Facts about California's High Risk Pool and the Federal High Risk Pool

California has been operating a high risk pool for medically uninsurable residents since 1991 and now provides coverage to 7,100 Californians who were denied insurance coverage in the commercial individual market. Broad estimates have indicated that there may be as many as 200,000 to 300,000 medically uninsurable people in California some of whom may benefit from the federal high risk pool provision which could be implemented as early as July 1, 2010.

Based on current information and interpretation, there are notable differences that should be considered by persons considered application to either of the pools.

Eligibility Provisions in MRMIP and the new federal high risk pool:

Major Risk Medical Insurance Program	Federal High Risk Pool
Resident of California	U.S. citizen, national or lawfully present

• Must be unable to obtain coverage in the individual market
  ○ Demonstrate rejection from insurance carrier in last 12 months, or
  ○ Offer of premiums equal to or exceeding those of the individual's first choice MRMIP product, or
  ○ Termination by carrier for reasons other than fraud or non-payment of premium, ineligibility.
• Also requires ineligibility for Medicare (except for end stage renal disease) and ineligibility for, or exhaustion of, COBRA and Cal-COBRA benefits.
	• Have no "creditable coverage" (encompassing most health insurance and public programs) in the six months prior to application and
	• a pre-existing condition as defined by the federal government.

• For PPO product, three months waiting period for services for pre-existing condition. • For HMO product, three month post-enrollment waiting period during which no benefits are provided (subscriber does not pay premiums during this period).	• No pre-existing condition exclusions permitted.

Benefits Structure of MRMIP and the new federal high risk pool:

Major Risk Medical Insurance Program	Federal High Risk Pool
• Comprehensive benefits with annual $500 household deductible; preventive services excluded from deductible. • The subscriber's share of cost of benefits is approximately 60 percent.	• To be defined by the U.S. Secretary for Health and Human Services. The subscriber's share of cost for benefits cannot exceed 35 percent.
• Maximum benefits of $75,000 annually and $750,000 lifetime.	• HHS Secretary has yet to define benefits and has not yet indicated whether market prohibitions on lifetime caps and unreasonable annual caps will apply.

Subscriber Premiums and Out-of-Pocket Expenses of MRMIP and the new federal high risk pool:

Major Risk Medical Insurance Program	Federal High Risk Pool
Subscribers pay premiums of 125-137% of the standard rate that a carrier would charge for MRMIP benefits (including annual benefit maximum) in the commercial market	Subscribers pay premiums of 100% of the standard rate for the benefits in the commercial market.
Rate variance for premiums allowed: • Six geographic regions with no limits on amount of variation; • 12 ages with no limit on amount of variation; • three possible family sizes (subscriber, subscriber plus one dependent; subscriber plus two dependents.	Rate variance for premiums allowed: Rates may very only by the following factors: • Age (maximum variation of 4 to 1), • Whether the plan covers an individual or a family, • Region and • Tobacco use (maximum variation of 1.5 to 1). The U.S. Secretary for Health and Human Services determines the regions and there is to be at least one region per state.
• Out-of-pocket expenses limited to $2,500 annually for an individual and • $4,000 annually for a household.	• Out-of-pocket maximums equal to those for HSA produces: $5,950 for an individual and • $11,900 for a family.

Subsidy Funds for MRMIP and the new federal high risk pool:

Major Risk Medical Insurance Program	Federal High Risk Pool
• Subsidy funding in the amount of $37 million from Proposition 99, with $10-$15 million spent for persons enrolled in a guaranteed issue pilot project. • The remainder is spent on subsidies for MRMIP.	• Subsidy funding of $5 billion nationally in federal funds to cover costs of the pool through 2013. • CMS will allocate federal funds using a combination of factors including non-elderly population, non-elderly uninsured and geographic cost as a guide. CMS estimates that California could receive up to $761 million out of the $5 billion available nationwide.

Enrollment Cap for MRMIP and new federal high risk pool:

Major Risk Medical Insurance Program	Federal High Risk Pool
MRMIP sets enrollment cap semi-annually based on available funding. (Current cap is 7,100 slots.)	If federal funding is inadequate, the U.S. Secretary for Health and Human Services can set a cap or seek additional funds.

This Fact Sheet will be updated as further information and interpretation becomes available from the U.S. Secretary for Health and Human Services.

