibility Categories for MCHA**

<p><b>1. Loss of Group Coverage</b></p> <ul style="list-style-type: none"> <li>- State resident as of date of application</li> <li>- Lost group coverage</li> <li>- Eligible individual under HIPAA</li> </ul>	<p><b>4. Health Related Rejection</b></p> <ul style="list-style-type: none"> <li>- State resident for at least 6 months prior to date of application</li> <li>- Due to health reason(s), rejected for individual health coverage from MN carrier or rejected from health insurance agent in last 6 months</li> </ul>
<p><b>2. Health Coverage Tax Credit (HCTC) Program</b></p> <ul style="list-style-type: none"> <li>- State resident as of date of application</li> <li>- Deemed eligible by federal HCTC program</li> </ul>	<p><b>5. Presumptive Condition(s)</b></p> <ul style="list-style-type: none"> <li>- State resident for at least 6 months prior to date of application</li> <li>- Treated within last 3 years for a special medical presumptive condition (e.g., AIDS/HIV, chemical dependency, and others)</li> </ul>
<p><b>3. Ineligible for Medicare Program</b></p> <ul style="list-style-type: none"> <li>- State resident for at least 6 months prior to date of application</li> <li>- 65 years of age or older</li> <li>- Deemed ineligible by federal Medicare program</li> </ul>	

Source: MCHA Website, available at: <http://www.mchamn.com/html/eligibility.html>

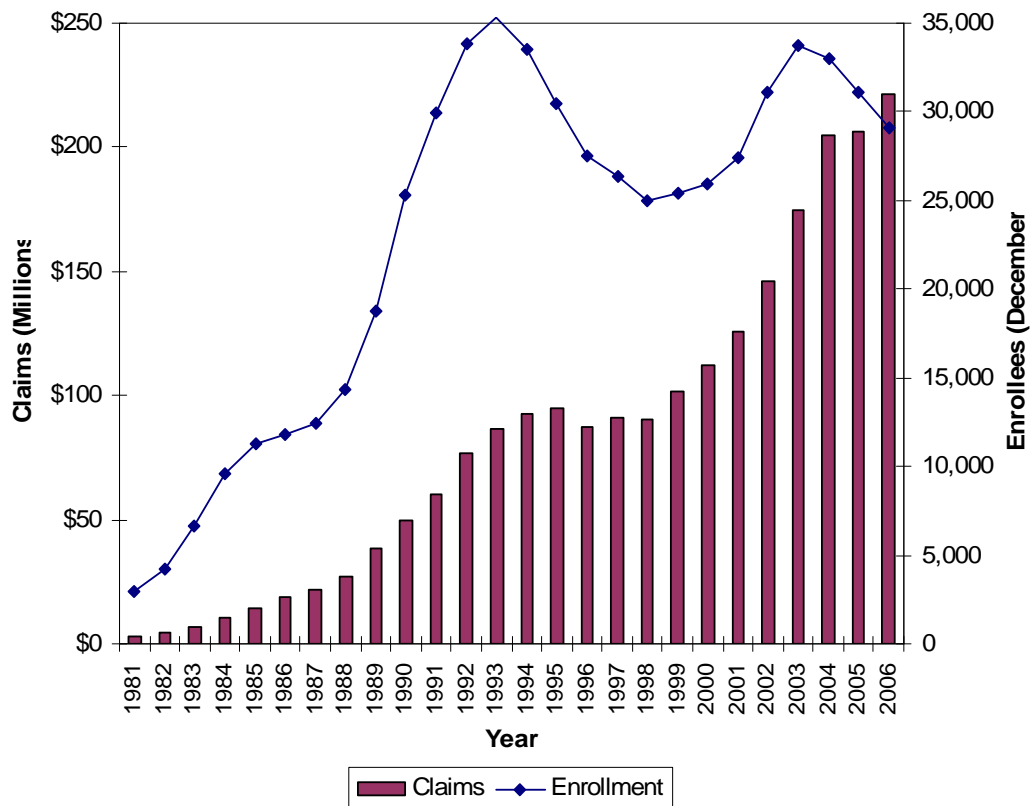
In the fall of 2004, MCHA conducted a survey of a random sample of its enrollees.<sup>36</sup> The majority (68.7%) of respondents (1,640 Medicare and deductible plan members) indicated that being turned down for an individual policy due to a pre-existing condition was a reason for their applying to MCHA. Approximately 23.0% 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% indicated that a reason for applying was that their employer did not offer health insurance. A much smaller percentage, 3.3%, 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%), cardiovascular condition (12.5%), diabetes or other endocrine disorder (12.4%), hypertension (11.4%), and mental health (9.0%) 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.<sup>37</sup> Of course, plan enrollment has not always been this high (see Figure 5). 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% to 24,954 members in 1998. Since then, enrollment has fluctuated but overall has increased by 16.6% to 29,089 participants in 2006. At the end of 2006, 4.8% of participants were enrolled in the Basic Medicare Supplement Plan, with 95.2% of the enrollees spread across the six deductible plans as follows: \$500 (18.7%); \$1,000 (27.5%); \$2,000 (28.9%); \$5,000 (9.2%); \$10,000 (5.1%); and high deductible health plan (5.8%).

