

**Managed Risk Medical Insurance Board  
April 21, 2010, Public Session**

Board Members Present: Cliff Allenby (Chairman);  
Areta Crowell, Ph.D.;  
Sophia Chang, M.D., M.P.H.; and  
Richard Figueroa

Ex Officio Members Present: Ed Heidig representing the Business,  
Transportation and Housing Agency; and  
Katie Marcellus representing the California  
Health and Human Services Agency

Staff Present: Lesley Cummings, Executive Director;  
Janette Casillas, Chief Deputy Director;  
Laura Rosenthal, Chief Counsel;  
Shelley Rouillard, Deputy Director for Benefits  
and Quality Monitoring;  
Teresa Krum, Deputy Director for Administration  
Division;  
Jeanie Esajian, Deputy Director Legislative and  
External Affairs  
Ernesto Sanchez, Deputy Director Eligibility,  
Enrollment & Marketing Division  
Seth Brunner, Senior Staff Counsel  
Loressa Hon, Manager in the Administration Division;  
Thien Lam, Manager for Eligibility, Enrollment, and  
Marketing Division;  
Kathy Dobrinen, Manager in the Eligibility, Enrollment  
and Marketing Division;  
Randi Turner, Manager in the Administration Division;  
Amanda Evans, Manager in the Administration Division;  
Tony Lee, Chief of Financial Operations, Rate  
Development and Contract Branch;  
Muhammed Nawaz, Manager in the Benefits  
and Quality Monitoring Division;  
Lilia Coleman, Policy & Operations Manager, Benefits  
and Quality Monitoring Division;  
Kim Elliott, Research Program Specialist I  
Larry Lucero, Manager in the Eligibility, Enrollment  
and Marketing Division;  
Darryl Lewis, Manager in the Eligibility, Enrollment  
and Marketing Division;  
Mary Watanabe, Research Program Specialist I;  
Juanita Vaca, Research Analyst II;  
Willie Walton, Research Analyst II;  
Charles Tolliver, Law Clerk;  
Maria Angel, Acting Executive Assistant to the  
Board and the Executive Director; and  
Elva Sutton, Board Assistant.

Chairman Allenby called the meeting to order at 10:00 a.m. The Board then went into Executive Session. It reconvened for public items at 11:35 a.m.

## **REVIEW AND APPROVAL OF MINUTES OF MARCH 17, 2010 PUBLIC SESSION**

Chairman Allenby asked for a motion to approve the February minutes. Lesley Cummings first offered some corrections to the minutes. A motion was made and seconded. Chairman Allenby asked for any discussion. There was none. The Board unanimously approved the minutes as corrected.

The minutes can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/agenda\\_item.3\\_minutes\\_3\\_17\\_2010.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/agenda_item.3_minutes_3_17_2010.pdf)

## **FEDERAL BUDGET, LEGISLATION AND EXECUTIVE BRANCH ACTIVITY (INCLUDING HEALTHCARE REFORM, ECONOMIC STIMULUS & BUDGET)**

Lesley Cummings reported on the passage of federal health care reform and noted that the Board had been provided with information in their packets. She summarized federal high risk pool provisions and how federal healthcare reform would affect the CHIP program. Ms. Cummings noted inclusion in the packet of Secretary Sebelius' letter to governors and insurance commissioners on establishment of a temporary federal interim high risk pool intended to bridge time between the present and when guaranteed issuance is enacted is in 2014.

She told the Board that there have been a lot of conversations nationally about the relationship between high risk pools operated by states and the relationship they may have with the new federal pool. Ms. Cummings noted that in the letter, Secretary Sebelius says it would be her preference that states administer the federal high risk pool on behalf of the federal government and that she would extend as much flexibility as possible to make that happen. Also in the letter, Secretary Sebelius asked each governor to appoint someone to be the primary contact for purposes of these discussions, and that Gov. Arnold Schwarzenegger appointed Richard Figueroa to be the point of contact with CMS.

Ms. Cummings said she and Mr. Figueroa will participate tomorrow in a call with CMS during which CMS will respond to a number of questions that existing state high risk pools have posed to CMS. Hopefully, she will obtain a greater understanding of the situation if California were to administer the federal high risk pool in the state. The Sebelius letter also asks governors to submit a letter of intent by April 30, which is under consideration by Governor Schwarzenegger at this time.

