Risky Business – The Transition of High Risk Pool Enrollees to Other Coverage in 2014

Findings from the 2012 Minnesota Comprehensive Health Association (MCHA) Enrollee Survey

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Presentation Overview

- High risk pools and the Affordable Care Act (ACA)
- 2012 MCHA Enrollee Survey
- Survey Results
- Implications for Outreach

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State High Risk Pools

- Established to provide coverage to the "uninsurable"
- Financed through assessments on fully-insured health plans, state general fund revenue, and enrollee premiums
- Stabilize risk in the individual market by spreading costs associated with individuals with high-cost health care needs
- Coverage is similar to underwritten plans offered in individual market and they do have similar rating practices
- Premiums are capped between 125% and 250%
- As of 2011, there were 35 states with high risk pools, covering approximately 227,000, with over $2.5 billion in paid claims

The Affordable Care Act (ACA) and Individuals with Preexisting Conditions

- Prohibits pre-existing condition exclusions
- Introduces premium rate restrictions in individual and small group markets
- Prohibits lifetime or annual limits
- 100% coverage for preventive care
- Provides new subsidized coverage options
  - Medicaid (income ≤ 138% FPL)
  - Premium and cost sharing subsidies through the exchange (income 139 to 400% FPL)
- Temporary national HRP (enrollment of 107,000 in January 2012)

Transition of High Risk Pool Enrollees

- Three programs to encourage gradual transition, spread risk and minimize adverse selection in exchange
  - **Temporary reinsurance** and risk adjustment from 2014 to 2016 and permanent risk corridors
- Guidance in December, 2012 stipulated that high risk pools were not eligible for reinsurance money
- Incentive for states to transition high risk pool enrollees quickly

Minnesota Comprehensive Health Association

- Five Eligibility Avenues:
  - Loss of group coverage
  - Medicare ineligibility
  - Health-related rejection
  - Presumptive condition(s)
  - Health Coverage Tax Credit (HCTC) program

- Among the longest-running and largest state high risk pools in the country
  - Currently, 26,000 enrollees
- Premiums capped at 125% of individual market
- Lifetime maximum benefit of $5,000,000
- Administered by Medica Health Plan

2012 MCHA Survey: Objectives

- Provide information to MCHA to help transition enrollees into new ACA coverage options
  - Assess potential eligibility for Medicaid and exchange
  - Gauge enrollee familiarity with ACA changes
  - Collect information to inform outreach and communication strategies
- Gain knowledge of how MCHA enrollees might impact risk pools
  - Collect information on health status, pent-up demand

Methodology

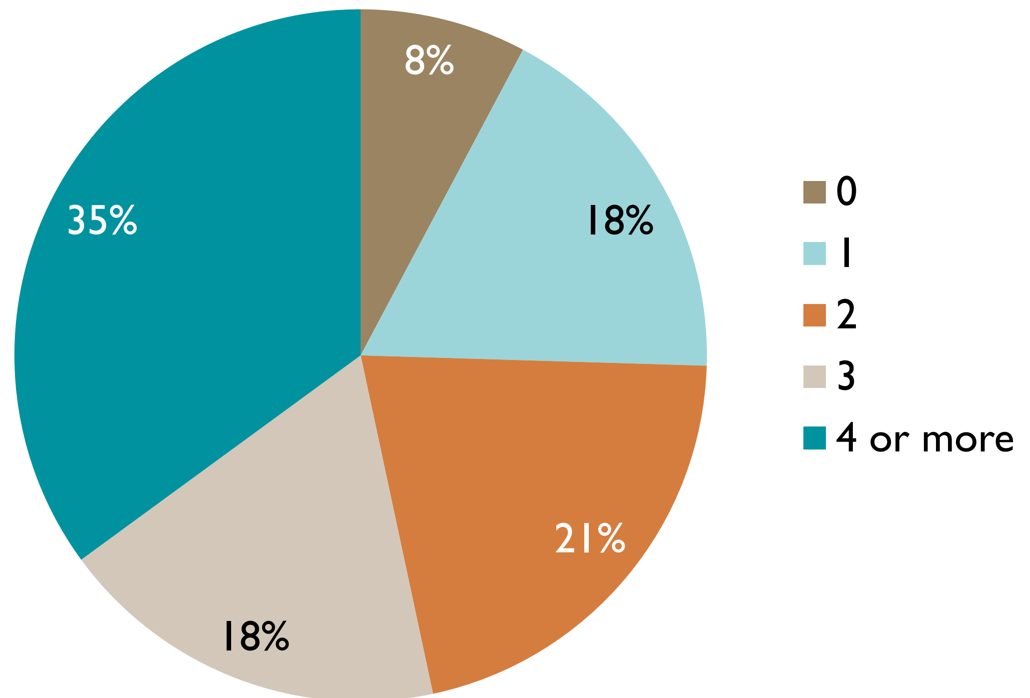
- Mail survey of 5,200 MCHA enrollees
  - Policy holders enrolled for 12 months
  - Excluded children and those with Ryan White and HCTC eligibility
- $2 incentive payment with survey mailing
- Oversampling of low-income enrollees (used receipt of low income subsidy as proxy) and those in rural areas
- Survey response rate was 50.2%
- Weighting adjustments were conducted
- Income imputed for 6% of cases

