Expert Q&A: Missouri's High-Risk Insurance Pool
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From 1991 to 2013, the state of Missouri operated a high-risk insurance pool for individuals without other coverage options to purchase insurance. Mary C. Becker, MHA Senior Vice President of Strategic Partnerships and Communications, served on the board of directors of the Missouri Health Insurance Pool from 2004 until all operations ceased in December 2016 and as its chair since 2014. Since the establishment of state-based high-risk pools is part of the federal Affordable Care Act replacement discussions, the following FAQs highlight the operational aspects of Missouri's former high-risk pool and the results.

What was the purpose of the Missouri Health Insurance Pool?
The Missouri Health Insurance Pool, established by statute in 1991, was one of 35 state-operated pools that provided an option for individuals to obtain health insurance in the commercial market. These Missourians were not able to purchase commercial insurance for various reasons, including medical condition, lack of available coverage through an employer or exhaustion of COBRA benefits. Lawmakers' intent was that, "All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state be members of the pool."

How was MHIP governed?
Oversight was provided by a nine member board of directors consisting of the director of the Department of Insurance, Financial Institutions and Professional Registration or designee, and eight members appointed by the director. Members of the board were to have a background and experience in health insurance plans or health maintenance organization plans, health care finance, or as a health care provider or member of the public.

Who operated the pool?
The pool was managed by a small staff, including an executive director, accountant and an administrative support staff person.

How was the pool funded?
MHIP was funded by premiums paid by its enrollees, and by assessments paid by health insurers and HMOs issuing coverage to Missouri residents. The health insurers received a tax credit on their assessments. Total revenue in 2012 was $50.5 million from the following sources.

- 59.9 percent from premiums
- 36 percent from insurer assessments
- 2.8 percent from federal grants (that went to help offset premiums for some enrollees)
- 1.2 percent from interest and/or rebates

What were the requirements for enrollment?
MHIP's state pool was designed as an alternative insurance option for insured individuals searching for more affordable or more complete coverage, and those who have recently lost coverage through a group plan. However, MHIP's authorizing legislation included in the plan design a pre-existing condition exclusion. Individuals treated, diagnosed or receiving prescription medication for a medical condition in the six-month period before the enrollment date would have no benefits provided for treatment of that same condition for 12 months. This requirement was waived in four situations.

What was the enrollment in MHIP?
Enrollment in MHIP fluctuated annually, with the highest enrollment at 4,116 in 2010. Details of the 2012 enrollment include the following.

- 2,103 total applications were received
- 74 percent of applications were accepted for coverage
- The average MHIP member was 48 years old and had been covered by the pool for 3.6 years

Beginning in 2010, the Affordable Care Act created a federal Pre-Existing Condition Insurance Plan. Missouri chose to operate a PCIP, which was in place between July 1, 2010, and January 1, 2014, serving part of the same population. MHIP operations began to wind down in 2013, when enrollment began to decline, and in advance of the federal health insurance marketplace.

Historic factors leading to enrollment shifts include, among others, the following.

- Contraction in the number of individual health insurers in Missouri.
- Stricter underwriting imposed by individual health carriers.
- Significant premium increases by carriers required to offer HIPAA guarantee-issue policies.
- Increased awareness of the federal pre-existing condition insurance pool and decision by MHIP members to wait out the six-month uninsured requirement to be eligible for the federal PCIP where premiums were lower.

It is estimated that in 2015, 30 percent of nonelderly Missourians had pre-existing conditions that would have been declinable before the Affordable Care Act.

How were premiums determined?
By law, MHIP premiums were based on separate schedules according to age, gender and deductible. Premiums could not be lower than 125 percent of the average individual standard rate nor exceed 200 percent of the average individual standard rate. As fewer carriers chose to underwrite these high-risk individuals, high premiums restricted the number who could afford to enroll, and many remained uninsured. In 1999, the MHIP board allowed premiums to gradually decrease relative to the average individual standard rate until the rates fell to 125 percent of the average individual standard rate.

Some subsidies were available for those with incomes below 175 percent of the federal poverty level; the monthly premium reduction (subsidy) amount was $150 (for 2013 premiums). For those with incomes between 175 percent and 300 percent of the federal poverty level, the monthly premium reduction or subsidy was $100.

What coverage was provided by the pool?
Individual coverage was offered through five major medical plans, including a health savings account qualified plan, with the primary difference being the amount of the annual deductible and the out of pocket maximums.

Coverage included benefits for all standard care and treatment, including durable medical equipment and prescription drugs. The benefit coverage was limited to the standard lifetime maximum offered by the health insurance industry in the early 1990s of $1 million. For many enrollees, this cap became problematic because of the severity of their medical conditions.

What was the average deductible for participants?
In-network deductibles for MHIP participants ranged from $500 to $5,000, while out of pocket maximums ranged from $2,500 to $5,000. In 2012, MHIP enrollees paid $626 per month on average and the majority of members faced a $5,000 in-network deductible.