Board Member Figueroa said that to date, the letter from Secretary Sebelius is the only correspondence received from the federal government on the high risk pool. Secretary Sebelius and a member of the White House staff, Valerie Jarrett, held a follow-up call with governors yesterday, during which they reviewed the letter again and indicated there were a lot of questions from governors about details and logistics of implementation. CMS will try to answer as many questions as possible before the 30<sup>th</sup> to equip the nation's governors in making an educated decision about whether to send a letter of intent to CMS. Most governors on the call were still seeking more information. The letter of intent Secretary Sebelius has requested is not a final

commitment for a state, but rather a way for CMS to get an idea of how many states have serious interest in operating the pool on the federal government's behalf.

Ms. Cummings added that the Association of High Risk Pool Directors (NASCHIP) is having an executive director meeting in Seattle the first week of June that she is hoping to attend. NASCHIP is inviting CMS staff to help states work through a number of related issues.

She directed the Board's attention to a comparison document in the Board packets. The document was developed to help readers gain an understanding of the differences between MRMIP's rules and the rules for the federal product. Initially, most state pool administrators thought the temporary high risk pool would be folded into their existing pools, which then would be modified to conform to the rules for the new federal product. However, given the differences between various aspects of the new federal temporary high risk pool and state pools – particularly California's – that is unlikely to happen. During her review of the rules for the federal product, she pointed to the fact that federal eligibility rules require that a person have had no coverage for 6 months prior to enrolling into the product. Several Board members commented that this is a key, troublesome provision.

Ms. Cummings reported that the federal law provides \$5 billion to cover the cost of the pool through 2013. The Secretary of DHHS will create a transition plan to move people from the high risk pools into the reformed market that manifests in 2014. The transition is important because the introduction of a book of high risk into the exchange could affect the viability of the exchange. Chairman Allenby said that it will be critical to establish a level playing field for insurers who chose to participate in the exchange so that they are not at a disadvantage (with a disproportionate share of high risk) once the Exchange is implemented.

Ms. Cummings indicated that there is no information available yet as to the allocation of the \$5 billion to the states. Hopefully the information will be provided tomorrow during the conference call with CMS. CMS has indicated that the allocation would be similar to that of CHIP. There is a general feeling among states that the \$5 billion will not be sufficient to cover all who come forward to seek coverage under the temporary high risk pool. However, she noted that the new federal statute does allow the Secretary to set an enrollment cap or seek additional funds if the initial allocation is not adequate.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience.

Beth Abbott, project director for Health Access California, said she had information to share. Ms. Cummings noted that a letter Health Access sent to Assembly Member Monning regarding the federal high risk pool was included in the Board packet.

Ms. Abbott urged the Board to ensure that there should be no barriers for people, and difficulties, and unusual hurdles to overcome in entering the temporary federal high risk pool. She said the allocation may not be enough and may cover no more than 9-10 percent of Californians who need it. Health Access would hope that Secretary Sebelius will seek additional funds rather than place a cap on enrollment if the initial allocation is not sufficient. She noted that she represents Health Access, one of 11

national consumer representatives, at meetings the National Association of Insurance Commissioners (NAIC) is holding to develop policy pieces on various aspects of health reform including state administration of the federal high risk pool.

Chairman Allenby thanked Ms. Abbott for her comments and asked if there were any additional comments from the audience. Hearing none, he asked Ms. Cummings to continue.

Ms. Cummings next focused on a description of how federal healthcare reform affects CHIP. She referred to a document in the Board packet developed by the Georgetown Center for Children and Families that summarizes these provisions. She noted that maintenance of effort (MOE) requirements are included in federal reform for both Medicaid and CHIP. The MOE prohibits states from reducing income eligibility levels or making changes to enrollment procedures that make enrollment more difficult. However, there is not yet CMS guidance about the CHIPMOE. Georgetown indicates that it expects the guidance will be very similar to that CMS provided for MOE provisions associated ARRA. MRMIB staff is in the process of analyzing the MOE provision.