CMS on April 22, 2010 released a Fact Sheet on the Temporary High Risk Pool Program and it is available at http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html.

Health Reform: A Closer Look

Families USA • May 2010

Help for Californians with Pre-Existing Conditions

In March, the President signed an historic package of health reforms into law. The new law offers critical protections for the millions of Americans who have pre-existing conditions today—as well as for those who are healthy now but who may develop a health problem as they grow older. As a result of health reform, no American with a pre-existing condition will be denied coverage, charged a higher premium, or sold a policy that excludes coverage of essential health benefits simply because he or she has a pre-existing condition.

On May 6, Families USA released a new report, *Health Reform: Help for Americans with Pre-Existing Conditions*, which was designed to take a closer look at the number of Americans with diagnosed pre-existing conditions who, absent reform, would be at risk of being denied coverage in the individual insurance market. The uninsured and those who do not have access to job-based coverage are at greatest risk, but even those who now have coverage at work could be at risk if they lose or leave their jobs and have to find coverage in the individual market.

Our analysis does not include every condition that may lead to a denial of coverage, nor does it capture every person with a pre-existing condition that would likely result in higher premiums or excluded benefits. Further, this analysis cannot capture the uninsured and underinsured Americans who, lacking a way to pay for care, do not seek treatment and whose health conditions, therefore, remain undiagnosed. Because people with low incomes and racial and ethnic minorities are disproportionately represented among the uninsured and underinsured, they are likely to be undercounted in our analysis.

To better understand the effect that health reform will have on these people, Families USA commissioned The Lewin Group to quantify the number of Americans who are diagnosed with conditions that commonly lead to denials of coverage. That report contains national data, as well as a detailed discussion of the methodology, and it is available online at www.familiesusa.org. This new fact sheet presents state-specific data that mirror the national data in *Health Reform: Help for Americans with Pre-Existing Conditions*.

One in Five Californians Is at Risk of Denial of Coverage

- Approximately 6,487,000 Californians under the age of 65 have a pre-existing condition that, absent reform, could lead to a denial of coverage by an insurance company (see Table 1).
- This means that, without health reform, more than one in five non-elderly Californians (20.3 percent) is at risk of being denied coverage.

Table 1. Californians under Age 65 Diagnosed With a Pre-Existing Condition that Could Result in A Denial of Coverage

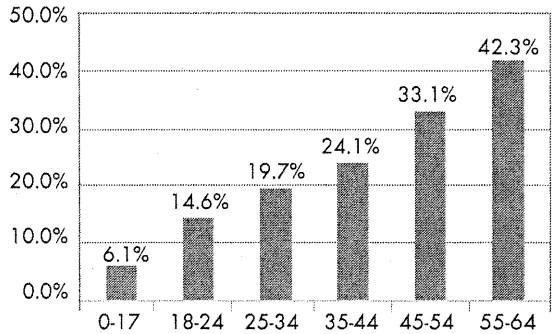
Population under 65*	31,925,000
Population under 65 With a Pre-Existing Condition	6,487,000
Percent of Population under 65 With a Pre-Existing Condition	20.3%

* Data are for the non-institutionalized, non-Medicare-eligible population.

Pre-Existing Conditions: A Problem that Grows with Age

- Individuals in every age group are affected by pre-existing conditions that, absent reform, could lead to a denial of coverage (see Figure 1, and Table 2 on page 3). However, those who are older are much more likely to have such a condition, as follows:
  - In California, more than one in seven young adults aged 18 to 24 (14.6 percent) has a pre-existing condition that could lead to a denial of coverage.
  - Nearly one-third of California adults aged 45 to 54 (33.1 percent) have a pre-existing condition that could lead to a denial of coverage.
  - More than two in five California adults aged 55 to 64 (42.3 percent) have a pre-existing condition that could lead to a denial of coverage.

Figure 1.
Percent of Age Group with a Pre-Existing Condition



- Adults aged 45 to 64 account for only 26.2 percent of the non-elderly California population, but they make up nearly half (47.4 percent) of state residents with pre-existing conditions.
  - This phenomenon is most pronounced among adults aged 55 to 64. Adults in this age group account for only 10.4 percent of the non-elderly California population, but they make up more than one in five (21.7 percent) of those state residents with pre-existing conditions.

