

## **Introduction**

The health reform law contains immediate access to insurance for uninsured individuals with pre-existing conditions through temporary high-risk pool funding. A recent CMS study estimates that up to 6% of the uninsured population is uninsurable, defining this population as individuals who were uninsured and who either could not work, were limited in the type of work they could do, or received any disability or worker's compensation income.<sup>1</sup> A PricewaterhouseCoopers study estimates that between 2.5% and 5% of individuals are medically uninsurable on the individual market due to medical underwriting.<sup>2</sup> Based on these estimates, the Managed Risk Medical Insurance Board (MRMIB), the governing body of the Major Risk Medical Insurance Program (MRMIP), finds that between 165,000 and 396,000 Californians may be uninsurable and in need of coverage.<sup>3</sup> In the following analysis, we summarize the provisions related to the program, review the current high-risk pool in California, and make recommendations regarding next steps.

## **Sec. 1101 of HR 3950: Temporary High-Risk Pool Program**

The pool will be established no later than 90 days after the bill was signed into law (on or before June 22, 2010) and will continue through January 1, 2014 when these individuals will transition to the Exchange. The law allocates \$5 billion over the course of the program, without fiscal year limitation. Based on our state's share of the nation's uninsured, California should be eligible for at least 14% of the federal funds, providing over \$700 million for the state. To qualify for the federal funds, a state or non-profit high-risk pool must adhere to the following new federal standards:

- No pre-existing condition exclusions
- Coverage requirements
  - Standard rates for a standard population
  - Minimum 65% actuarial value
  - Age rating no more than 4:1
  - Annual out-of-pocket maximum of \$5,000/\$10,000 for individual/family
- Eligibility for individuals
  - Has been uninsured for 6 months<sup>4</sup>
  - Has a pre-existing condition

The California Major Medical Risk Insurance Program (MRMIP) is the existing program dedicated to those individuals who cannot obtain insurance on the individual market, and is a logical choice for expansion with these funds.

## **Overview of MRMIP**

### Eligibility

1. Must be a resident of the state (present with intent to remain). A person absent from the state for a period longer than 210 consecutive days is not considered a resident.

2. Must not be eligible for Medicare **both** Part A **and** Part B, unless eligible solely because of end-stage renal disease.
3. Not eligible for COBRA (the MRMIP program allows COBRA beneficiaries to apply for deferred enrollment in the MRMIP if COBRA coverage will soon expire)
4. Must be unable to secure adequate coverage within the previous year.

### How the Program Works

#### *General*

Health plans (Anthem Blue Cross PPO, Kaiser Permanente, and Contra Costa Health Plan) are contracted to provide and coordinate services. The annual deductible is \$500 and annual subscriber out of pocket max costs are \$2,500 for an individual and \$4,000 for a family. MRMIP's benefit limits are \$75,000 per year and \$750,000 in a lifetime. Californians qualifying for the program participate in the cost of their coverage by paying premiums (called subscriber contributions) equal to 125% of the cost of equivalent individual coverage. The State of California supplements those premiums to cover the cost of care in MRMIP. Tobacco tax funds currently subsidize the MRMIP.

#### *Applying*

The potential subscriber completes and submits the application along with the first month's contribution. The applicant is then either enrolled or placed on a waiting list if the MRMIP is at maximum enrollment (7,100). Dependents may be covered up to age 23; unmarried dependents above age 23 may be covered if that dependent is incapable of self-support due to physical or mental disability. For those wishing to enroll in a PPO plan (Anthem Blue Cross), there is a 3-month exclusion period on coverage for pre-existing conditions. For those enrolling in an HMO plan (KP or CCHC), there is a 3-month post-enrollment waiting period where the MRMIP will not provide any benefits or services. No subscriber contributions are paid during this time. After the waiting period is up, the first-month payment provided with the application will be applied. The subscriber may be eligible to waive all or part of the exclusion/waiting period if:

1. The subscriber has been on the MRMIP waiting list for 180 days or more. The exclusion/waiting period will be waived entirely.
2. The subscriber was previously insured and the application to the MRMIP was submitted within 63 days of the termination of the previous coverage. If the subscriber was enrolled in previous coverage for at least 3 months, the entire exclusion/waiting period will be waived. If the subscriber was covered less than 3 months, the subscriber will get credit for either 1 or 2 months toward the exclusion/waiting period depending on the length of coverage.
3. The subscriber was enrolled in employer-sponsored coverage that was terminated and the application to the MRMIP was received within 180 days of termination of coverage. The subscriber may be eligible for a waiver up to 3 months.
4. The subscriber was enrolled in a similar program in another state within the last 12 months. In this case the exclusion/waiting period will be completely waived.

### *Waiting list*

If the MRMIP is at max enrollment, a waiting list begins from the date the completed application was received. There are two types of enrollees on the waiting list, those due to closed enrollment and those due to deferred enrollment. Currently there are 84 on the MRMIP waiting list due to closed enrollment and 43 waiting due to deferred enrollment for a total of 143.