Ms. Cummings said the federal reform enacts a “bright line” for Medicaid coverage at 133% of the federal poverty level (FPL). It also expands Medicaid coverage to cover parents and childless adults up to that FPL. This “bright line” will result in transfer of a number of HFP children ages 6-18 to the Medicaid program. Federal reform also changes the way income is evaluated for Medicaid and CHIP, something that staff needs to look into further. It extends CHIP through 2019. This was an important policy decision as some had envisioned merging children’s health coverage with that available to parents in the Exchange. Congress elected to maintain a separate program for children through 2019 because of concerns that children’s coverage would be less in the context of family coverage. Congress increased the FMAP for CHIP starting in 2015 by 23 percent. Of note is that the MOE requirement takes effect immediately, but enhanced federal funding does not arrive until 2015. The act also provided for a new and not yet well understood option of access to CHIP for children of state employees.

Chairman Allenby asked if any states provided this coverage. Ms. Cummings said there may be one that currently provides it under a waiver.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. Hearing none, he asked Ms. Cummings to continue.

Ms. Cummings asked Laura Rosenthal to brief the Board on how federal health reform impacts insurance rules and creation of the Exchange.

Board Member Crowell asked to return to the topic of the federal high risk pool. She asked, given the short time for implementation, what steps are being contemplated by the Administration and MRMIB staff.

Ms. Cummings replied that state operation of the temporary federal high risk pool would require state legislation. To meet the time frames contemplated, emergency legislation would be needed which requires a two-thirds vote. One approach that

could be taken is to have MRMIB operate the pool. Staff has reserved time on the Board's calendar over the next few months in case additional Board meetings are needed to implement any law that is enacted.

Board Member Figueroa noted that another option for enactment of state legislation would be for the Governor to call for a special session. Implementation for special session bills is 90 days after enactment.

Board Member Crowell asked if there was any indication from HHS as to how they would implement the pool in states that elect not to operate the federal pool. Ms. Cummings replied that there is no information on that yet. Board Member Crowell commented that leaving the responsibility to operate the pool to the federal government is an option.

Board Member Figueroa said to date the only thing CMS has provided to the states is the Sebelius letter previously discussed. Ms. Cummings said states, particularly those with existing high risk pools, have submitted a series of questions to CMS. She said there would be a call with CMS tomorrow where states are hoping to get answers to some of their questions.

Board Member Crowell asked if answers to the questions will be posted on the Internet so that everyone interested can have access to the information.

Ms. Cummings indicated that MRMIP does not have its own website as HFP does because of the lack of funding for the program. Staff has struggled with what to communicate to people newly applying for coverage under the state's existing high risk pool – MRMIP. She noted that if an applicant accepts the offer of MRMIP coverage, that could make them ineligible for the new temporary federal high risk pool because of the eligibility criteria that they have no creditable health coverage for six months. And it may be that the federal product provides better, cheaper coverage.

Chairman Allenby commented that it is most unlikely that current MRMIP subscribers would be eligible for the new temporary federal high risk pool given the limits that are included.

Ms. Cummings said staff concluded that. Despite the fact that there are many unknowns about the federal program, given the fact that an applicant could be at a real disadvantage, staff concluded that the state had a duty to inform applicants of the situation. The vendor is inserting a notice in MRMIP applications and staff has posted information to this effect on MRMIB's website. As more information is obtained, staff will update the website. Board Member Crowell expressed her support for this approach. Board Member Figueroa said that this dilemma is faced by all states that have high risk pools.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience.

Ms. Abbott said staff is probably underestimating the amount of confusion in the California populace about this issue. Health Access is conducting health care reform presentations all over the state and one of the most common questions concerns how to apply for the new federal high risk pool product. She encouraged the Board to think

about tracking calls from potential subscribers and establishing their eligibility for the program based on that call-in date.

Chairman Allenby asked if there were other comments from the audience. Hearing none, he asked Ms. Rosenthal to proceed with her presentation on the Insurance and Exchange provisions of federal reform.

Ms. Rosenthal reported that the Act made significant changes in the rules affecting carriers in the individual and, in some cases, group markets. These occur in two stages. First, she said there are new insurance market rules that become effective six months following enactment, which is being interpreted as late September/October. And then there are additional reforms that take effect in January of 2014.