Table 2. Californians under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage, by Age

Age Group	Number in Age Group*	Number in Age Group with a Pre-Existing Condition	Percent of Age Group with a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
0-17	9,428,200	576,500	6.1%	8.9%
18-24	3,612,800	529,300	14.6%	8.2%
25-34	5,226,400	1,027,400	19.7%	15.8%
35-44	5,297,000	1,277,600	24.1%	19.7%
45-54	5,031,400	1,667,400	33.1%	25.7%
55-64	3,329,100	1,409,100	42.3%	21.7%
Total**	**31,925,000**	**6,487,000**	**20.3%**	**100.0%**

* Data are for the non-institutionalized, non-Medicare-eligible population.
** Numbers do not add to total because of rounding.

Children and Young Adults with Pre-Existing Conditions

- While the percentage of California children and young adults who have a pre-existing condition that could lead to a denial of coverage is low relative to older Californians, a substantial number of children and young adults are affected.
  - In California, 576,500 children under the age of 18, and 529,300 young adults aged 18 to 24, have a pre-existing condition that could lead to a denial of coverage.

Every Income Group Is Affected

- People of every income group have pre-existing conditions that, without health reform, could lead to a denial of coverage (see Table 3 on page 4). By income group, we see the following trend:
  - The lowest-income Californians are the most likely to have such a condition, with more than one in five (21.5 percent of) individuals in families with incomes below 100 percent of the federal poverty level (less than $22,050 for a family of four in 2010) affected.
  - Approximately 20.0 percent of Californians in families with incomes between 100 and 199 percent of poverty ($22,050-$44,100 for a family of four in 2010) have such a condition.
  - Approximately 20.2 percent of Californians in families with incomes at or above 200 percent of poverty ($44,100 or higher for a family of four in 2010) have such a condition.

Table 3. Californians under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage, by Income

Family Income Relative to the Federal Poverty Level	Number in Income Group*	Number in Income Group with a Pre-Existing Condition	Percent of Income Group with a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
<100%	4,404,400	948,700	21.5%	14.6%
100-199%	5,930,800	1,187,200	20.0%	18.3%
≥ 200%	21,589,700	4,351,400	20.2%	67.1%
200-399%	9,084,500	1,827,400	20.1%	28.2%
≥ 400%	12,505,200	2,524,100	20.2%	38.9%
Total**	**31,925,000**	**6,487,000**	**20.3%**	**100.0%**

* Data are for the non-institutionalized, non-Medicare-eligible population.

** Numbers do not add to total because of rounding.

- While the lowest-income Californians are slightly more likely to be affected by pre-existing conditions, middle-class and higher-income Californians (those in families earning more than 200 percent of poverty, or $44,100 for a family of four in 2010) make up more than two-thirds (67.1 percent) of those with pre-existing conditions that could lead to a denial of coverage.

Every Racial and Ethnic Group Is Affected

- People of every racial and ethnic group have pre-existing conditions that, absent reform, could lead to a denial of coverage (see Table 4 on page 5). By race and ethnic group, we see the following trend:
  - In California, American Indians and Alaska Natives are the most likely to be affected, with more than one-quarter (28.4 percent) having a pre-existing condition that could lead to a denial of coverage.
  - Approximately one-quarter (24.5 percent) of whites (non-Hispanic) have such a condition.
  - Nearly one-quarter (24.3 percent) of African Americans (non-Hispanic) have such a condition.
  - Nearly one in five Hispanics (17.6 percent) is affected.
  - One in eight Native Hawaiians and other Pacific Islanders (12.9 percent) and Asian Americans (12.8 percent) have a pre-existing condition that could lead to a denial of coverage.

Table 4. Californians under Age 65 Diagnosed with a Pre-Existing Condition that Could Result In a Denial of Coverage, by Race or Hispanic Origin

Racial or Ethnic Group	Number in Group*	Number in Group With a Pre-Existing Condition	Percent of Group With a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
American Indian/Alaska Native	299,100	84,800	28.4%	1.3%
Asian	3,839,500	490,100	12.8%	7.6%
Black, non-Hispanic	1,943,000	472,100	24.3%	7.3%
Hawaiian/Pacific Islander	246,100	31,800	12.9%	0.5%
Hispanic	12,594,000	2,218,500	17.6%	34.2%
White, non-Hispanic	13,003,100	3,190,000	24.5%	49.2%
Total**	**31,925,000**	**6,487,000**	**20.3%**	**100.0%**

* Data are for the non-institutionalized, non-Medicare-eligible population.