### Declined enrollment

MRMIP surveys individuals who did not accept their enrollment offers after being admitted off the waiting list<sup>5</sup>. The vast majority of survey responders (33 out of 49) had obtained other health coverage. Eight out of the 49 could not afford their contribution cost. These reasons are consistent when comparing to the various reasons why individuals are disenrolled from the MRMIP during the Annual Disenrollment Survey.

### **Recommendations**

In regard to the Major Risk Medical Insurance Program and the new federal funding opportunities, MRMIB should be in close contact with HHS to assure qualification for federal funds. Certain policies, such as the current three-month pre-existing condition exclusion period and the annual and lifetime benefit limits, will need to be changed.

Federal guidelines stating that the high risk individual be uninsured for the previous 6 months may pose a challenge unless a potential enrollee has been on the wait list without coverage for a period longer than 6 months. Further, if this federal stipulation isn't modified or unless there is an alternative agreement made between federal and state officials, federal high-risk dollars might not be available to fund upgraded coverage for current MRMIP subscribers unless they disenroll for 6 months.

With a substantial increase in funding, it is essential that the dollars be used effectively in order to enroll as many of the medically uninsurable uninsured as possible. Existing programs such as the Genetically Handicapped Persons Program (GHPP) may be able to increase capacity through new MRMIP contracts. An increase in enrollment applications can also be expected in anticipation of the program's expansion. A greater administrative capacity should parallel the increased volume as needed. There may be an opportunity to expand benefits within the high-risk program as needed (improving the actuarial value, cost sharing, benefits package, etc.); contracting plans may seek rate increases from MRMIP; non-contracting plans may increase their medical underwriting rejections with the expectation that MRMIP will cover those they reject. In our view, the priority should be covering as many of the medically uninsurable as possible within federal fiscal constraints without opening the floodgates to a cascade of new rejections and stiffer underwriting exclusions from some plans.

It is the intention of the federal dollars to (1) provide a coverage option for those who are unable to find appropriate insurance elsewhere and (2) smooth the transition of these populations into the health exchange beginning in 2014. California's MRMIP already satisfies the first point but only for those able to pay the elevated cost. The main reason

why people are disenrolled from and decline enrollment offers through the MRMIP is because the subscriber contributions are too costly.

California may wish to increase the number of private and public health plans offered through the MRMIP. Additional safety net plans, such as Local Initiatives, and County Operated Health Systems (COHS) may wish to consider offering coverage.

MRMIP may wish to offer benefit options similar to the bronze, silver, and gold levels stipulated for the Exchange in 2014 under the new federal law. This could provide a choice of more affordable coverage options for high-risk populations, but it may be far too complex for what is a very small pool of high-risk enrollees. This approach could pre-test elements of an exchange in California and work out some of the inescapable “bugs”, thereby dramatically smoothing this particular population’s transition into the health insurance exchange in 2014. The federal law stipulates a 65% actuarial value, which would be lower than a bronze plan offered through the exchange.

Current state dollars for MRMIP (\$40 million in tobacco tax funding) could be realigned to lower the subscriber contribution for moderate-income Californians who qualify for MRMIP but can’t participate due to the high cost of the current subscriber contributions. There is a federal maintenance of effort (MOE) requirement so the new federal funds cannot simply be used by the state to plug its budget deficit.

The changes that will take place will need to balance the availability of new federal funds and subscriber contributions while maintaining a keen eye on the limit on total federal funds available. Under one possible future, California may be stuck in a ‘Cash for Clunkers’ scenario where a significant federal funding increase would be exhausted in an unexpectedly short period of time, once again stranding “medically uninsurable” Californians without insurance until 2014. Under another, Californians could debate, delay and squander a valuable opportunity for California to demonstrate how a well-planned implementation effort of federal health reform law could be executed.

Whatever changes will take place to enhance MRMIP should be done swiftly. Options involving a prolonged state legislative debate or an expansion with lengthy timelines are not recommended. From the beginning, the KISS (Keep it Simple, Stupid) rule should apply with modifications phased in later.

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<sup>1</sup> Frakt, A.; Pizer, S.; and Wrobel, M.; High Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects: Winter 2004-2005, Health Care Financing Review; Volume 26, Number 2; page 74.

<sup>2</sup> Hunt, S.: Individual Health Insurance Options for California; September 2000 (Report presented to the Managed Risk Medical

Insurance Board by PricewaterhouseCoopers, the Board’s contract actuary.)

<sup>3</sup> Managed Risk Medical Insurance Board, California Major Risk Medical Insurance Program 2006 Fact Book, March 2006

<sup>4</sup> Health plans that dump individuals based on health status prior to risk-pool enrollment will be responsible for any medical expenses incurred to the program (what does this mean?)

<sup>5</sup> Major Risk Medical Insurance Program, 2010 MRMIP Survey Individuals on the Waiting List Declining Enrollment Offers