The Impact of the Patient Protection and Affordable Care Act on Low-Income Individuals Currently Enrolled in Minnesota's High-Risk Pool

A Project Submitted to the Faculty of the Division of Health Policy & Management of the University of Minnesota School of Public Health by

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Abstract

Objective. To identify the health insurance coverage options for low-income individuals enrolled in Minnesota's high-risk pool, the Minnesota Comprehensive Health Association (MCHA), upon full implementation of the Patient Protection and Affordable Care Act (ACA) in 2014.

Data Sources/Study Setting. Data on approximately 26,000 beneficiaries were obtained from enrollment files of the 2010 MCHA Low-Income Subsidy Program. The files are maintained by the firm of Halleland Habicht for purposes of administering the subsidy program.

Study Design. Data obtained from approximately 26,000 MCHA enrollees were used to generate an estimation of the number of low-income enrollees that might be eligible for new coverage options under the ACA. First, and estimate of low-income enrollees was generated using data from 2,744 individuals enrolled in MCHA's 2010 Low-Income Subsidy Program. These enrollment files included 2009 gross household income (which must be less than 220% or less of the Federal Poverty Level (FPL); $23,826 for an individual), age, plan type (by deductible levels from $500 to $10,000), and household size. While there is limited information on MCHA enrollees above 220% FPL (approximately 25,000 enrollees) zip code is available. A second analysis utilized data from the American Community Survey to impute a proxy income based on zip code for all MCHA enrollees.

Data Collection/Extraction Methods. Data were collected during the summer of 2010 when the Low-Income Subsidy Program was administered.

Principal Findings. Upon full implementation of ACA, most of the MCHA enrollees eligible for the low-income subsidy program will be eligible for either the Medicaid expansion (up to 138% of the FPL), the basic health plan (139-200% of FPL) or premium subsidies offered through the exchange (201-400% FPL). This is largely due to the elimination of the asset test for eligibility under the ACA. MCHA does not currently have an asset test for the low-income subsidy.

Conclusions. Preliminary findings suggest that health coverage options under the ACA in 2014 will offer low to no cost coverage for low-income enrollees than what is currently provided under current MCHA policy. There will be substantial movement of MCHA enrollees to new health plans options offered under the ACA in 2014.

Implications for Practice or Policy. Affordability of health coverage for low-income Minnesotans with pre-existing conditions will be a pressing issue as federal health reform is implemented. Upon full implementation of the ACA the state will need to consider the proportion of MCHA enrollees that will be transferring to public coverage – both Medicaid and subsidies in the Exchange. Because MCHA enrollees are by definition "high risk", their new enrollment into Medicaid, the basic health plan, and the exchange will increase average costs for each of these new options. Policymakers will need to assess the impact of enrollment of current MCHA enrollees in terms of costs, adverse selection and potential moral hazard.

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Introduction

Health insurance coverage is a key issue addressed in the Patient Protection and Affordable Care Act (ACA) passed in 2010. Among other fundamental issues related to improving the American health care system, the ACA aims to increase health insurance access for roughly 34 million people, reducing the number of uninsured from 57 million to approximately 23 million (Foster, 2010). Increased access to health insurance is addressed in the ACA through (1) the expansion of state Medicaid programs; (2) the creation of health insurance exchanges and (3) increased subsidies for both premiums and cost-sharing.

In the state of Minnesota, one program that will be impacted by health reform is the Minnesota Comprehensive Health Association (MCHA). MCHA is Minnesota's high-risk pool, an organization that provides health insurance coverage for Minnesota's medically uninsurable – defined as people with pre-existing conditions who are unable to find affordable coverage in the private markets. MCHA has been in operation for over thirty years and is one of the nation's longest-running high-risk pool programs (National Association of State Comprehensive Health Insurance Plans [NASCHIP], 2009). In 2010, the program covered roughly 28,000 Minnesotans (Minnesota Comprehensive Health Association [MCHA], 2010).

The ACA brings new insurance options for the uninsured and more affordable coverage options for those who are currently insured – including MCHA enrollees. Despite capped premiums and availability of plans, many low-income MCHA members find coverage unaffordable.

Upon implementation of the ACA, some MCHA enrollees will become eligible for public health coverage programs. Eligibility for public programs will continue to be based on income, but will expand to include a larger population—up to 133% of the federal poverty level (FPL) for single adults with no children. Although MCHA enrollees are screened for public program eligibility when they enroll, annual household income is not routinely collected during the application process.

The purpose of this study is to estimate the number of MCHA enrollees that will be eligible for the new coverage categories established the ACA. Specifically, this research aims to estimate the household income level based on percentage of federal poverty level to predict enrollees' anticipated eligibility for Medicaid, the basic health plan, or subsidies (i.e. tax credits) provided in the health insurance exchange.

If the proportion of low-income MCHA enrollees is significant, their transition to public coverage poses serious implications for the state's health care spending in 2014. Due to the health needs and service utilization of their participants, high-risk pools require subsidization for inevitable operating losses (NASCHIP, 2009). In Minnesota, consideration for the future of these enrollees is crucial in determining who will bear these costs. This study will contribute to the needs of the state in assessing the possible influx of enrollees into public coverage programs and the impact of high-risk health insurance consumers entering a new market.

Background

High-risk Pools

There are currently thirty-five states that operate high-risk pools in the United States, providing health insurance coverage to approximately 200,000 individuals (NASCHIP, 2009). High-risk pools are aimed at coverage for the medically uninsurable, but often extend coverage to other eligible groups in order to maintain compliance with federal law and regulations. Most high-risk pools include people eligible for coverage under The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (NASCHIP, 2009). The Act provides that individuals with creditable continuous coverage for 18 months cannot be denied coverage should they care to transition to another type of coverage (NASCHIP, 2009). For example, an employee who loses their job but who has maintained coverage for two years without lapses must have access to a health insurance option.