** Numbers do not add to total because of rounding.

Our analysis is based on the number of Californians who are *diagnosed* with a pre-existing condition that could lead to a denial of coverage. The analysis did not control for disparities in access to care and in the delivery of care that may result in lower rates of diagnosed disease among certain racial and ethnic minority groups. For a more in-depth examination of this point, please see the Discussion on page 6 of the national report, available online at www.familiesusa.org.

Source for all tables: Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA (see the Technical Appendix in the national report for details).

Acknowledgments

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These state fact sheets are available online at www.familiesusa.org.

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The Voice for Health Care Consumers

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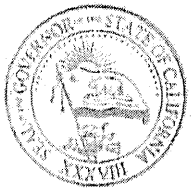


GOVERNOR ARNOLD SCHWARZENEGGER

April 29, 2010

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary,

As Governor, I have been an advocate for broad, comprehensive health reform. In 2007, my administration tried to enact comprehensive health care reform in California, and I am proud that the newly enacted federal legislation draws upon the same principles as my reform.

As we begin the challenge of implementing this complex and ambitious plan, it is clear that states will need to be your partners in making sure it is done responsibly, thoughtfully and appropriately. In fact, if national health care reform is going to succeed, it is up to the states to make it happen. California is ready to act, and our first opportunity for action is immediate. For the thousands of Californians who have been turned down for insurance, I intend to contract with the federal government to operate a temporary health insurance program for currently uninsured individuals with preexisting medical conditions.

Since the early 1990s, California has operated a similar program, governed by an appointed board composed of five public members using a private sector enrollment administrator and partnering with private health insurance plans. I plan to submit an application for California to contract with the federal government to operate the federal high-risk pool alongside our current state high-risk pool under the same governance and operational framework.

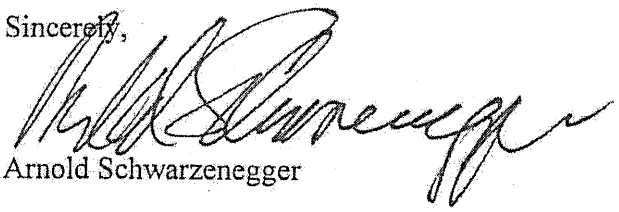
The application I will submit is shaped by your assurances that 100 percent of the costs will be provided by the federal government for the duration of the program until other key reform provisions are enacted January 1, 2014. I am also encouraged by comments from your staff on the most recent weekly call with the states indicating that your department will be flexible with the program and benefit design to minimize state implementation challenges.

I am aware that the funds will be available as early as July 1, 2010, and I will immediately begin working with the California Legislature and stakeholders to allow our state to take advantage of this contracting opportunity and offer more Californians access to critical health care services. The number of statutory changes necessary will depend on those discussions.

STATE CAPITOL • SACRAMENTO, CALIFORNIA 95814 • (916) 445-2841

Currently, California has more than 8 million individuals without health coverage. For the good of all Californians and our economy, we need to roll up our sleeves and get to work fixing this broken system. I look forward to continuing to work with the Obama administration and Congress to ensure that California and all states have the fiscal, technical and administrative resources we need to successfully implement federal health reform and ensure it delivers its promise of expanded coverage, greater affordability and improved health outcomes.

Sincerely,



Arnold Schwarzenegger

/la

April 27, 2010

The Honorable Felipe Fuentes, Chair
Assembly Appropriations Committee
State Capitol
Sacramento, CA. 95814

Re: AB1887 (Villines): Support if Amended

Dear Assemblymember Fuentes,

Health Access California, a coalition of more than a hundred consumer, community, senior and other organizations would support AB1887 (Villines) if it were further amended to provide an adequate high risk pool for Californians.

We recognize that the interim high risk pool is a significant policy issue: we offer these observations and request these amendments as part of that policy process.

1. California's High Risk Pool and Federal Health Reform:

First, Health Access California is very pleased that federal health reform will mean that California can likely triple the size of its high risk pool from about 7,000 enrollees with dangerously inadequate coverage and high premiums to an estimated 20,000-25,000 enrollees, most with decent coverage and premiums based on standard rates.