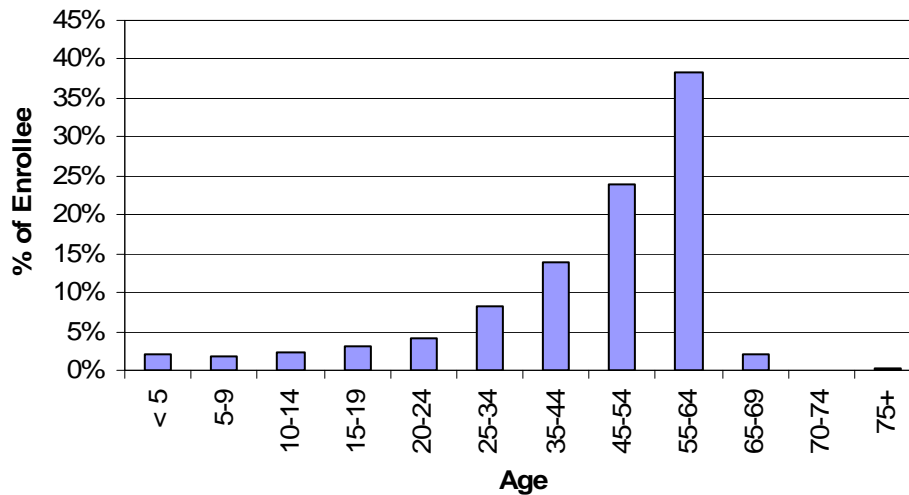
**Figure 5. MCHA Claims and Enrollment (1981-2006)**



Sources: Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007).

Figure 6 below shows enrollment by age group for MCHA participants enrolled in the individual deductible plans. In 2006, the majority (62.0%) of these enrollees were between 45 and 64 years of age, and another quarter (26.4%) were 20-44 years. Fewer enrollees were below 20 years of age (9.2%) or 65 and above (2.3%). Overall, just over half (53.8%) of the enrollees were female.