Enrollee General Demographics

- Mean age is 52 years
- Slightly more females than males (53%)
- Almost 60% live in an urban area
- A quarter have less than a high school education
- 70% are employed or self-employed
- Majority report incomes above 400% FPG
- Most enrollees (82%) have total family assets that exceed $20,000

Enrollee Health Characteristics

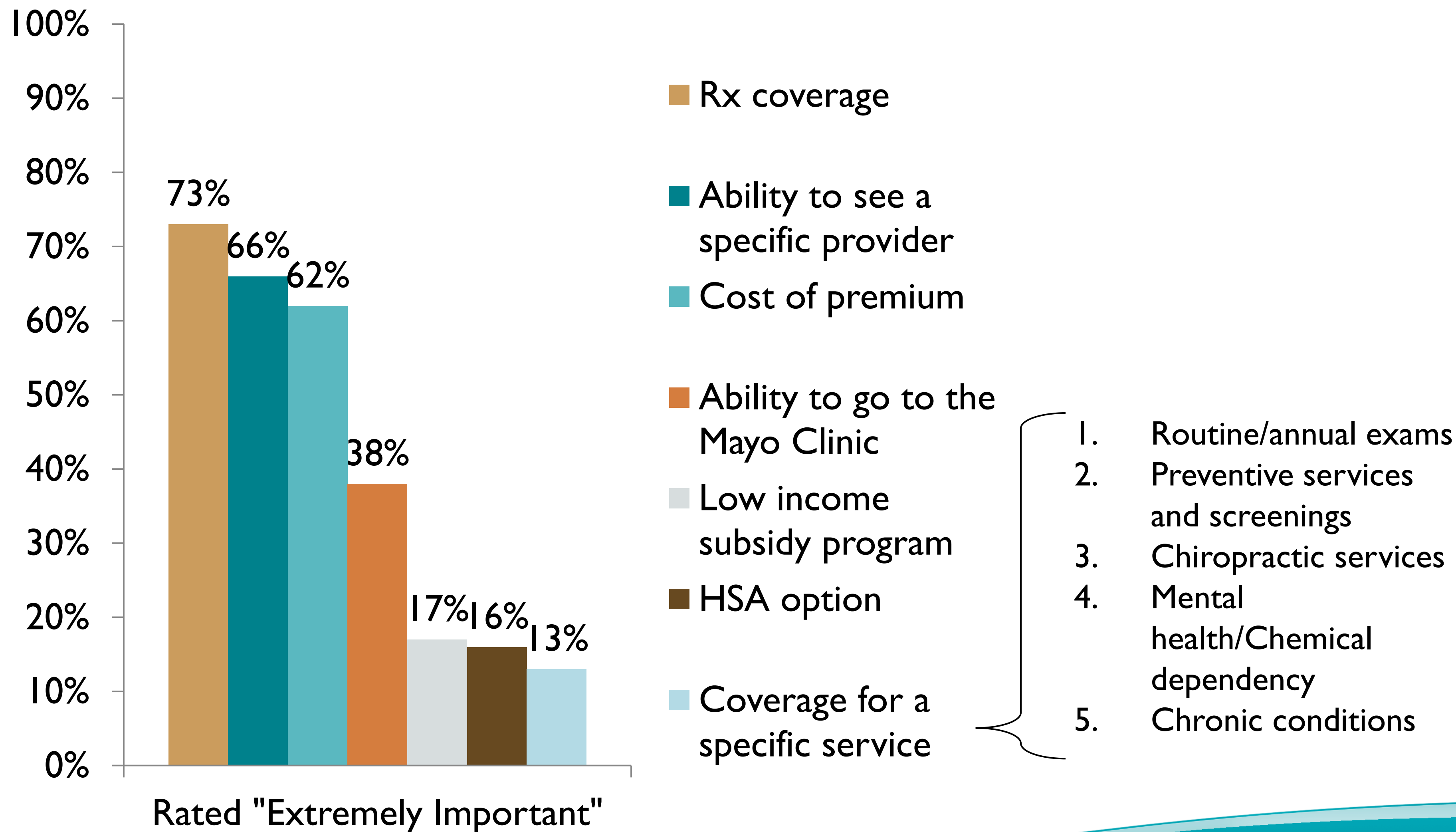
- MCHA enrollees report good health, only 15% report fair or poor health
- 92% of enrollees report having at least one chronic condition
- The most common chronic conditions:
  - high blood pressure
  - weight condition
  - high cholesterol
  - allergies
  - arthritis/osteoporosis