Another group of people often included in high-risk pools are those eligible for the federal Health Care Tax Credit (HCTC). Individuals and their family members can receive assistance in purchasing health insurance (currently 65% of their premiums) if they receive benefits through Pension Benefit Guaranty Corporation (PBGC) or through Trade Adjustment Assistance (TAA) (Internal Revenue Service, 2010a; Internal Revenue Service, 2010b). TAA is a federal program aimed at assistance for unemployed workers who have been impacted by trade (United States Department of Labor, 2011).

All thirty-five high-risk pools are financed through enrollee premiums, but there is significant variance in sources of funding across states from insurer assessments to specific state-allocated funding. Sixteen state high-risk pools operate a premium subsidy program, funded through federal operating or bonus grants (NASCHIP, 2009). As shown on Table 1, states utilize various mechanisms for subsidizing costs to their low-income enrollees. Minnesota is currently the only high-risk pool to distribute these funds in a one-time lump sum to low-income enrollees. Distribution of the subsidy in this fashion allows for avoidance of left-over funds that can result when subsidies are based on enrollee premiums. By delivering the subsidy through a one-time reimbursement, the funds can be equally distributed to all eligible enrollees.

Table 1. State high-risk pools that administer premium subsidy programs, 2008.

State	Eligibility	Monthly discount	Percent of members who receive a subsidy
Alabama	*subsidy program implementation to begin in 2009		
Arkansas	*applying for federal subsidy program in 2009		
Colorado	Two levels: (1) Adjusted Household Income below $40,000 (2) Adjusted Household Income between $40,000 and $50,000	Average: 28% Maximum: 29%	30%
Indiana	Members who are not receiving subsidy from any other source	Average: 40% Maximum: 45%	6%
Maryland	(1)Income <300% FPL (2)Income <200% FPL	Average: 40% or $183 Maximum: 70% or $345	26%
Minnesota	Annual Household Income based on number of people in the household that is below a predetermined percent of FPL	One-time subsidy check Average: $50.86	9%
Missouri	Based on FPL	Average: $150 Maximum: $150	12%
Montana	Members who qualify for the Premium Assistance Plan, a sub-plan of the Association (traditional) plan	Average: 45% Maximum: 45%	9%
New Hampshire	(1) Income <200% FPL [receives 20% discount] (2) Income 201%-250% FPL [receives 10% discount]	Average: 18% or $81 Maximum: 20%	10.7%
New Mexico	(1) Income < 200% FPL [75% discount] (2) Income between 200 and 299% FPL [50% discount] (3) Income between 300 and 400% FPL [25% discount]	Average: 66% Maximum: 75%	43%
Oregon	Must be both: (1) Uninsured at least six months prior to application (2) Income at or below 185% FPL	Average: 95% Maximum: 95%	9.9%
Tennessee	(1) FPL <100% = 90% discount (2) FPL 100-150% = 80% discount (3) FPL 151-200% = 60% discount (4) FPL 201-250% = 40% discount (5) FPL 251-350% = 20% discount	Average: 82% or $582 Maximum: 90%	86%
Utah	Based on income level	Average: 36% Maximum: 50%	21%
Washington	(1) FPL <251% = up to 27% discount (2) FPL 250-300% = up to 15% discount *No rates may go below 110% SRR	Average: 15% Maximum: 27%	1.1%
Wisconsin	Household income <$33,000	Average: 33% or $157 Maximum: 43% or $275	19%
Wyoming	Annual adjusted gross income below 250% FPL	Average: 30% Maximum: 30%	35%

Source: NASCHIP, Health Insurance for High-Risk Individuals: A State-by-State Analysis. 23rd edition: 2009-2010.

The Minnesota Comprehensive Health Association (MCHA)

The Minnesota Comprehensive Health Association (MCHA) is the largest state high-risk pool, covering 27,645 enrollees in 2009 (MCHA, 2010b). MCHA is also one of the longest running pools in the country, in operation since 1976 when it was created by the state legislature (NASCHIP, 2009). Although MCHA currently receives no state funding, the Minnesota State Legislature has allocated funding to MCHA to offset losses in the past (Blewett, Spencer & Burke, 2011). Premium rates are set by state law, which requires premiums to remain between 101% and 125% of the average premium rate for a comparable plan in the private market (NASCHIP, 2009).

Minnesota's pool covers residents with pre-existing conditions that have been denied insurance on the private market but also includes HIPAA-eligibles, HCTC-eligibles, people who are ineligible for Medicare or who have been diagnosed with a specific medical condition, referred to as a presumptive condition (MCHA, 2010a). Individuals with these conditions are presumed to be uninsurable on the private market and must show proof of diagnosis to be eligible. Diagnoses that would fit this criterion include leukemia, AIDS or HIV, paraplegia or quadriplegia, history of organ transplant or cystic fibrosis (MCHA, 2010a).

Currently MCHA offers deductible plans and Medicare supplement plans. Most enrollees have deductible plans (97%), or health plans where the enrollee pays an initial amount of their own health care costs before the insurer begins to contribute. Plan deductibles range from $500 to $10,000, including a federally qualified high deductible health plan (HDHP) that allows enrollees to open a Health Savings Account (HSA) (MCHA, 2010c). Plans with lower deductibles have higher premiums, but gender, smoking status and age are also used in assessing premium amount (MCHA, 2010c).

MCHA Low-Income Subsidy Program

The MCHA Low-Income Subsidy Program (LSP) has distributed grant funds six times to low-income members, starting in 1998. The Centers for Medicaid and Medicare Services (CMS) is currently the source of this funding and has offered grants to high-risk pools since 2006 under the State High Risk Pool Funding Extension Act of 2006 (United States Department of Health & Human Services, [HHS] 2010). CMS awards three types of grants to high-risk pools: (1) seed grants to states looking to implement qualified high risk pools; (2) operational losses grants; and (3) bonus grants for the development of consumer programs such as disease management or subsidy programs (HHS 2010).