The immediate reforms include a prohibition on lifetime benefit limits in individual and group health plans. Additionally, a prohibition on annual benefit limits, except as permitted by the Secretary of Health and Human Services, will take effect this year. That becomes a blanket prohibition on annual benefit limits in January 2014. She said it is unsure as to what sort of limits, if any, DHHS will permit in the interim.

There also is an immediate ban on pre-existing condition exclusions for children. Secretary Sebelius has taken the position that that means not just pre-existing condition exclusions for children who have coverage, but also refusals by carriers to accept children into coverage based on pre-existing conditions. Initially, the industry and Secretary Sebelius were at odds over this provision, but the industry has decided to accept the Secretary's interpretation and will accept children for coverage, notwithstanding previous existing conditions. Ms. Cummings pointed out that no rating limits accompany the provision until January 2014.

Ms. Rosenthal said that effective January 2011, carriers are obligated to provide rebates to large group, small group and individual coverage purchasers for premium payments where overall costs don't meet specified loss ratios. Starting with the 2010 plan year, carriers in the individual and group market are required to track and report their loss ratios and then, for the 2010 plan year, are obligated to give rebates to large groups for dollars that basically bring the loss ratio below 85 percent, and the ratio would be 80 percent for small group and individual coverage. The concept is that if a high enough percentage of the premium dollar is not spent on health care services, the purchaser would get a refund starting this coming year. Along with this, the Secretary of Health and Human Services is required to establish a process for reviewing health plan premium increases. The Act provides grants to states to carry out these beginning in 2010.

Chairman Allenby asked how the law would be enforced. He noted that HFP has a loss ratio requirement which is enforced via audits conducted by the Department of Managed Health Care (DMHC). Ms. Rosenthal replied that she is still reviewing the new law and would be in a better position to opine on it at a later date.

Effective this year, the new law requires plans to cover dependents up to age 26. Ms. Cummings told the Board members their packets included a letter from Secretary Sebelius encouraging carriers not to disenroll young adults from coverage who would subsequently be eligible for coverage under this provision.

Ms. Rosenthal reported that the Act contains provisions establishing a temporary re-insurance program for employers who are providing coverage for retirees over age 55, who aren't eligible for Medicare. This helps employers pay for coverage of early retirees. The new law also prohibits of rescission of health plans, except for fraud and misrepresentation. So those are the immediate changes.

Beginning January 2014 changes up the ante further on insurance regulation and coincide with the individual mandate in which, essentially, the whole population will be required to have or purchase coverage. As of that date, there is a complete prohibition on annual benefit limits. There will be guaranteed issue in the individual market. The Act establishes new benefits standards for all new plans in the market, including an "essential benefits package," to be defined by DHHS, with varying levels: bronze, silver, gold and platinum. These levels track to different percentages of the benefit costs versus cost sharing by subscribers covered by the different plans. There are specific limits on deductibles and out-of-pocket maximums specified in the statute. "Grandfathered" plans have to comply with many of the market reforms, such as the immediate rules on dependent coverage and rescission, etc.

New rating rules will go into effect, with no variance based on health status. Plan rates can vary only by family composition, age (with a three-to-one maximum rate band), geographical area and tobacco use. A 1.5 to 1 variance is permitted for tobacco use. There will be mandatory risk adjustment in the individual and small group markets. To address concerns that individuals enrolling in the new interim federal high risk pool could disproportionately be those who first enroll in the exchange. The Act provides for a reinsurance mechanism to equalize costs across plans.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience.

Ms. Abbott, representing Health Access, warned the Board that insurance companies are aggressively reformulating what constitutes the medical loss ratio, and publicly sharing that with their stockholders. They are also muddying the definition of turning age 26. Does it mean that a person has coverage to the month before the month you turn 26, or until the month before the month you turn 27?

Chairman Allenby asked if there were any other comments from the audience. Hearing none, he asked Ms. Rosenthal to proceed to her presentation on the Exchange.

Ms. Rosenthal explained that come January 1, 2014, each state is required to establish an exchange, which can be either a government or nonprofit entity. The state is required to establish both an individual market exchange, meaning an exchange for individuals to purchase individual coverage, and a small business exchange. A state can chose to operate them together. The law also allows interstate compacts, so that more than one state can jointly do an exchange.