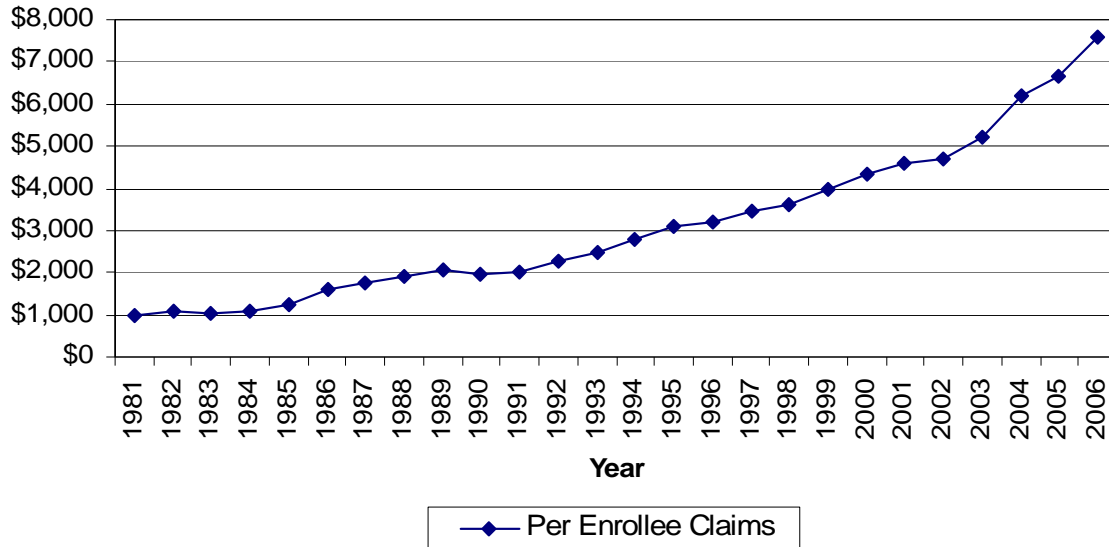
**Figure 6. Age Distribution of MCHA Deductible Plan Enrollees (2006)**



Source: Gruber (2008).

In addition to showing trends in enrollment, Figure 5 on the prior page 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 7 below presents medical expenditures expressed as total claims per enrollee at the end of each year, revealing similar steady growth in claims. In 1981, total claims per enrollee amounted to under \$1,000; in 2006, that amount was \$7,605. (Note: Data in graphs were not adjusted for inflation.)

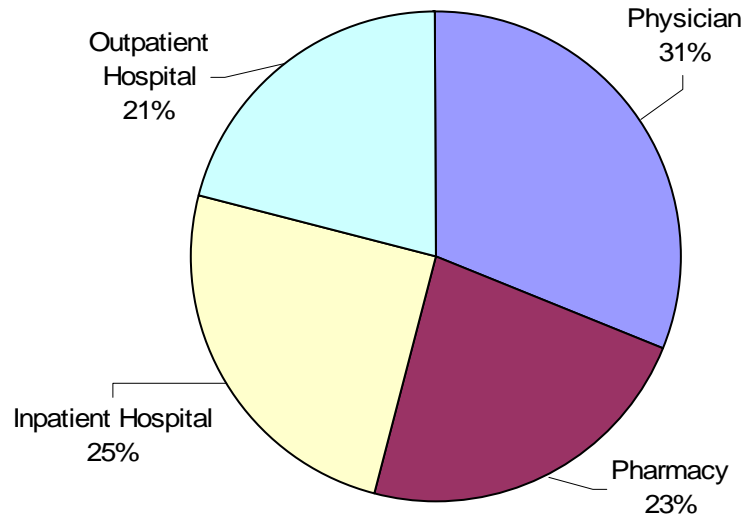
**Figure 7. MCHA: Per Enrollee Claims (1981-2006)**



Sources: Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007). Value represents total claims divided by number of enrollees at end of year.

MCHA's 2004 Annual Report<sup>38</sup> provides information on service utilization and expenditures. Figure 8 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% of costs). For the Medicare supplement enrollees, the top two diagnostic categories, comprising 31.7% of costs, were cardiovascular and genitourinary. While only representing 2.1% of total MCHA enrollment, catastrophic cases (cases in which claim payments exceeded \$50,000 in a year) contributed 34% to total expenditures during 2004.

**Figure 8. MCHA Expenditures by Type of Service (2004)**



Source: MCHA (2005).