MCHA's Low-Income Subsidy Program (LSP) has been funded primarily through the federal bonus grant. This grant has not been offered every year, but MCHA has applied for it each year it has been offered. Grant funds have been distributed to low-income MCHA members through the subsidy program in 1998, 2005, 2006, 2007, 2008 and 2010 (Halleland Habicht Health Consulting, 2010).

Initially, MCHA administered the low-income subsidy program based on annual premium contribution. Enrollees with low incomes qualified for the subsidy and a specific amount based on the premiums they paid the prior year was distributed. Subsidy amounts based on premiums were established prior to the application period, which resulted in funds that were left over from the federal grant that were not distributed. In 2006, MCHA changed the distribution method in order to effectively distribute the entire amount of grant funding received for administration of the subsidy program. Instead of the subsidy amount reflecting the total premiums paid by the member, each member would receive the same amount of subsidy. After applications had been processed, the total amount of funding was divided equally amongst eligible members. Table 2 details the variation in funding from 2005 to 2010 and the change in distribution method in 2006. Income eligibility for the subsidy has also increased from 2005 from 180%FPL to 220%FPL in 2010.

The numbers of applicants that qualify for the subsidy as well as those that are denied have stayed relatively the same from 2007 to 2010 (See Table 2). Common reasons for denial include inadequate documentation of income, incorrect reporting of income or household size, or an incomplete application.

Table 2. MCHA Low-Income Subsidy Program Funding and Eligibility Information, 2005-2010.

	2005	2006	2007	2008	2010
Amount Distributed	$267,040	$2,700,000	$2,000,000	$1,250,000	$1,674,608
# Applications Mailed	26,885	24,000	24,709	24,512	23,000
Income Eligibility	180% of Poverty	180% of Poverty	200% of Poverty	220% of Poverty	220% of Poverty
Applications Received	1,860	1,767	2,988	2,896	2,778
# Qualifying Applications	1,558	2,707	2,422	2,427	2,399
Distribution Method	Determined by policy holder premium	Total $ divided by # of qualified members	Total $ divided by # of qualified members	Total $ divided by # of qualified members	Total $ divided by l # of qualified members
Subsidy Amount	$171.40 (average per member)	$857.69 per member	$716.08 per member	$438.59 per member	$610.28 per member
Applications Denied (% of total applications received)	302 (16.2%)	440 (25%)	566 (19%)	469 (16%)	379 (14%)

Source: Halleland Habicht Consulting, LLC. Minnesota Comprehensive Health Association. 2010 Low Income Subsidy Program Final Report.

Affordable Care Act Implications for High-Risk Pool Enrollees

The Patient Protection and Affordable Care Act (ACA) includes provisions that directly impact high-risk pool enrollees. Expansion of insurance coverage is a main objective of the ACA and is addressed through the expansion of public coverage and regulation of the private market. Currently, states are obligated to provide Medicaid coverage for select populations including Social Security Income (SSI) recipients, low-income children and pregnant women. For adults without

children, states retain discretion over the operation of their public coverage programs and the level of coverage offered (Centers for Medicare and Medicaid Services [CMS], 2005). The ACA introduces a national standard for Medicaid, requiring states to cover residents with incomes up to 133% of the federal poverty level (138%FPL including a 5% disregard). The new law also requires that Medicaid expand eligibility to all individuals, including childless adults. It also eliminates the use of an asset test for determination of eligibility in public coverage. For low-income MCHA enrollees, the ACA opens up Medicaid as a new option for health insurance.

Under the new ACA provisions, income eligibility for all Medicaid programs will be based on the household's Modified Adjusted Gross Income (MAGI) without an asset test (Kaiser Family Foundation, 2010). This carries significant implications for people who have little annual household income, but might have annuities, savings or assets that put them over eligibility limits for public coverage. Many MCHA enrollees are farmers, self-employed individuals or small business owners whose assets would exceed these limits. MCHA eligibility does not include an income test or asset test so these groups are able to purchase coverage as long as they meet other criteria. Because these individuals are unable to enroll in public coverage and have been denied insurance on the private market, coverage through MCHA is their only health insurance option.

High-risk pools exist to provide coverage for people who have been denied insurance based on health status, or "pre-existing conditions." The ACA eliminates the ability of insurance companies to deny applicants insurance for these reasons, opening a new market for high-risk pool enrollees. This provision became active for children on September 23rd, 2010, banning insurance companies from denying children health insurance for having a pre-existing condition (The Patient Protection and Affordable Care Act [ACA], 2010). The reaction from health insurers has been to drop their child only policies, meaning that children can only get coverage if they are added as dependents on another enrollee's plan (Ramshaw, 2011). Unfortunately, until this protection is effective for adults on January 1st, 2014, high-risk children who do not have access to private

insurance and are not eligible for public coverage will continue to have limited options. With the elimination of underwriting, or price setting based on health status, those previously denied due to chronic conditions or pre-existing conditions will be able to access private health insurance in 2014.

Finally, the law adds new federal premium and cost-sharing subsidies for low-income individuals not eligible for Medicaid but with incomes of 139%-400%FPL. The ACA requires that each state operate a health insurance exchange, or Heath Benefit Exchange, where consumers can purchase plans and compare them across benefit sets. States have some flexibility in how they establish exchanges – they can develop multiple regional exchanges within the state, operate a statewide exchange, or collaborate with other states (Carey, 2010). The ACA enables creation of Small Business Health Options Programs (SHOPs), or exchanges for small groups that states can choose to operate independently or together with Health Benefit Exchanges at their discretion.

People who purchase health insurance in the exchange and who have incomes between 201-400%FPL will be eligible for federal subsidies. The ACA also allows states to create a basic health plan for people with incomes of 139%-200%FPL that would also be subsidized by the federal government. It is currently not known how the subsidies in the basic health plan and the exchange will compare with subsidy programs in high-risk pools, but it is possible that the basic health plan and plans in the exchange would yield alternative and possibly more affordable health insurance option for low-income high-risk pool enrollees.