The exchanges will offer standardized benefits. The benefits offered in the exchange will have to be "essential" benefit packages as defined by Secretary Sebelius, meeting the aforementioned bronze, silver, gold or platinum standards. There will be standardized formats for understanding benefit choices.

Subsidies will be available for people to purchase coverage based on income up to 400 percent of poverty. There is guaranteed issue in the exchange, as in the outside market. To be eligible, an individual has to be a U.S. citizen or a legal immigrant and not be incarcerated. States have the option of covering some new Medicaid populations that are newly mandated to be covered in Medicaid through the exchange. CHIP enrollees will be transitioned into the exchange in 2019.

The same insurance market rules apply in the exchange, as to the private market, such as the rating rules. There will be a risk adjustment component. There is no public funding for abortion in the exchanges, except for abortions that are necessitated by incest, rape or are necessary to save the life of the mother.

Chairman Allenby asked if there were any questions or comments. Hearing none, he thanked Ms. Rosenthal for her report.

The documents on health care reform can be found at:

Agenda Item 4.b.1:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_4.b.1\\_Fed\\_Healthcare\\_Reform\\_High\\_Risk\\_Pool.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_4.b.1_Fed_Healthcare_Reform_High_Risk_Pool.pdf)

Agenda Item 4.b.2:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_4.b.2\\_Fed\\_Healthcare\\_Reform\\_CHIP.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_4.b.2_Fed_Healthcare_Reform_CHIP.pdf)

Agenda Item 4.b.3:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_4.b.3\\_Fed\\_Healthcare\\_Reform\\_Insurance\\_Rules.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_4.b.3_Fed_Healthcare_Reform_Insurance_Rules.pdf)

#### Update and Consideration of Action on HFP Benefits Review

The Chairman suggested that the Board take up the issue of HFP Benefits Review (Agenda Item 7.1) in consideration of the time of the project consultants, Deborah Kelch of Kelch Associates and Tim Doyle from Mercer.

Ms. Rosenthal indicated that before the Board had a discussion of the issue, it needed to make a determination that it had a need to take immediate action on the issue which came to its attention subsequent to the posting of the meeting agenda. Staff posted a revised meeting agenda reflecting the additional item well in advance of the 48-hour notice required by the Bagley-Keene Act. The need to take immediate action is based on the context of the current budget crisis and the Board's need to consider cost savings and potential cost savings related to benefit changes, specifically as a result of the maintenance of effort provisions in the recently enacted health reform legislation, the Patient Protection and Affordable Care Act, which reduced the State's options for cost savings through eligibility-related program changes. Staff understanding of the implications of the MOE provisions occurred after the original agenda was mailed and posted. Ms. Rosenthal noted the Assembly Budget Subcommittee No. 1 had recently voted to reject the Governor's eligibility restrictions and premium increases in Healthy Families citing the MOE provisions in federal health care reform.

A motion was made and seconded to adopt the resolution citing an immediate need for the Board to consider cost savings through modifications to the Healthy Families

Program benefits as a result of circumstances that include the maintenance of effort provisions. The motion was unanimously adopted.

Debra Kelch, President of Kelch Associates, and Tim Doyle an actuary in Mercer Consulting's Phoenix office, introduced themselves. Ms. Kelch reminded the Board that the project scope had been to develop a framework for review of Healthy Family benefit options, to identify the options that might be consistent with federal CHIP law, to look at other states and to work with Mercer to complete analyses of potential benefit options.

Ms. Kelch indicated that at the March meeting, the Board asked Kelch and Associates and Mercer Consulting to model potential cost savings from the benefit designs of a benchmark equivalent, with the minimum benefits required under federal law; a benefit plan with annual and lifetime maximums, similar to one that Wyoming currently has in place; and coverage with benefit limits that might include number of hospital days, office visits and the like, to the extent that those limits have been approved in other states. Ms. Kelch found that most other states do not have those types of benefit limits, although they do have them in their mental health programs. Given the mental health parity provisions of CHIPRA, those states will likely need to revise their mental health benefit. Pennsylvania, however, has a 90-day inpatient day limit that includes physical and mental health. Ms. Kelch indicated that she had consulted Mercer on whether to model this approach. Mercer advised that given the low utilization of hospital services in HFP (except for CCS conditions) savings would be quite low. Mercer also indicated that modeling the option would be challenging given the mix of physical and mental health limits.