### **MCHA Organization**

The Minnesota Legislature established MCHA as a non-profit corporation in 1976. Chapter 317A of Minnesota law provides the organizing framework for the 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 directors, 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. As of 2008, the board members are as follows<sup>39</sup>:

1. **Tim Luy (Chair):** Industry Board Member, General Manager Commercial Health, Federated Mutual Insurance Company
2. **Kathy Mock (Vice Chair):** Industry Board Member, Vice President, Public Policy and Legislative Affairs, Blue Cross and Blue Shield of Minnesota
3. **Rich Sykora (Treasurer):** Industry Board Member, Vice President and General Manager, Medica
4. **Dave Dziuk:** Industry Board Member, Senior Vice President of Finance and Controller, Health Partners
5. **Dorothy Petersen:** Industry Board Member, Corporate Actuary, Health Partners
6. **Mary Vollkommer:** Industry Board Member, Vice President and Product Actuary, Assurant Health
7. **Sheryl Radle (Secretary):** Public Board Member, Licensed Insurance Broker

8. **Kristin Flaten**, Public Board Member, Mental Health Advocate, MCHA Policyholder
9. **Bernard Reisberg**, Public Board Member, Retired Businessman
10. **Harlan Johnson**: Public Board Member, Licensed Health Insurance Agent
11. **Rolf Halstensen**, Public Board Member, MCHA Policyholder

In addition, as MCHA President, Lynn Gruber of the MCHA Executive Office, participates in the board meetings.

### **MCHA Operations**

MCHA’s every day 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 5.

**Table 5. History of MCHA Administration**

<b>Years</b>	<b>Writing Carrier</b>
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 Communicating for Agriculture and the Self-Employed, Inc. (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 ERISA, 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.<sup>40</sup>

Typically about half of the program's total funding has come from enrollee premiums.<sup>41</sup> In 2005, premiums totaled \$113.3 million, about 51% of total funds. State law requires MCHA premiums to fall between 101 to 125% 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% of the market.<sup>42</sup> Since 2004, there have been two premium rates: a tobacco user premium rate and a standard premium rate (for nonusers). Table 6 shows the standard and tobacco user rates currently in effect for the six deductible plans.

**Table 6. MCHA Standard and Tobacco-User Monthly Premium Rates (July 2007 – June 2008)**

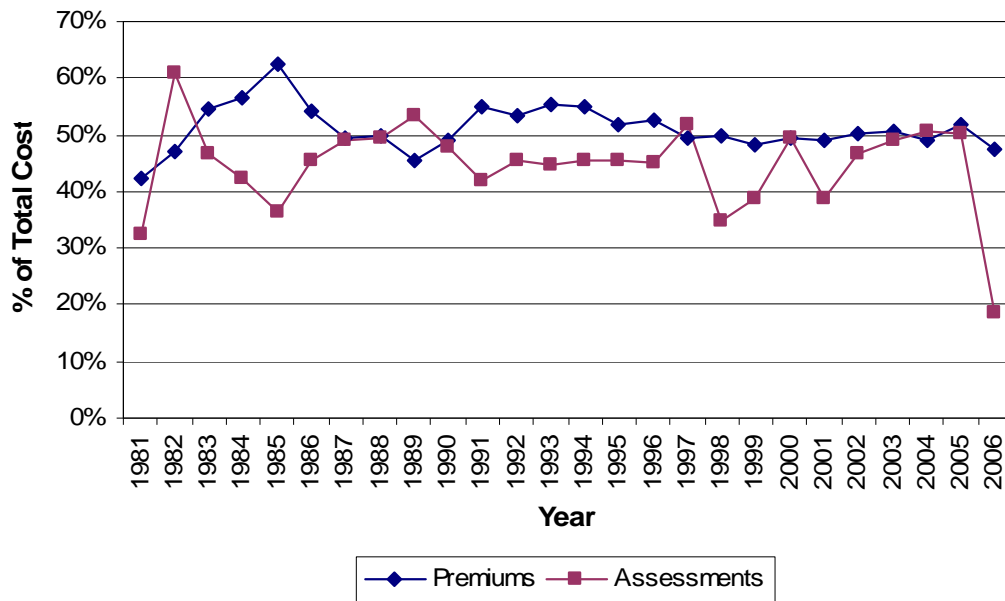
Age	\$500 Deductible		\$1,000 Deductible		\$2,000 Deductible		High Deductible		\$5,000 Deductible		\$10,000 Deductible	
	S	T	S	T	S	T	S	T	S	T	S	T
< 15	\$252	\$315	\$187	\$234	\$153	\$191	\$148	\$184	\$113	\$142	\$77	\$96
15-29	\$260	\$325	\$191	\$239	\$157	\$196	\$152	\$190	\$117	\$147	\$80	\$100
30-34	\$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 are 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% of total pool funds). It has been estimated that the assessments result in a 2% increase in commercial health insurance premiums.<sup>43</sup> Exhibit 9 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 (discussed more below).