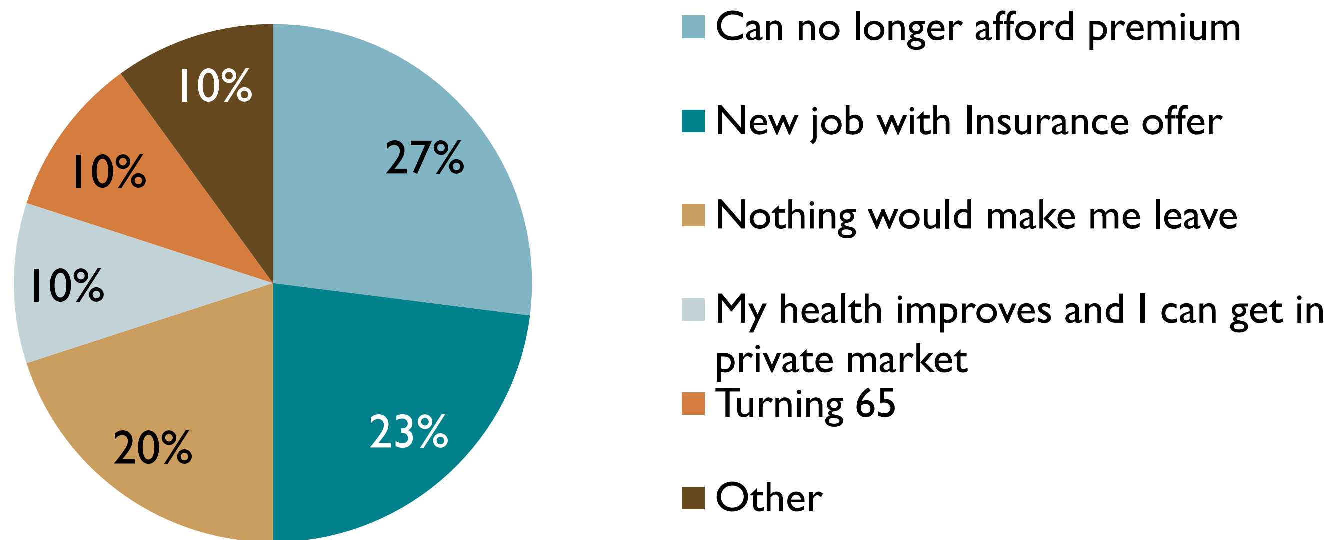
Enrollee Experience with MCHA

- More than two-thirds have been in MCHA for more than 4 years
- Almost a quarter have been in MCHA for 10 years or more
- Rural enrollees are more likely to have been on the program for 10 years or more (26% vs. 20%)
- More than one third of enrollees have high deductible plans ($5,000 and $10,000)
- **81% report being somewhat/very satisfied with their MCHA insurance coverage**

Features of MCHA Coverage that are Important to Enrollees



Primary Reasons Enrollees Would Leave MCHA



Of the enrollees that responded, "nothing would make me leave":

- 29% are unaware of other health insurance options
- 19% report that other companies will not cover me/my family due to preexisting conditions
- 14% report that MCHA is the only coverage that offers Mayo clinic
- 13% report other plans will not cover me/my family