Second, Health Access also recognizes that there are literally hundreds of thousands of Californians who are medically uninsurable and who cannot buy individual health insurance at any price. While we are not certain precisely how many meet the requirements of the new federal law or who would choose to afford coverage under its provisions, our policy premise is that the interim high risk pool should be available to every Californian that qualifies for it. We seek amendments to AB1887 to direct the administering agency to attempt to enroll every qualified Californian as quickly as possible.

Fundamentally, the pathetic inadequacy of the existing high risk pool in California and the need for the interim high risk coverage under federal health reform reflect a very badly broken individual insurance market and a desperate need for federal reforms as soon as possible---in 2014 at the latest, sooner if possible.

2. California's Utterly Inadequate High Risk Pool

The existing California high risk pool is utterly inadequate:

- It serves 7,100 people out of an estimated 400,000-800,000 medically uninsurable
- with caps on benefits as low as $75,000
- at a premium above standard rate and
- at a cost to the California budget of $40 million

- has never advertised or publicized this benefit and yet routinely faces waiting lists for the inadequate benefits at extremely high cost to both the consumer and state government

Federal law requires improving the benefit: for the current population covered, this will increase the cost for the enrollees in the existing high risk pool. Federal law imposes a maintenance of effort requirement on the current level of *spending*, not enrollment. California could maintain its contribution at $40 million while allowing disenrollment to shrink the number of enrollees covered by MRMIP. For some MRMIP enrollees, waiting six months for better coverage at a lower price may be a better deal than the existing MRMIP coverage: for others, continuous coverage even with inadequate benefits and high premiums may be essential.

3. High Risk Pools Generally Inadequate to the Need, California's is particularly inadequate

Currently, about 35 states spend an estimated $900 million to subsidize coverage for 200,000 people. Some national experts have estimated that 2 million might be eligible. Given that California alone is estimated to have 400,000-800,000 medically uninsurable while enrolling only 7,000 in our existing high risk pool, we find that California's existing high risk pool and individual insurance market are especially problematic.

4. Minimum Standards for New High Risk Pool

Health Access seeks amendments to accomplish the following:

a. Available to All in Need

Health Access very strongly believes that the new high risk pool should be made available to all in need—that is, all those who meet the minimum requirements under federal law. If funds allocated to California are insufficient to meet this objective, the administering agency must seek additional federal funding early and often based on the depletion of available funds, so that all Californians who need coverage have access to it.

Minimum Recommendations: Available to All in Need

- Create a core program objective of serving all in need
- Seek additional federal funding if funding is not sufficient to meet the need—and do so early and often when need exceeds demand
- If waiting lists are established, clear them as quickly as money is available. Health Access was very disappointed by the slow progress of MRMIB in clearing the Healthy Families waiting list, a process that took over six months.

Minimum Recommendations: Outreach and Education

- Advertise broadly the availability of coverage through the high risk pool to all those who are uninsured and have a pre-existing condition. These publicity efforts should incorporate the multi-lingual/multi-cultural dimensions of CA's population.
- Provide broad public notice through all available state, county, and local government agencies, including to parents of Healthy Families enrollees, those denied Medi-Cal coverage, those receiving TANF benefits, those receiving general assistance/general relief from CA counties, those covered by UI and DI, those graduating from or ineligible for AIM, as well as any other state program which intersects with those likely to be uninsurable.
- Coordinate with federal agencies, including Medicare and Social Security, to publicize this information.
- Include this information for trained counselors at any federally-funded or state-funded consumer assistance programs who advise consumers on insurance issues; such as the Health Insurance Counseling and Advocacy Program and the Health Consumer Alliance.
- Do outreach to caregivers, advocacy groups and others that have communication networks and who interact with consumers and those who are likely to be uninsured, such as safety net physicians, public hospital staff, discharge planners, regional center personnel etc.
- Replicate one of the most successful screening and referral techniques from the early days of the Health Families Program by training community, faith-based, neighborhood, and school-based groups as volunteers to identify eligible uninsured consumers.

b. Consumer Friendly

The high risk pool is the first element of comprehensive reform in which government will interact with consumers. It is essential that government serve the needs of consumers and small businesses, not the convenience of those administering the program.