Affordable Care Act Implications for MCHA Enrollees

Minnesota's high-risk pool will certainly be impacted by the ACA. The most significant impact will likely be on low-income enrollees who are considering dropping coverage due to high cost. Currently, many low-income enrollees in MCHA are not eligible for public coverage programs like Medicaid (called Medical Assistance in Minnesota) because of income thresholds and asset

limits. Both income and asset criteria must be satisfied to be eligible for Medical Assistance or MinnesotaCare. Furthermore, income and asset limits vary depending on the person enrolling – for example, adults without children are only eligible for MinnesotaCare and have an asset test of $10,000 or $20,000 depending on the number of people in their household (see Table 3). In contrast, pregnant women and children eligible for Medical Assistance are not required to meet an asset test. Because the public coverage eligibility is more generous for parents and children, low-income MCHA members typically impacted by these criteria are childless adults.

Table 3 describes current public health coverage programs in Minnesota, their eligibility criteria and whether eligibility is determined using an asset test.

Table 3. Eligibility Determinants for Current Minnesota Public Health Coverage Programs.

<table>
<tr><th></th><th>Populations Eligible</th><th>Income Eligibility by FPL</th><th>Asset Limit</th><th>Changes Anticipated with ACA</th></tr>
<tr><td rowspan="5">Medical Assistance (Medicaid)</td><td>Pregnant Women</td><td>At or below 275%</td><td>No asset limit</td><td rowspan="5">Eligibility to include all people up to 138%FPL with no asset limit. Income eligibility to be determined using new Modified Adjusted Gross Income (MAGI) methodology.</td></tr>
<tr><td>Children</td><td>At or below 280% (under age 2)
150% (age 2-18)
100% (age 19-20)</td><td>No asset limit</td></tr>
<tr><td>Parents with children under 19</td><td>At or below 100%</td><td>$10,000 (one)
$20,000 (two or more)</td></tr>
<tr><td>Elderly, blind and people with disabilities</td><td>At or below 100%</td><td>$3,000 (one)
$6,000 (two or more)
$200 for each dependent</td></tr>
<tr><td>Employed persons with disabilities</td><td>No income limit</td><td>$20,000 per enrollee</td></tr>
<tr><td rowspan="3">MinnesotaCare</td><td>Adults without children</td><td>At or below 250%</td><td>$10,000 (one)
$20,000 (two or more)</td><td rowspan="3">Beneficiaries who fit new Medicaid (Medical Assistance) eligibility criteria will be transitioned to that program.</td></tr>
<tr><td>Pregnant women and children under 21</td><td>At or below 275%</td><td>No asset limit</td></tr>
<tr><td>Parents, legal guardians, foster parents and relative caretakers of children under 21</td><td>At or below 275%</td><td>$10,000 (one)
$20,000 (two or more)</td></tr>
<tr><td>General Assistance Medical Care</td><td>All populations</td><td>At or below 75%</td><td>$1,000 per household</td><td>Transitioned to Medicaid (Medical Assistance) as part of early Medicaid opt-in on March 1, 2011.</td></tr>
</table>

Source: Minnesota Department of Human Services, 2010. Available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4346-ENG.

The Medicaid expansion to 133% FPL (138% FPL including the 5% income disregard) will require a shifting of public coverage programs in Minnesota, primarily the shifting of MinnesotaCare and General Assistance Medical Care (GAMC) populations to Medical Assistance so that the state can reap federal matching funds for those individuals. Through repositioning of these programs, Minnesota will be able to consolidate populations and gain additional funding previously not available for these groups.

Low-income MCHA enrollees with incomes at or below 400%FPL will have access to new health insurance options as a result of the provisions in the ACA. To further identify the impact of these new options on the MCHA population, this study will provide estimates of the number of enrollees who will be eligible for each new coverage option established by the Affordable Care Act. Specifically, estimates will be generated for the number of MCHA enrollees that will be eligible for Medicaid (with incomes between 0-138%FPL), for the basic health plan (139-200%FPL) and for subsidies to purchase insurance in the exchange (201-400%FPL).

In addition to the increase in income eligibility, the methodology for how income will be determined will also change in 2014 as a result of the ACA. States currently hold some discretion in how family income is determined, but the ACA mandates the use of Modified Adjusted Gross Income (MAGI), a tax-based measure of income defined by the Internal Revenue Code of 1986 (Social Security Administration, 2010). Part of the reason for the introduction of MAGI is that the subsidies to purchase insurance in the exchange will occur through a tax credit (Czajka, 2011). In anticipation of the need to deliver the tax credit, a tax-based measure of income was introduced.

Minnesota's Medicaid program, Medical Assistance, currently defines income as "net countable income after certain allowable deductions" (Aves, 2010). Income includes wages, salaries, unemployment, self-employment income, child support, Social Security and income from other sources (Minnesota Department of Human Services, 2011). In contrast to current eligibility determination, MAGI includes income based on the tax filing unit, including dependents of the tax filer. One of the major differences with MAGI is that it utilizes annual income instead of current income. In determining eligibility for low-income residents, states anticipate guidance from the Centers for Medicare and Medicaid Services, which is forthcoming.

Methods

This study analyzed MCHA enrollee data from the 2010 Low-Income Subsidy Program (LSP). The data is comprised of approximately 25,000 records containing all active MCHA members with deductible plans on March 1, 2010. Enrollees with Medicare supplement plans were not eligible for the low-income subsidy in 2010 and were excluded from the data. Furthermore, the new ACA coverage options addressed in this study exclude Medicare beneficiaries so their inclusion is unnecessary.