She noted that the affect of federal health care reform has not been factored into the analysis.

Mr. Doyle proceeded with his power point presentation which focused on four potential savings: minimum benchmark equivalent analysis, implementing an annual benefit maximum, cost-sharing options available up to the five percent federal limit, and potential cost savings related to prescription services. Mercer's analysis is that half of HFP's spending is for physician office visits. The second highest spending category is outpatient facility services, which is less than half the spending amount of the physicians.

The other item to point out is virtually all the services, other than the "other" category, are required under benchmark equivalents making it impossible to exclude a service area to achieve great savings.

Mr. Doyle reviewed the data sources Mercer used for its analyses. There is no encounter data for the Healthy Families Program. Mercer instead reviewed the rate development templates plans file with HFP, provided information on categories of service, PMPM's, utilization and unit cost. Mercer supplemented this information with Medi-Cal encounter data, Medi-Cal fee-for-service data and a proprietary commercial database for the southwest United States that was comprised of 75 percent California data.

In looking at minimum benchmark equivalents, federal law requires that they include specified benefits and then, where a benchmark includes the following services, at

least 75 percent of their actuarial value: prescription drugs, mental health, vision and hearing.

Next Mercer looked at the benefits HFP provides which are not required by the benchmarks. These include home health, durable medical equipment and supplies, physical and occupational therapy, and speech therapy. Mercer estimated that eliminating these benefits would produce about 1.1 percent in capitation savings, approximately \$3.9 million in savings to the state's General Fund. Board Member Figueroa asked if the supply category included diabetic supplies which are mandated under state law. Mr. Doyle said he was unsure but concurred that elimination of the benefits could raise Knox-Keene issues. Ms. Kelch reported that all the benefits are required under Knox-Keene with the exception of durable medical equipment.

Mr. Doyle proceeded to discuss savings associated with the potential of instituting an annual or lifetime benefit maximum, although he noted that federal health care reform does prohibit lifetime benefit maximums as well as unreasonable annual maximums. Mercer estimated savings assuming lifetime caps of \$200,000 and \$50,000 respectively, and did so assuming the limits applied to CCS services or excluded them. Application to CCS became a significant variable for the \$50,000 cap. Mr. Doyle reviewed the savings under each scenario. He emphasized that prior to trying to implement such caps, MRMIB would have to seek CMS guidance on whether caps are permitted and assess the Knox-Keene implications. Ms. Cummings added that a change in the benchmark or choice of benchmarks would require a change in state statute. Board Member Figueroa asked what Mercer assumed about how the Board would exempt CCS given the CCS carve out. Mr. Doyle replied that it was offered only as an instructive comparison.

Mr. Doyle next addressed savings from alternative benefit designs, such as service-specific utilization limits like a \$10,000 inpatient annual max, a 30-day inpatient max or four prescriptions per month. The state could pursue these types of limits as Secretary-approved coverage, although generally states' use of Secretary-approved coverage has been to expand benefits beyond the benchmark. Ms. Kelch's research found that the only example of such an approach had been Pennsylvania. Therefore, Mercer had not attempted to model this option. Board Member Figueroa asked if Ms. Kelch was aware of situations in which states sought to impose certain limits but had been denied by CMS. Ms. Kelch indicated that she did not have that data which would require her to read all state plan amendments (SPA's). She is reading through some of them as she finishes up a table for the report, but does not plan on reading all SPA's. Ms. Kelch emphasized that she and Mercer could not model unlimited benefit variations and had chosen instead to do estimates in areas that had some logic or potential savings.

Mr. Doyle proceeded to Mercer's analysis of permissible subscriber cost-sharing. The federal government limits subscriber cost sharing (premium plus co-payments) to 5% of family income. One wants premiums to be set at a level that provides for financial responsibility but is affordable. Setting co-payments at high levels will result in less utilization of services by healthy children and discourages children who need services from accessing them. So, it is important to find a delicate balance of financial responsibility and access to services. Mercer's review found that at HFP's existing co-payments and premiums for families with incomes above 150%, there is some room for increases as HFP is at about 3.21 percent for a family with three children in Category B.