Minimum standards for Consumer-Friendly Service:

- Hotline operated by state employees 24/7 with full language access. (DMHC meets this standard with its HMOHELP line.)
- There should be availability of in-person assistance from state employees in numerous locations around California. Limited access during business hours to a contractor is not sufficient. Social Security and Medicare meet this standard. So should the high risk pool and any exchange.
- Formal grievance and appeals process for all individual consumers and small businesses for denials of coverage and other difficulties with obtaining coverage. The grievance and appeals processes operated by DMHC and CDI are not a substitute: these processes deal with covered benefits and medical necessity, not obtaining coverage. This is a minimum standard for the high risk pool and the exchange.
- In addition to resolution of appeals and grievances for individual consumers, the regulating agency should track the data by insurer. This data should include the numbers of denials by volume and type of denial by each insurer. In addition, the

agency should track the numbers and types of denial of that are decided in favor of the consumer at the second appeals stage (i.e. beyond the grievance filed with the insurer itself).

- On-line web access: in addition, but not as a substitute for any of the other consumer-friendly services, the administering agency should provide on-line web-based access. Social Security and Medicare do so but in addition to rather than in place of other forms of consumer assistance.
- Cooperative working relationship with Navigator: Federal law requires the creation of navigators to help steer consumers through the new system. The high risk pool and the exchange should work cooperatively with the navigator which will be operated by private entities. Again, such cooperation is not a substitute for other avenues of consumer assistance.

c. No wrong door

Health reform means a multi-payer system will persist for some time to come. If California is forced to operate a separate high risk pool from the existing MRMIP program, this will be only one of numerous programs that consumers may obtain coverage.

Minimum Recommendations:

- No wrong door between high risk pool and MRMIP
- No wrong door between AIM and MRMIP
- No wrong door between Medi-Cal and both high risk pools
- No wrong door between county indigent access and high risk pools
- No wrong door between COBRA/CalCOBRA/HIPAA and high risk pool (this may require legislation)

d. Insurer responsibility

Californians are medically uninsurable because insurers either refuse to sell to those with pre-existing conditions or price premiums at a higher rate for those with pre-existing conditions exclusions. This will end in 2014.

Today we do not know which insurers deny how many people or precisely for what reason. Today we do not know what insurers charge in terms of higher premiums or precisely for what reason.

Minimum requirement:

- The agency responsible for the high risk pool ought to require that any insurer or health plan that has a contract with any program administered by the State of California, including Medi-Cal as well as Healthy Families and AIM as well as MRMIP, disclose publicly by insurer the number of individuals denied coverage, the proportion of applicants for coverage denied and those asked to pay higher premiums because of pre-existing condition. Give the millions of taxpayer dollars for

which MRMIB is responsible, it ought to get more accountability out of the insurers who are denying Californians coverage they need.

We appreciate consideration of these important policy issues. For information, please contact our advocate, Beth Capell at (916) 497-0760 or bcapell@jps.net

Sincerely,

Anthony Wright
Executive Director

CC: Members and staff of the Assembly Appropriations Committee
Assemblymember Mike Villines, author

May 10, 2010

Thank you for your interest in working with the U.S. Department of Health and Human Services (HHS) to operate a high-risk pool program in your State consistent with the provisions in the Patient Protection and Affordable Care Act. As you know, this is a temporary program to provide coverage to your uninsured residents with preexisting conditions. In the interests of providing coverage to as many individuals as possible within the funds available, we encourage States to operate these programs as efficiently as possible.

Attached is an application solicitation to establish the temporary high-risk pool program. We understand that you are likely to have questions throughout the application process, and we are committed to providing States with all the information they need to establish this program. To that end, we anticipate scheduling a working session in the near future to give States that plan to operate the high-risk pool program an opportunity to ask questions and receive technical assistance directly from our subject matter experts. We will contact you directly with more information about that call.

I appreciate your willingness to work with HHS to establish a high-risk pool program in your State. We look forward to working with you to provide improved access to affordable insurance coverage.

Sincerely,

Jay Angoff
Director
Office of Consumer Information
and Insurance Oversight

SOLICITATION FOR STATE PROPOSALS TO OPERATE QUALIFIED HIGH RISK POOLS

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1085**. The time required to complete this information collection is estimated to average **(684 hours)** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SOLICITATION FOR STATE PROPOSALS TO OPERATE QUALIFIED HIGH RISK POOLS

SECTION A – STATEMENT OF WORK

A.1 PURPOSE AND BACKGROUND

The Department of Health and Human Services (HHS), as provided by Section 1101 of the Patient Protection and Affordable Care Act ("Affordable Care Act," Public Law 111-148) seeks contracts with States to establish and operate temporary high risk health insurance pool programs to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013. This solicitation seeks proposals from States that wish to enter into non-competitive contracts with HHS to establish and administer these high risk pools.