Data on general membership were obtained from MCHA and were used for administration of the 2010 LSP. The data include gender, age, plan type (deductible and premium), zip code, and whether the enrollee was a policyholder or dependent. Applicants submitted household size and documentation of household income to confirm their eligibility for the subsidy program. For 2,398 qualified applicants who received the subsidy in 2010, total gross income for the household in 2009 and household size were recorded. An additional 376 dependents who were listed on the plans of qualified applicants also received the subsidy, but income and household size was not tracked.

Eligibility for the subsidy was based on household income at or below 220% of the federal poverty level (FPL). Applicants were required to submit proof of household income, preferably through a Form-1040 Federal Income Tax Return for each member of the household or alternative documentation to support their income claim. Additionally, applicants with non-taxable income such as Social Security or unemployment (in 2009 the first $2400 of unemployment income was not taxed) were asked to submit documentation of that income.

Figure 1 describes the MCHA population and the LSP policyholder subgroup for whom income data was available. As shown, the LSP population represents only a portion of the total MCHA population.

Figure 1. MCHA Population, 2010.

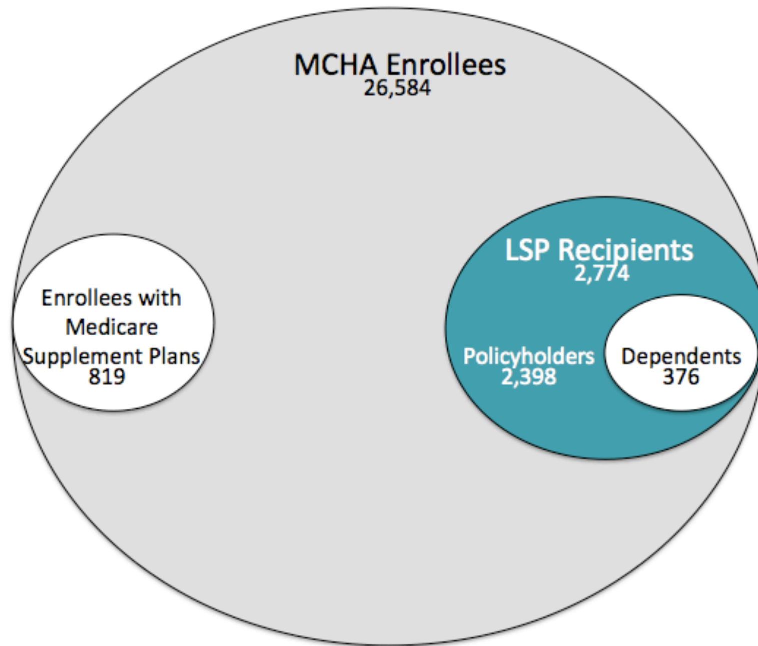


Table 4 describes MCHA enrollment numbers in deductible plans and Medicare supplement plans. As shown in the table, 2,398 policyholders and 376 dependents qualified for the subsidy.

Table 4. MCHA Enrollment by Plan Type and Participation in the 2010 Low-Income Subsidy Program, 2009-2010.

Enrollees with Deductible Plans				Enrollees with Medicare Supplement Plans
Policyholders = 22,196		Dependents = 3,569		819
LSP	*No subsidy*	*LSP*	*No subsidy*	
2,398	19,798	376	3,193	

Source: MCHA 2010 LSP data and MCHA 2009 Health Care Report.

Analysis

Estimates of the number of MCHA enrollees who will meet the new income eligibility criteria under the ACA were generated in two ways. First, estimates were generated using the LSP data only. A second estimate was generated using the 2009 American Community Survey, an annual household survey conducted by the United States Census Bureau.

In order to identify future coverage options for low-income MCHA enrollees under the ACA, enrollees were identified based on whether their current housheold income would meet the new

income eligibility criteria for Medicaid, the basic health plan and subsidies in the exchange. One of the major coverage initiatives included in the ACA is the expansion of Medicaid to include all individuals with incomes up to 138% of the federal poverty level (FPL). The new eligibility criteria includes a five percent income disregard so the number of MCHA enrollees with incomes from zero to 138% FPL will be estimated (ACA, 2010).

MCHA enrollee eligibility for the basic health plan will be estimated based on incomes from 139% to 200% FPL. Finally, the number of enrollees who would be eligible for federal subsidies to purchase private insurance in the exchange will be predicted by estimating incomes ranging from 201% to 400% FPL.

Although a limited source of income data for MCHA enrollees, the LSP data provide the only available records of exact gross household income to generate these estimates. The rules regarding determination of income eligibility for public coverage or subsidies have not yet been released by the Centers for Medicaid and Medicare Services (CMS), however total gross household income including taxable and non-taxable income was used to determine eligiblity for the LSP. Based on information currently available about income calculation using MAGI, it appears the total gross household income calculation used for the LSP will align closely. Estimates of low-income enrollees using the LSP data represent MCHA members with incomes from 0 to 220%FPL, as these were the members who supplied household information for application to the Low-Income Subsidy Program.

Household income estimates for all MCHA members were generated using the 2009 American Community Survey (ACS) Public-Use Microdata Sample (PUMS). The ACS is an annual survey conducted by the United Stated Census Bureau that collects information on demographics, income, education, education, employment, occupation and other topics. The sample used for this analysis included civilian non-institutionalized residents of Minnesota, which resulted in a sample size of 1,917,748 for 2009 (United States Census Bureau, 2010). Five-digit zip codes were aggregated to Public Use Microdata Areas (PUMAs), the geographic unit of analysis in the ACS, using

a crosswalk available through the Missouri Census Data Center (Missouri Census Data Center, 2010). Some zip code regions in the crosswalk spanned multiple PUMAs. In these cases, the zip code was assigned to the PUMA which encompassed the largest proportion of the zip code area. For example, a zip code area that crossed three PUMAs – 40% in one PUMA and 30% in two others – would be assigned to the first PUMA. There were 36 records for which zip code could not be identified. These zip codes were outside the state of Minnesota and so the records were removed from the analysis.