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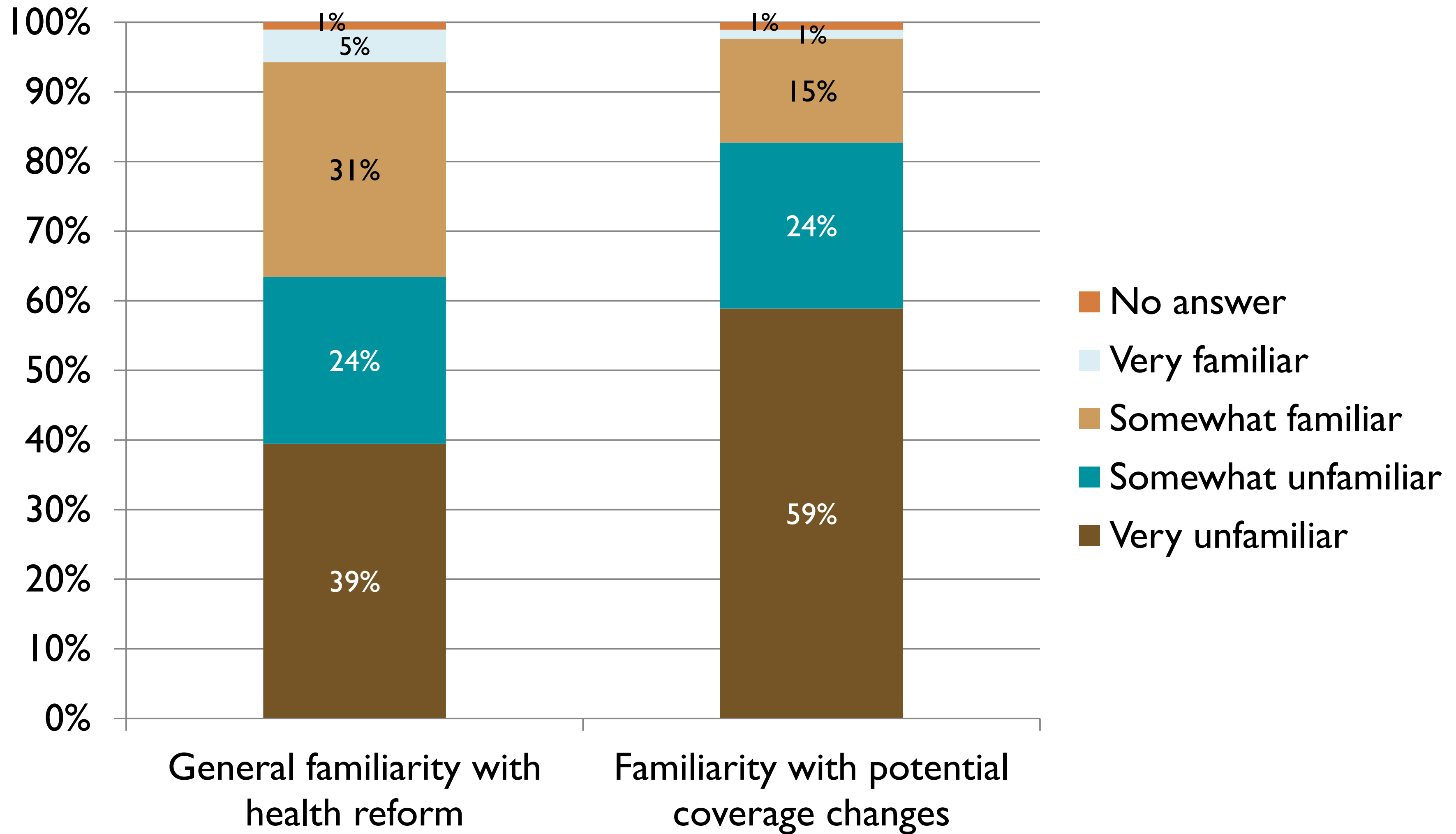
MCHA Enrollees Potential Eligibility for New Coverage Options in 2014

- The majority of enrollees will likely get no federal financial support for their health insurance coverage

Income as % FPG	% MCHA Enrollees	Eligibility for Financial Support
Less than or equal to138% FPG	9%	Medicaid
139-400% FPG	37%	Premium and cost-sharing subsidies through the exchange
Above 400% FPG	55%	None