The contracts awarded through this solicitation will include a start-up period of performance that will run until December 31, 2010, and three additional one-year periods of performance that will run until December 31, 2013. There will be a final closeout period that will run from January 1, 2014 through March 31, 2014.

A.2 DEFINITIONS

Administrative costs refers to reasonable costs incurred by the Contractor to administer the pool.

Creditable coverage has the meaning given such term under both section 2701(c)(1) of the Public Health Service Act before enactment of the Affordable Care Act and 45 CFR 146.113(a)(1).

Enrollee refers to an individual receiving coverage from a qualified high risk pool established under this section.

Nonprofit entity refers to a nonprofit insurer or other organization capable of operating a qualified high risk pool.

Qualified high risk pool or Pool refers to a program which provides coverage in accordance with the requirements of section 1101 of the Affordable Care Act of 2010, as determined by HHS.

Pre-existing condition exclusion has the meaning given such term in 45 CFR 144.103.

Resident means an individual who is legally domiciled in a State.

Service Area refers to the geographic area encompassing an entire State or States in which a qualified high risk pool furnishes benefits.

State refers to any one of the 50 States or the District of Columbia.

A.3 BACKGROUND

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Public Law 111-148), hereafter referred to as the Affordable Care Act. Section 1101 of the Affordable Care Act establishes a "temporary high risk health insurance pool program" to provide health insurance coverage to currently uninsured individuals with pre-existing conditions. The Affordable Care Act authorizes HHS to carry out the program directly or through contracts with States or private, nonprofit entities.

This is a non-competitive solicitation for States to establish and administer temporary high risk health insurance pool programs to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013. On April 2, 2010, HHS issued a letter to governors and state insurance commissioners asking each State to indicate its interest in participating in this temporary high risk pool program. This solicitation is being sent to the designated contacts for all states who indicated a willingness to participate in establishing this program. In response to this solicitation, States are asked to submit proposals to establish and administer those qualified high risk pools under contracts to be issued by HHS.

As a result of this solicitation process, HHS intends to award the proposing States a negotiated contract for the administration of the high risk insurance pool. HHS will also establish an account through which each state can draw down their respective benefit claims.

As stated in the April 2, 2010 letter, HHS will carry out the coverage program in States that do not submit proposals to operate qualified high risk pools. HHS may pursue a separate acquisition process to acquire any services it may find necessary to operate high risk health insurance pools in those States.

HHS's goal is to grant the flexibility needed to permit successful and expeditious implementation of the program by States. HHS encourages States to take advantage of that flexibility in developing proposals, including consideration of the following options:

- Operate a new high risk pool alongside a current State high risk pool;
- Establish a new high risk pool (in a State that does not currently have a high risk pool);
- Build upon other existing coverage programs designed to cover high risk individuals;
- Sub-contract with a current HIPAA insurance carrier of last resort or other insurance carrier, to provide subsidized coverage for the eligible population.

States may designate a nonprofit entity as the proposed contractor to operate a qualified high risk pool on behalf of the State. All proposals submitted in response to this solicitation must include written confirmation that the submitting entity has been approved to do so by the governor or state insurance commissioner. Only 1 (one) proposal may be submitted per state. Two or more States may elect to join together to establish and operate a single qualified high risk pool that covers enrollees in each State.

The Affordable Care Act establishes standards that a qualified high risk pool must follow to be eligible for Federal contract funding. To meet the requirements of this solicitation, a proposal must be structured in a manner that is consistent with the terms described in service and delivery tasks below.

A.4 SPECIFIC SERVICE AND DELIVERY TASKS OF CONTRACTED STATE HIGH RISK POOL PROGRAMS

A.4.1 The Contractor shall have the capacity and technical capability to perform all functions necessary to the design, implementation, and operation of a qualified high risk pool that will provide coverage to eligible individuals, that is, currently uninsured individuals with pre-existing conditions. If the Contractor operates another high risk pool, the Contractor shall segregate funding and expenditures for the two programs and track all benefits and services separately for enrollees in each program.

A.4.2 The Contractor shall design, implement, and operate a qualified high risk pool that is compliant with the following basic design requirements of the temporary high risk pool program.