Department of Health and Human Services (HHS) Poverty Guidelines were used to identify income groups of interest related to implementation of the ACA. The HHS guidelines were considered to be more appropriate than the poverty thresholds included within the ACS as they are used for financial determination for program eligibility (HHS, 2011).

A single imputation method was used to generate income as percentage of the federal poverty level using number of MCHA enrollees in each PUMA. Percentage of the population within a poverty level threshold was identified for each PUMA and used to estimate income for the MCHA population. For example, if 20% of residents in one PUMA had incomes from 0 to 138% FPL, we estimate that 20% of MCHA enrollees in that PUMA have similar incomes. Because income eligibility for Medicaid, the basic health plan, and subsidies in the exchange will no longer require an asset test in 2014, we can estimate income eligibility from total gross income reported in the ACS.

Results

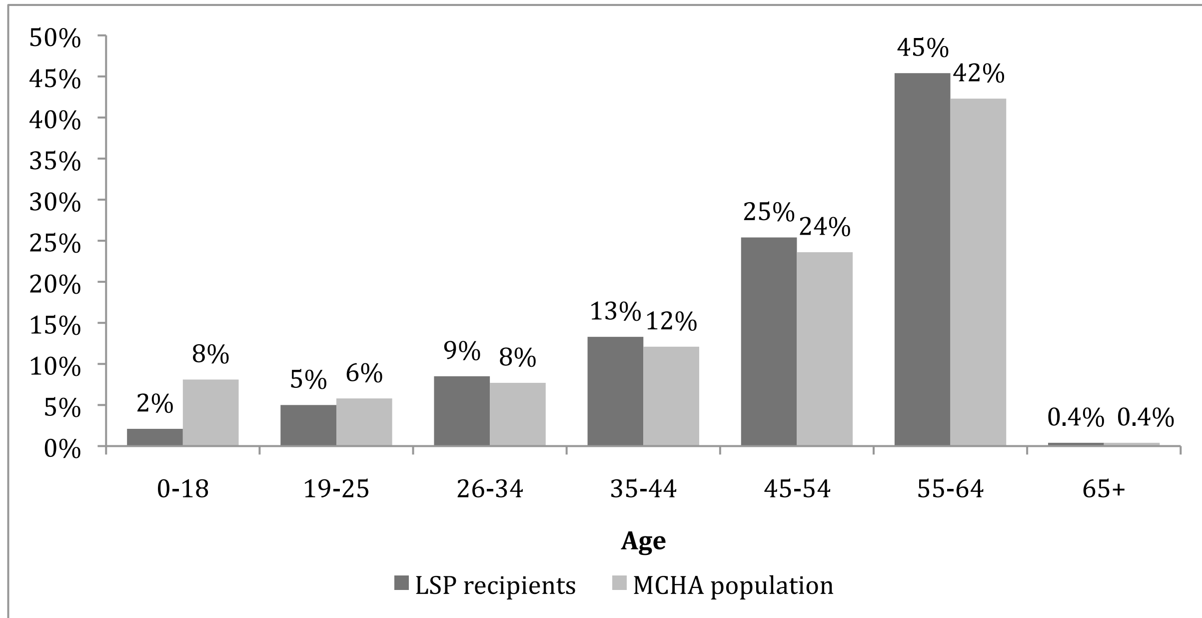
The 2010 Low-Income Subsidy Program distributed $610.28 to each of 2,774 eligible MCHA enrollees totaling $1,674,608. For the purposes of the LSP, eligibility was tracked only through policyholders. Although both policyholders and dependents received the $610.28 subsidy, the LSP

data identified only policyholders as subsidy recipients. Income and household size were not documented for the 376 dependents that received the subsidy, but were included in the estimates.

Demographics

The MCHA population consists of slightly more female enrollees (53.4%) than male enrollees (46.6%). LSP gender distribution is similar (52.5% women; 47.5% men). Most enrollees are over age 45, with over 40 percent of MCHA enrollees and LSP recipients comprising ages 55 to 64. Figure 2 shows that 45% of MCHA enrollees and 42% of LSP enrollees between ages 55 and 64. As shown, these MCHA enrollees represent an older population that is not yet eligible for Medicare benefits, but who have a higher likelihood of being denied health insurance on the private market due to age and health status. Most people in the United States become eligible for Medicare at age 65, yet a very small percentage of enrollees age 65 and over (0.4% or 101 enrollees) are enrolled in MCHA deductible plans. These individuals are likely not eligible for Medicare and so choose to purchase MCHA coverage. Reasons for Medicare ineligibility are not having citizenship or permanent resident status in the United States or not having worked 10 years in Medicare-covered employment for entitlement of Medicare benefits (HHS, 2011).

Figure 2. Age distribution of low-income subsidy recipients and MCHA population, 2010.