Enrollee Familiarity with Health Reform



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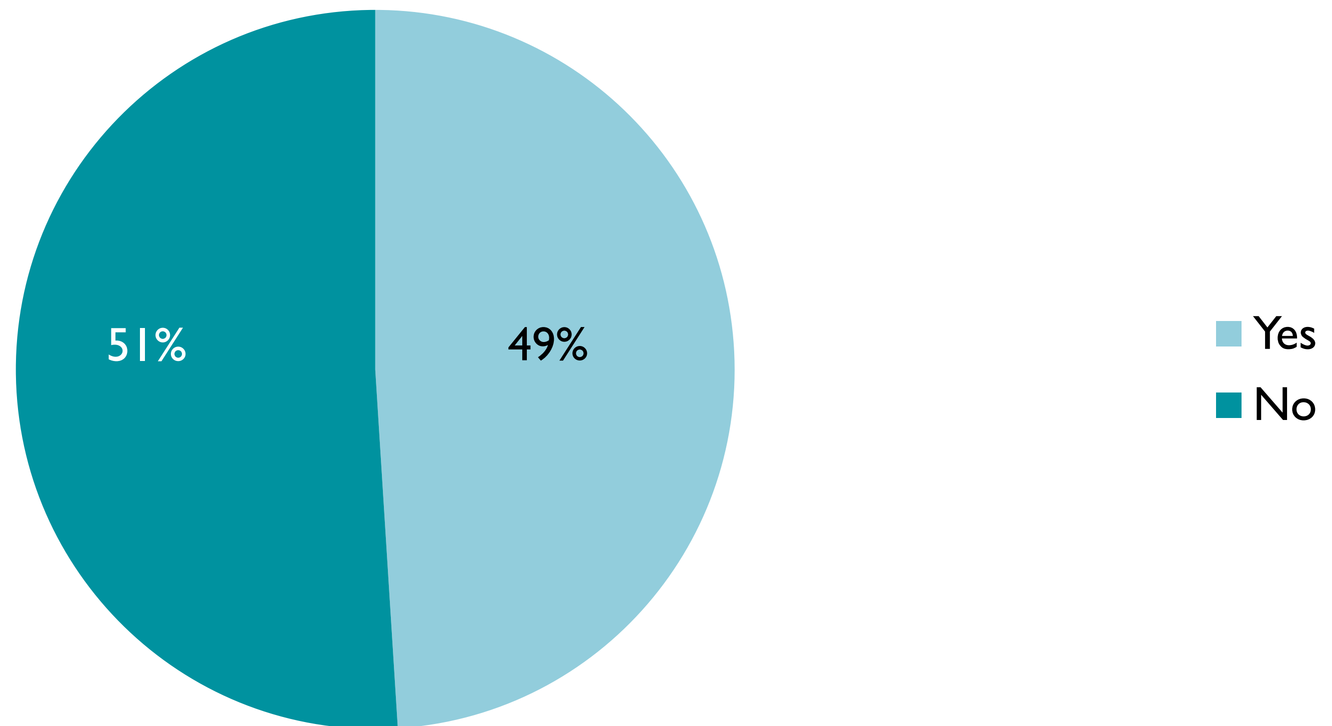
Enrollees Worries About Changes Under Health Care Reform