However, if the premium increases proposed in the Governor's budget are included, the figure rises to 4.73 percent, which is getting close to the 5 percent federal maximum. He reminded the Board that premium increases may be precluded by the MOE. Mercer estimated savings if the Board increased physician co-pays from \$10 to \$15. Doing so could shift some costs over to the emergency room. Nevertheless, Mercer estimates a savings of 4.1 percent of health plan capitation rates.

Lastly, Mr. Doyle reported Mercer's findings on the potential of obtaining savings associated with prescription drugs in HFP. Mercer obtained information from the plans on dispensing fees, discounts, use of formularies and utilization of generic drugs. Mercer concluded that the plans are doing a good job managing the pharmacy benefit and did not find it to be an area for additional savings. Chairman Allenby commented that this was likely because HFP subscribers are healthy children. The result could be different with a different population.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none. The Chairman emphasized that they would have to spend time looking at these very difficult choices to maintain the integrity of the program given the state's dire fiscal situation.

Ms. Rosenthal clarified that the CHIP maintenance of effort requirements in the new law relate to eligibility, not benefits and this was an important point regarding the Board's need to consider the issue at this meeting. Ms. Cummings added that CMS could interpret the CHIP maintenance of effort provision to preclude increases in premium as it has already done for ARRA. The Chairman replied that he is aware that the Board has a limited hand, but that the discussion must continue. He thanked Ms. Kelch and Mr. Doyle for their helpful work.

Ms. Kelch indicated that unless otherwise directed by the Board, she and Mercer would proceed with their plans to wrap things up and submit their final report,

The Board resolution and Mercer's Powerpoint presentation can be found at: [http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.I\\_Kelch\\_Asoo\\_PowerPoint\\_Presentation\\_4-21-10.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.I_Kelch_Asoo_PowerPoint_Presentation_4-21-10.pdf)

The Chairman indicated that given the shortness of time remaining for the meeting, he would triage those agenda items needing action to the top of the agenda.

### Staff Recommendations to Fill Advisory Panel Vacancies

Mr. Sanchez reminded the Board that they had been advised that the Advisory Panel would have vacancies amounting to one-third of its membership. After advertising the positions, he said staff recommends that the Board's reappoint four members, as specified in the document, and appoint one new member, Dr. Maria Tupas, a practicing pediatrician.

The appointments were moved and seconded and the Board took unanimous action to approve their appointments.

The document detailing staff can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.e\\_recommended\\_appt\\_to\\_HFP\\_to\\_AP.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.e_recommended_appt_to_HFP_to_AP.pdf)

Adoption of Emergency Regulations Modifying Mental Health Benefits, Clarifying Plan Responsibilities for Children with Severe Emotional Disturbance and California Children's Services Eligible Conditions, and Modifying the Definition of Benefit Year (ER 1-10)

Lilia Coleman said today's meeting marked the second viewing of the proposed regulations regarding modifying mental health benefits for children with severe emotional disturbance and children eligible for services through California Children's Services. She noted one minor change since the first viewing of the regulations and that is to add the date of October 1, 2010, to signify the end of the benefit year.

It was moved and seconded to adopt the finding of emergency as well as the proposed regulations. These motions were approved unanimously by the Board.

The regulation package can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.f\\_Emergency\\_Regulations\\_ER-1-10.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.f_Emergency_Regulations_ER-1-10.pdf)

Approval of Contract for Oral Health Quality Improvement Project

Ms. Rouillard thanked the California HealthCare Foundation for providing MRMIB a grant to contract for a dental quality improvement project as outlined in the memo in the Board's packet. She asked the Board to authorize the Executive Director to enter into this contract.

Chairman Allenby said that the motion was to authorize a consultant contract or to authorize the Executive Director to enter into negotiations for an oral health quality contract. It was moved and seconded and unanimously approved by the Board with one abstention (Board Member Chang).

Board Member Chang said families may not be as aware of the need for an annual dental visit as they are for a general health visit. She suggested that families enrolled in the program receive an annual reminder for a dental visit.