**Figure 9. Role of Enrollee Premiums and Insurer Assessment in Financing MCHA (1981-2006)**



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

As mentioned above, state funds have been leveraged to subsidize MCHA costs and offset losses at several points in time during the program’s history.<sup>44</sup> First, until 1987, the state subsidized contributing insurers by granting them a 100% 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 were appropriated to cover MCHA's losses in 2001. These monies came out of a surplus from the Minnesota's Workers Compensation assigned risk plan.<sup>45</sup>

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.<sup>46</sup>

### ***Key Issues and Insights***

MCHA is a stable, mature, and well-managed high risk pool that has been viewed as a relatively small but important component of our state's health care system and safety net option for the uninsured. 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 a high risk pool.

*Implementation and Organization.* 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. Inherent in this approach is the involvement of 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."<sup>47</sup>

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 in the design and implementation of the pool, but there was flexibility built into the language, allowing space for Department of Commerce and stakeholder input.

*Administration/Management.* Because there is no employer or agency to push for change or better managed or preventative care, there has been a lack of incentive 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 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.<sup>48</sup> Otherwise, MCHA enrollee service utilization is managed largely through co-payments and deductibles similar to the private sector.

*Market Issues.* By directing residents with serious (and costly) health problems to MCHA, the 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 the entrance of relatively healthy individuals into the pool as well. The average cost per enrollee has been relatively low due to the number of relatively healthy individuals.

In 2004, the Department of Commerce, in collaboration with MCHA, studied the eligibility criteria used for preemptive conditions.<sup>49</sup> 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 preemptive 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) was recently 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 proposes 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.” If the bill passes, Council recommendations would be due to the legislature in November 2009.

*Expenses and Cost Control.* A prominent concern with MCHA pertains to growth in costs, and this concern is of course 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.”<sup>50</sup>

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 are generally satisfied with MCHA benefits. However, in order to make MCHA more affordable in future, some consideration has been given to limiting the provider network or establishing network tiers to reduce costs.

*Financing.* “All state risk pools inherently lose money and need to be subsidized.”<sup>51</sup> As already mentioned, MCHA has been primarily supported through enrollee premiums and insurer assessments, with occasional support from the state. Minnesota’s high risk pool premium rate

level (up to 125% of the standard risk rate) falls on the lower end of rate limits used in other states. In most states, the maximum is at least 150% and, in a handful of states, it is 200%.<sup>52</sup>

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% 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 during 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.* While premiums are relatively low (again capped at 125% of private individual market average), still many enrollees 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 pharmaceutical 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.<sup>53</sup> Federal TIAAA grant funds supported these subsidies. In 2007, 2,422 MCHA beneficiaries below the 200% of the federal poverty level received subsidy checks.

