Appendix K. Examples of States' Risk Pool Programs

Minnesota

Minnesota has had a risk pool longer than any other state in the U.S. The Minnesota Comprehensive Health Association (MCHA) is a nonprofit corporation established by the Minnesota State Legislature in 1976 and regulated by the Minnesota Department of Commerce. Like other state pools it offers individual health insurance policies to residents of the state who have been rejected for insurance in the private market due to preexisting health conditions. MCHA policies exclude coverage for preexisting conditions for the first six months, but there are ways to get this waived.

Health insurance policies issued by MCHA are priced between 101 percent and 125 percent of the average private market individual policy. The State of Minnesota does not provide any financial support. Premiums paid by those enrolled in MCHA pay for part, but not all, of MCHA's insurance claims and administrative costs. The remainder of MCHA's insurance claims and administrative costs are paid for by assessments made to Minnesota's commercial health care insurance carriers, HMOs, Blue Cross and Blue Shield of Minnesota, and other organizations.

Health insurers are assessed for net losses in proportion to share of total health insurance premium received in the state during the year. Originally, the Health Care Access Fund (HCAF) was funded by a 2 percent tax on hospital and provider charges. A 1997 amendment to the law reduced the health care provider tax to 1.5 percent for calendar years 1998 and 1999. While hospitals and providers pay the tax, it is passed to purchasers in the form of increased charges. Self-insured employers must pay the tax, and therefore contribute indirectly to the HCAF. Most of the Access Fund's resources go to fund the Minnesota Care low-income health care subsidy program. Currently there are 26,000 participants in HCAF, 0.0055 percent of the total population of Minnesota.

Source: Minnesota Attorney General's Office, *Minnesota Health Care Consumer Connection*. Online. Available: http://www.ag.state.mn.us/consumer/health/MMHC_gov.htm. Accessed: February 12, 2001.

Oregon

The Oregon Medical Insurance Pool (OMIP) was established by the 1987 Oregon Legislature to provide medical insurance coverage for all Oregonians who are unable to obtain medical insurance because of health conditions. OMIP issued its first policy in July 1990. It also provides health benefit portability coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them.

One of four states including California, Minnesota, Oklahoma and Oregon to have premium caps set at no more than 125 percent of average on their risk pool premiums. The state legislature expanded the subsidized insurance coverage available to low income, uninsured people above Medicaid. While the program's primary purpose is to provide subsidies to assist the low income uninsured, it employs a subsidy system using

the private insurance system that is also used to subsidize coverage through the state risk pool. The plan provides subsidies at different percentages, based on the applicant's income, from Medicaid up to 170 percent of the federal poverty level. Currently there are 6,500 participants in OMIP, 0.00196 percent of the total population of Oregon.

Source: Oregon Department of Consumer and Business Services, *Oregon Medical Insurance Pool*. Online. Available: http://www.cbs.state.or.us/external/omip/index.html. Accessed: February 12, 2001.

Tennessee

During the 1990s Tennessee made several significant changes in its risk pool and now has one of the most unique methods of insuring its citizens. Until 1990, pool association members were assessed for net losses in proportion to their share of total health insurance premiums received in the state during that year. This is similar to the current method in Texas except that the assessments were granted as a tax offset up to $3 million. In 1990 the assessments were changed so that that insurers were assessed based on their share of the number of participants in their program as compared to the total number in the state. During this period no tax credit was allowed and association membership was expanded to included HMOs and PPOs. In 1992 Tennessee reverted to assessing based on net losses, but in 1994 Tennessee passed legislation creating the TennCare program. Its risk pool program was phased out as of June 30, 1995.

Currently in Tennessee individuals with preexisting health conditions and rejected applicants now have access to coverage through TennCare and pay premiums at a sliding scale rate similar to others in the Medicaid and low income population. TennCare extends health care coverage beyond the Medicaid population to some 400,000 previously uninsured low-income workers, and to the high-risk, medically uninsurable. The high-risk, uninsurable people and families in TennCare pay premiums on the same, sliding scale based on income as the other categories of the TennCare population.

Premiums for the uninsured range from $0 for people at the federal poverty level or below, and are scaled up according to income. Premiums for the uninsurable population are similarly scaled, with the top two categories being for people between 400 and 749 percent of poverty and for 750 percent of poverty and above. At the highest income levels, individuals pay the full cost of the insurance coverage without a state subsidy. Premium costs are still lower compare to most other special state high-risk programs. Pooling federal, state and local expenditures for indigent care finances TennCare's plan.

Source: Tennessee Bureau of TennCare, *Tennessee's TennCare Program*. Online. Available: http://www.state.tn.us/health/tenncare. Accessed: February 12, 2001.

California

California has the second-largest risk pool in the U.S., only surpassed by Minnesota. As of June 1999 California had 21,429 participants in its high-risk pool compared to 4,929 participants in Texas. Currently 0.000647 percent of the citizens of California participate in its high-risk pool. As a result of the high demand for risk-pool services in California and limited resources, there is a waiting list for participation that can last anywhere from three to six months.

Established in 1991, the plan is funded through subscriber contributions and the Major Risk Medical Insurance Fund directly by the State of California. The California Major Risk Medical Insurance Program (MRMIP) is an innovative program developed to provide health insurance for Californians who are unable to obtain coverage on the open market. Services in the program will be delivered through contracts with health insurance providers. Californians who qualify for the program participate in the payment for the cost of their coverage by paying premiums on their own behalf. The program is funded by $40 million from tobacco tax funds. California is one of only five states who fund their pool with funds from general revenues, income tax revenues, or tobacco tax revenues.

Source: California Managed Risk Medical Insurance Board, *Major Risk Medical Insurance Program*. Online. Available: http://www.mrmib.ca.gov/MRMIB/MRMIP.html. Accessed: February 12, 2001.