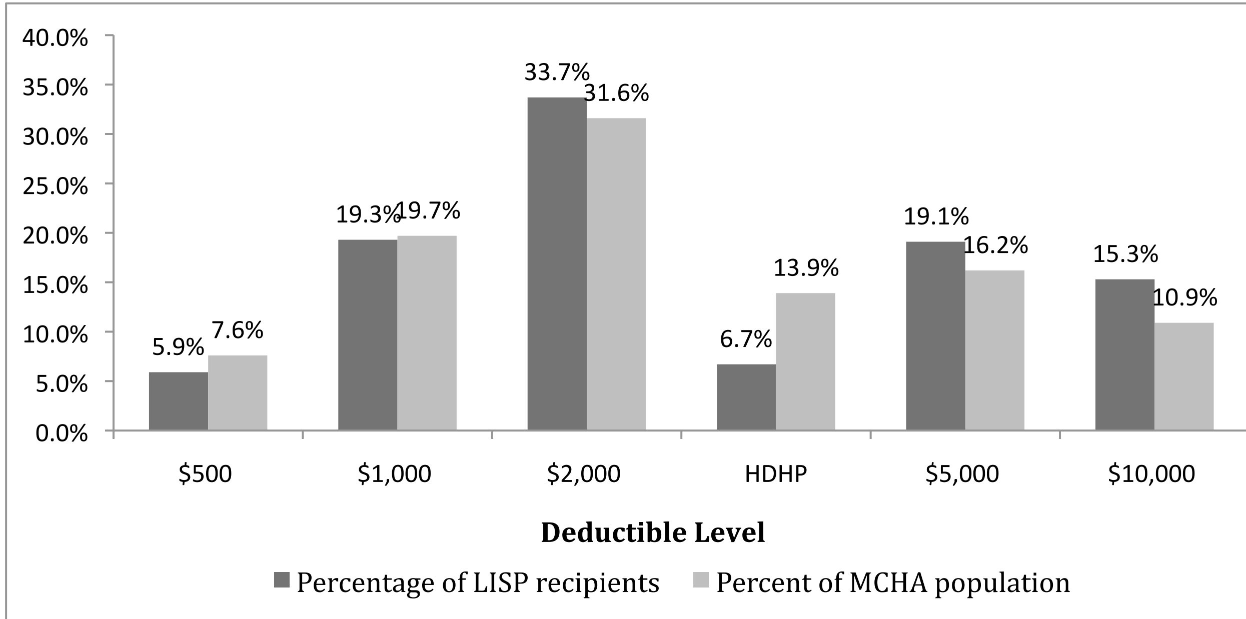


Plan types

The majority of MCHA enrollees are policyholders, approximately 86% of all enrollees. MCHA allows families to enroll spouses and children on one plan, however, many families choose to hold individual plans for each family member to cater towards their deductible and premium level preferences. Of the 2,744 enrollees who received the subsidy for 2010, 2,398 were individual policyholders, or roughly 86% of recipients.

Figure 3 identifies the distribution of deductible levels for low-income subsidy recipients and all MCHA enrollees. Low-income subsidy recipients have plan choices similar to the general MCHA population. A deductible of $2,000 is the most common plan for both groups of enrollees (33.7% and 31.6%, respectively). As shown, 15.3% or subsidy recipients (367 enrollees) have plans with a $10,000 deductible.

Figure 3. 2010 Low-income subsidy recipient and MCHA population health plan deductible level on 3/1/2010.



Income estimates from LSP enrollee information

Almost half of subsidy recipients (0-220%FPL), or 49.1%, were found to have incomes between zero and 138% of the federal poverty level (FPL). Under ACA, these enrollees would be eligible for Medicaid. Table 5 provides information on income for policyholder recipients and estimates for dependent recipients.

Table 5. Estimated income level of Low-Income Subsidy Program recipients using 2010 LSP income data.

Percent of Federal Poverty Level (FPL)	Number of LSP (Policyholder) Recipients	% LSP Policyholder Recipients	Estimate of LSP (Dependent) Recipients	Estimate of Total LSP Recipients	% MCHA Enrollees
0-138%	1,177	49.1%	185	1,362	5.3%
139-200%	829	34.6%	130	959	3.7%
201-220%	392	16.3%	61	453	1.8%
Total	**2,398**	**100%**	**376**	**2,774**	**10.8%**

Assuming LSP recipients represent all MCHA enrollees with incomes from 0-220%FPL, the percentage of MCHA enrollees with incomes at this level would be 10.8%. Because we know that some enrollees with incomes between 0-220%FPL did not apply to the LSP, this calculation likely represents a conservative estimate of the number of MCHA enrollees with incomes 220%FPL or below. For this reason, a second analysis to estimate all low-income MCHA enrollees was conducted.

Income estimates from the American Community Survey (ACS)

The estimates generated using the American Community Survey found a much higher proportion of low-income MCHA enrollees than the estimates using LSP enrollees only. Approximately 16.7% (compared to 5.3%) were found to fall in the lowest income category (138%FPL or below). Table 6 illustrates the number of enrollees estimated to be eligible for Medicaid (0-138%FPL), for the basic health plan (139-200%FPL), or subsidies in the exchange (201-400%FPL) based on ACS data. As shown, 58% of enrollees could be eligible for subsidized or free health care coverage in 2014 as their incomes reflect poverty level thresholds below 400%FPL.

Table 6. Estimated income distribution of MCHA Enrollees by federal poverty level (FPL) using 2009 American Community Survey estimates.

Percent of FPL	Number of MCHA Enrollees	% MCHA Enrollees
0-138%	4,288	16.67%
139-200%	2,387	9.28%
201-400%	7,504	32.04%
401%FPL+	10,811	42.02%
Total	**25,730**	**100%**

Discussion

The results of this study provide evidence that a majority of high-risk pool enrollees in Minnesota could be eligible for new coverage options under the Affordable Care Act. At a minimum, roughly 2,800 MCHA enrollees will likely be eligible for some form of subsidized health insurance in 2014, determined from participation in the LSP. This is undoubtedly an underestimate due to the voluntary nature of participation in the low-income subsidy program for MCHA. Because participation in the LSP is voluntary, we know there are likely more MCHA enrollees at an income level between 0-220%FPL than applied for the subsidy.

Estimates from the American Community Survey yield a much larger percentage of MCHA enrollees that could be eligible for new subsidized coverage options. The ACS income estimates show a three-fold increase in the number of enrollees that would be eligible for Medicaid in 2014. The number of enrollees expected to be eligible for the basic health plan (139-200%FPL) were also markedly higher with the ACS estimate.

MCHA does not have an income limit or an asset test for determining eligibility, but does screen applicants for eligibility in Minnesota's public coverage programs at enrollment. It is possible, however; that some enrollees who were not eligible at the time of their enrollment have since become eligible due to a change in income or asset limits. If, based on ACS estimates, over 4,000 MCHA enrollees currently have incomes at or below 138%FPL, this poses questions about their lack of participation in the subsidy program as well as the possibility they might currently be eligible for public coverage. Current eligibility in public coverage might be limited due to the asset test used for Medicaid (Medical Assistance) and MinnesotaCare. In 2014, however; the asset test will be eliminated and MCHA enrollees with incomes at or below 138%FPL will be eligible regardless of their assets.