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## Notes

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- <sup>1</sup> NASCHIP (2007).
- <sup>2</sup> Based on analyses of 2006 and 2007 Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC) data. Estimates are for the total population including all age groups.
- <sup>3</sup> For uninsured children, the employment characteristic refers to a parent.
- <sup>4</sup> Minnesota Department of Health and University of Minnesota School of Public Health (2008).
- <sup>5</sup> Minnesota Department of Health, Health Economics Program (2007).
- <sup>6</sup> Minnesota Department of Health, Health Economics Program (2007).
- <sup>7</sup> Data not shown. Derived from data presented in Minnesota Department of Health, Health Economics Program (2007).
- <sup>8</sup> Minnesota Statute 62L.02, Subdivision 26.
- <sup>9</sup> Minnesota Department of Health, Health Economics Program (2007a).
- <sup>10</sup> Medical Expenditure Panel Survey – Insurance Component (2008a) and Medical Expenditure Panel Survey – Insurance Component (2008b).
- <sup>11</sup> Minnesota Department of Health, Health Economics Program (2007a)
- <sup>12</sup> Minnesota Department of Health, Health Economics Program (2007a.)
- <sup>13</sup> U.S. Government Accounting Office (GAO) (2002).
- <sup>14</sup> AHIP Center for Policy and Research (2006).
- <sup>15</sup> AHIP Center for Policy and Research (2006).
- <sup>16</sup> Employee Benefit Research Institute (1995) and Pollitz et al. (2006).
- <sup>17</sup> Minnesota Statute 62L.02, Subdivision 26.
- <sup>18</sup> Kaiser Family Foundation (2008).
- <sup>19</sup> Kaiser Family Foundation (2008).
- <sup>20</sup> GAO (2003).
- <sup>21</sup> Pender (2005).
- <sup>22</sup> Pender (2005) and Minnesota Statute 62L.
- <sup>23</sup> U.S. Department of Labor (DOL) (2008a).
- <sup>24</sup> Kaiser Family Foundation (2008), Minnesota Office of the Legislative Auditor (2001), and Levin et al. (1997).
- <sup>25</sup> GAO (2003) and Kaiser Family Foundation (2008).
- <sup>26</sup> Minnesota Department of Health, Health Economics Program (2003).
- <sup>27</sup> Kaiser Family Foundation (2008).
- <sup>28</sup> U.S. DOL (2008b).
- <sup>29</sup> Kaiser Family Foundation (2008).
- <sup>30</sup> Pollitz et al. (2006).
- <sup>31</sup> MCHA (2000), pg. 4.
- <sup>32</sup> MCHA (2007a) and MCHA (2006).
- <sup>33</sup> Communicating for Agriculture and the Self-Employed (2005).
- <sup>34</sup> MCHA (2007b).
- <sup>35</sup> MCHA (2007a).
- <sup>36</sup> Betzner et al. (2005).
- <sup>37</sup> NASCHIP (2007).
- <sup>38</sup> MCHA (2005).
- <sup>39</sup> A list of the current board members are available at <http://www.mchamn.com/html/board.html>
- <sup>40</sup> Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007).
- <sup>41</sup> MCHA (2005).
- <sup>42</sup> MCHA (2007b).
- <sup>43</sup> MCHA (2007b).
- <sup>44</sup> See, for example, MCHA (2005), Communicating for Agriculture and the Self-Employed (2005), and NASCHIP (2007).
- <sup>45</sup> Communicating for Agriculture and the Self-Employed (2005).
- <sup>46</sup> NASCHIP (2007).
- <sup>47</sup> Association of MCHA Policyholders (2008).
- <sup>48</sup> NASCHIP (2007).
- <sup>49</sup> Minnesota Department of Commerce and MCHA (2005).

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<sup>50</sup> NASCHIP (2007), p. 11.

<sup>51</sup> Minnesota Department of Commerce and MCHA (2005).

<sup>52</sup> NASCHIP (2007).

<sup>53</sup> Ripley, Brodsho, and Nwoke (2007).