The Resolution can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.i.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.i.pdf)

Approval of Interagency Agreement with the Department of Managed Health Care (DMHC) to Conduct Minimum Loss Ratio Audits

It was moved and seconded to approve the resolution approving an interagency agreement with DMHC for lost ratio audits. The Board unanimously adopted the resolution.

The Resolution can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.j\\_Board\\_Resolution.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.j_Board_Resolution.pdf)

#### Approval of Molina Contract Extension

The resolution extending Molina's contract was moved and seconded. The Chairman asked for any discussion. There was none. The resolution was unanimously approved by the Board.

The Molina Contract Extension approval can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/agenda\\_item\\_8.c.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/agenda_item_8.c.pdf)

#### Final Adoption of Regulations Eliminating the Durational Residency Requirement (ER 3-09)

It was moved and seconded to finally adopt the regulations. The Board unanimously approved the motion..

The Regulations can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_8.d\\_Final\\_Adoption\\_of\\_ER-3-09.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_8.d_Final_Adoption_of_ER-3-09.pdf)

Chairman Allenby said standard reports would be accepted without discussion due to time constraints. These were The Healthy Families Program Enrollment and Single Point of Entry Report, the Healthy Families Administrative Vendor Performance Report, the Access for Infants and Mothers Enrollment Report, the Access for Infants and Mothers Administrative Vendor Performance Report, the Major Risk Medical Insurance Program Enrollment Report, Update on Enrollment Cap and Waiting List and the Administrative Vendor Performance Report.

He indicated that the HFP retention and open enrollment reports would be taken up at the next meeting. Ms. Cummings added that the 2008-09 California Children's Services Report would also be taken up at the next meeting.

#### **STATE BUDGET UPDATE**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_5\\_State\\_Budget\\_Update.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_5_State_Budget_Update.pdf)

#### **STATE LEGISLATION**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_6a\\_Legislative\\_Summary\\_regular\\_session\\_4-21-10.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_6a_Legislative_Summary_regular_session_4-21-10.pdf)

#### **HEALTHY FAMILIES PROGRAM (HFP) UPDATE**

Enrollment and Single Point of Entry Report

The Enrollment Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.a\\_HFP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.a_HFP_Enrollment_Report.pdf)

#### Administrative Vendor Performance Report

The Administrator Vendor Performance Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.b\\_HFP\\_Admin\\_Vendor\\_Perf\\_March\\_2010\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.b_HFP_Admin_Vendor_Perf_March_2010_Summary.pdf)

#### Retention Reports

The Retention Reports can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.c\\_Retention\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.c_Retention_Report.pdf)

#### 2009 Open Enrollment Report

The 2009 OE Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.d\\_2009\\_Open\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.d_2009_Open_Enrollment_Report.pdf)

#### 2008-09 California Children's Services (CCS) Report

#### Final 2008 Dental Quality Report

The 2008 Final Dental Quality Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_7.h.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.h.pdf)

#### CHIP Reauthorization Implementation

There was nothing new to report.

### **ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE**

#### Enrollment Report

The AIM Enrollment Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_8.a\\_AIM\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_8.a_AIM_Enrollment_Report.pdf)

#### Administrative Vendor Performance Report

The Administrative Vendor Performance Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_8.b\\_AIM\\_Admin\\_Vendor\\_Perf\\_March\\_2010\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_8.b_AIM_Admin_Vendor_Perf_March_2010_Summary.pdf)

### **MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE**

The MRMIP Enrollment Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_9.a\\_AIM\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_9.a_AIM_Enrollment_Report.pdf)

The MRMIP Enrollment Cap and Waiting List report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_9.b\\_MRMIB\\_Enrollment\\_Cap\\_Waiting\\_List.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_9.b_MRMIB_Enrollment_Cap_Waiting_List.pdf)

The Administrative Vendor Performance Report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_042110/Agenda\\_Item\\_9.c\\_MRMIP\\_Adm\\_Vendor\\_Perf\\_for\\_March\\_2010.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_9.c_MRMIP_Adm_Vendor_Perf_for_March_2010.pdf)

Chairman Allenby asked if there was anything else to bring before the Board. When no one brought any issue forward, he adjourned the meeting. Public session concluded at 1:12 p.m.