One limitation of these estimates is the lack of guidance currently available from the Centers for Medicare and Medicaid Services on the new income determination methodology using Modified

Adjusted Gross Income (MAGI). Income for the LSP was determined using total gross income or money entering the household, including non-taxable sources of income such as Social Security, alimony, and pensions. Although this aligns closely with the taxable and non-taxable income included in MAGI, the LSP required inclusion of all individuals in the household instead of being based on tax filing status reflected in MAGI. There are also considerations for how MAGI will be used for low-income individuals below the tax filing requirement ($9,350 for a single individual under age 65) and whether annual income used for tax purposes will be utilized in determining current income for public coverage eligibility (IRS, 2011).

Affordability will be key to whether individuals choose to purchase insurance through the exchange. Medicaid coverage will undoubtedly be a more affordable option for high-risk pool enrollees, as they will not be required to pay premiums. It is currently unknown, however; how the subsidies offered in the exchange compare with the high-risk pool subsidy and whether this will make insurance coverage in the exchange a more affordable option in 2014.

Policy Implications

In Minnesota, the Minnesota Comprehensive Health Association (MCHA) provides coverage for roughly 27,000 enrollees. Although its impact seems small, MCHA is an important safety net for high-risk Minnesotans, providing a coverage option for a population that might not have any other options. It should be recognized that the MCHA population has specific needs in the insurance market. Most MCHA enrollees are medically uninsurable, meaning they have chronic health conditions that require routine and specialized care. Enrollees with these types of health needs often have difficulty maintaining employment, which results in strained finances and lower income.

The expansion of public coverage to include MCHA enrollees poses implications for state spending. In 2008, total health care claims for MCHA totaled $245,773,335 for approximately 28,107 enrollees, or about $8,744 per enrollee (MCHA, 2010b). These costs, currently paid for

through enrollee premiums and insurer assessments in MCHA, would be transferred to the state and federal government for those enrollees taking up Medicaid coverage.

Medicaid is financed through federal and state government contributions. The federal share is known as the Federal Medical Assistance Percentage (FMAP) and is determined for each state in Title XIX of the Social Security Act (Chun, 2010). The original FMAP for Minnesota is 50%, which was raised to over 60% during 2008, 2009 and 2010 in the American Recovery and Reinvestment Act (ARRA). Starting in 2011, the FMAP returned to its original 50%.

The Affordable Care Act establishes a 100% federal match for newly eligible populations in 2014, but this financial assistance is scheduled to last only until 2016 (ACA 2010). After 2016, the state must gradually assume more of the cost for the newly eligible population as the Federal Medical Assistance Percentage (FMAP) decreases. In 2017, the FMAP becomes 95% and decreases 1% for two years. Starting in 2020, the FMAP will be 90% and remain there (ACA 2010). Although a 90% FMAP relieves some burden on the state as compared to the original 50% FMAP, there are still additional costs that will be incurred by the state with a high-risk, high cost population entering Medicaid.

Thousands of high-risk enrollees entering new insurance markets will certainly hold implications for the risk profiles of the exchange population as well as those in public coverage programs. Cost containment is an ongoing concern for MCHA, especially considering the higher rates of increase for health care spending for this population when compared with average costs in the state of Minnesota (Blewett et al, 2011). Introduction of these enrollees into the exchange could impact the affordability of plans for healthy individuals considerably. In developing the Health Benefit Exchange, the state should consider the unique high-risk population and the changing risk profile for the exchange market. Blewett et al (2011) suggests that the transition of high-risk pool enrollees to the exchange will require substantial subsidies in order to prevent adverse selection by health plans. Development of a risk-adjustment mechanism in the exchange that incentivizes health

plans to offer plans that enroll higher-risk people will also be important in discouraging adverse selection and ensuring plans compete on consumer choice (Lueck, 2009).

Participation in the LSP has remained relatively stable over the last three years, with approximately 2,800 applications received and 2,400 qualifying individuals, despite the economic downturn and recession (Halleland Habicht Health Consulting, 2010). Further research on the impact of the economy for MCHA enrollees could shed light on the number of newly eligible high-risk candidates in 2014. It is possible that subsidy participation has remained stable due to low-income MCHA enrollees dropping coverage they can no longer afford, and other MCHA enrollees fitting the new low-income eligibility for the subsidy due to economic hardship.

The most common plan for MCHA enrollees is a $2,000 deductible plan. Low-income enrollees had similar choices in plan types as the general MCHA population, but their usability of the plan varies drastically as their deductible rises. For households of one in the $10,000 deductible group, average income was $11,306. This means that for an adult with this salary, averaging $942 per month, a routine visit for preventive care isn't covered by the plan until they have paid $10,000 out-of-pocket. This high-risk individual likely has unmet health needs and only uses health insurance when absolutely necessary – or when they have the funds to pay for their care. For low-income enrollees who cannot afford the premiums for low-deductible plans, the only option for coverage becomes the higher deductible plan they can't afford to use.

The complicated needs of the low-income high-risk pool enrollees of the Minnesota Comprehensive Health Association are vast and varied. As the state starts its outreach to a newly eligible Medicaid population and newly eligible basic health plan population, consideration for low-income high-risk pool enrollees could be advantageous in further identifying new populations that are unfamiliar with public coverage programs. Health plans in the exchange will require a structure that supports the needs of the chronically ill, allowing them affordable access to care while controlling for the additional costs of treating their conditions. Low-income high-risk pool enrollees

will certainly have new options under implementation of the ACA and it will be important for the state, for MCHA and for the private insurance market to ensure they transition smoothly.

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