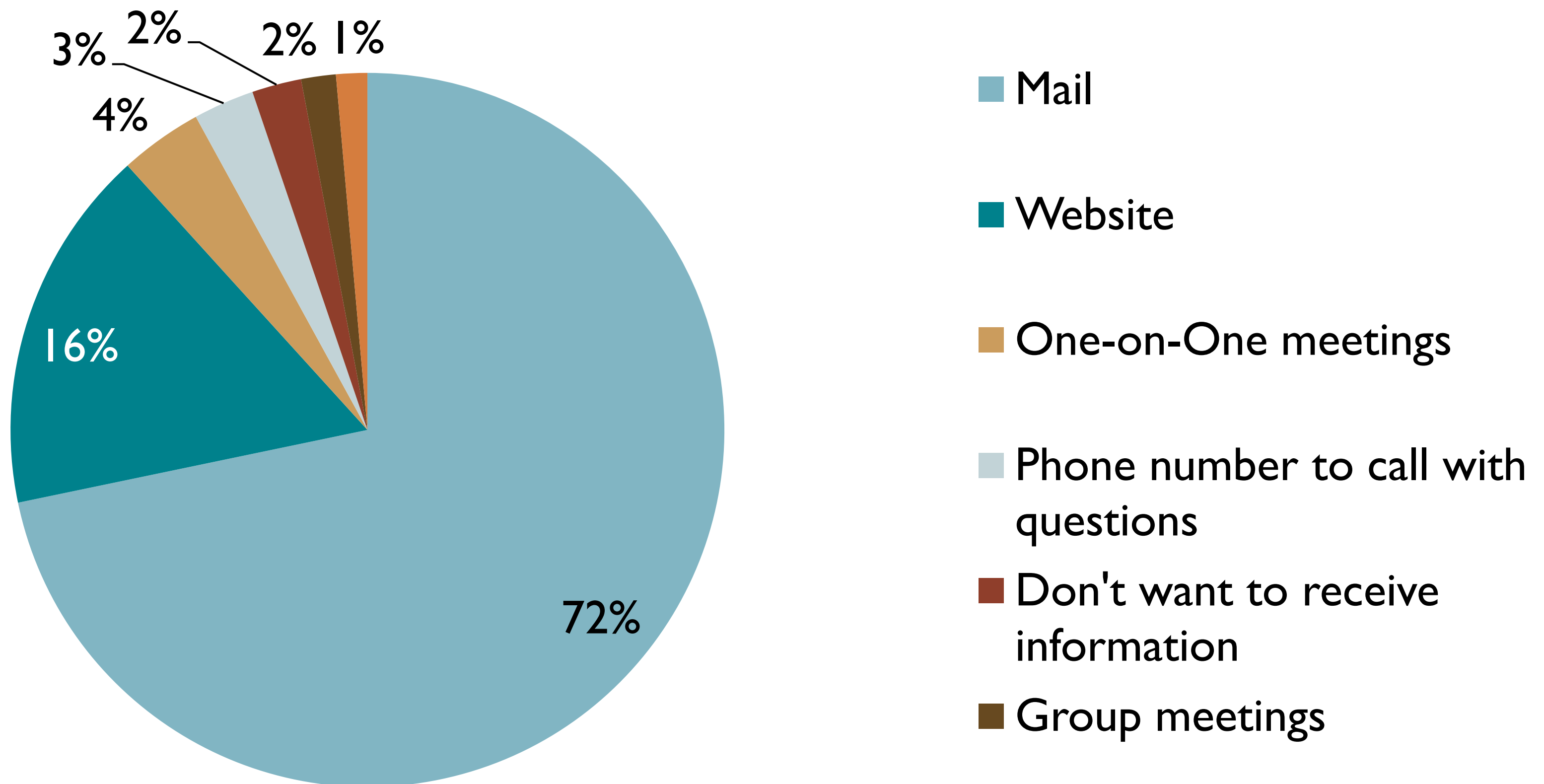
Self Report of Worried/Very Worried	% Enrollees
Having to pay more for premiums	92%
Having to pay more for deductibles and coinsurance	91%
Not being able to afford the health care services you think you need	86%
Not being able to afford the prescription drugs you need	79%
The quality of health care services you receive getting worse	74%
Having to change doctors	73%
Not being able to get the health care services you need for reasons other than money	73%
Having to change health plans	69%

Willingness to Enroll in a Public Program

If you learned you were eligible for a public program at no cost, would you enroll?

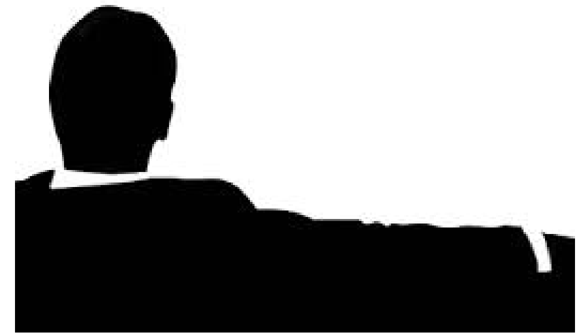


Possible Outreach Methods



Implications for Marketing and Outreach

- The "selling" of the new coverage options needs to start now in a variety of formats
- Messaging should include:
  - No exclusion based on pre-existing conditions
  - First dollar coverage for preventive services
  - No lifetime limits
  - Financial support (for those that qualify)
  - Information about finding insurance that covers preferred doctors and Rx



Implications for Outreach

- Messaging and outreach may need to differ by:
  - Rural vs. urban
  - Eligibility type (Medicaid vs. exchange)
- Outreach will need to address expectations about the cost of new coverage options (very difficult!)
- Messaging needs to combat the negative image of "public programs"
- Ideally, assistance should be specialized for this population (e.g., special training for in person assisters)

Contact Information

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