***Important Note**: As of the date of this solicitation, the final regulations for the high risk pool program have not yet been published. If there are significant changes to the requirements below as a result of Federal regulations, HHS will amend this solicitation and give States an opportunity to make changes in their proposals prior to the issuance of contracts.*

1) Eligibility for Individuals to Enroll in High Risk Health Insurance Pool Programs – The Contractor shall develop eligibility criteria for participation in a high risk pool subject to the approval of HHS. Generally, HHS anticipates Contractors will develop criteria that include all of the requirements included in A.4.2.1.a and A.4.2.b Subject to the approval of HHS, the Contractor shall develop eligibility criteria meeting some or all of the elements included in A.4.2.1.c. That is an individual:

a) Is a citizen or national of the United States or lawfully present in the United States;

b) Has not been covered under creditable coverage for a continuous 6-month period of time prior to the date on which such individual is applying for coverage in the high risk pool program.

c) Meets the pre-existing condition requirement established for a qualified high risk pool. HHS anticipates that Contractors will use methods to define pre-existing condition that include, but are not limited to:

i) Evidence of denial of coverage.

ii) Evidence that coverage is available only with an exclusionary rider.

iii) The presence of certain medical conditions specified by the State and approved by HHS.

2) Benefits Requirements – The qualified high risk pool may offer one or more benefit plans, provided that they are actuarially consistent with the statutory requirement that the issuer's share of the costs is not less than 65 percent of the total costs of the benefit. Contractors may propose the benefit and coverage structure to be used by the qualified high risk pools within the limits of their allotments.

3) A qualified high risk pool must provide to all eligible individuals that it enrolls in a qualified high risk pool, health coverage that does not impose any pre-existing condition exclusions with respect to such coverage, and may not deny enrollment based on a pre-existing condition.

4) The premiums charged under the high risk pool may not exceed 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State or States. The qualified high risk pool shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques. A qualified high risk pool may not use other methods of determining the standard rate, except with the approval of the Secretary. Premiums charged to enrollees in the qualified high risk pool may vary on the basis of age, by a factor not greater than 4 to 1.

5) The qualified high risk pool's average share of the total allowed costs of the required benefits must be at least 65 percent of such costs. The out-of-pocket limit of coverage for cost-sharing for the required benefits may not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved.

6) A qualified high risk pool may specify the networks of providers from whom enrollees may obtain services. The qualified high risk pool must demonstrate to HHS that it has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

7) A qualified high risk pool shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations. Minimally, the appeals procedures must provide enrollees and potential enrollees the right to a timely redetermination by the qualified high risk pool or its designee of a determination concerning eligibility or coverage, and the right to a timely reconsideration of a coverage redetermination by an entity independent of the qualified high risk pool or the entity designated to make that redetermination.

A.4.3 The Contractor shall perform all eligibility determination and enrollment functions.

1) The Contractor shall develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage (as described in A.4.2.1) receive benefits from the program.

2) As part of the enrollment application process, the Contractor will obtain the name, address, date of birth and Social Security number of a person applying for coverage.

3) The Contractor shall implement a process to confirm that the enrollee is a citizen or national of the United States or an alien lawfully present in the United States. The Contractor shall submit to HHS for approval a plan for verifying citizenship in accordance with the Affordable Care Act.

4) The Contractor shall develop and operate an enrollment process that ensures eligible individuals timely access to benefits under the qualified high risk pool and that enrollment is maintained per the eligibility criteria established by the qualified high risk pool. The Contractor shall submit a description of the enrollment process to HHS for approval. HHS anticipates that, in general, the enrollment process proposed by the Contractor will provide that an individual eligible for enrollment who submits a complete enrollment request by the 15th day of a month must have coverage take effect by the 1st day of the following month, except in exceptional circumstances that are subject to HHS approval.

5) The Contractor shall develop and operate a disenrollment process. The Contractor shall submit a description of the disenrollment process to HHS for approval. HHS anticipates that the disenrollment process will include provisions that include, but are not limited to, policies for disenrolling an individual if the monthly premium is not paid on a timely basis; when an individual no longer resides in the qualified high risk pool's service area; when an individual obtains other creditable coverage; and, in the case of a death of the individual.

A.4.4 The Contractor shall provide customer service functions on behalf of high risk pool enrollees.

1) The Contractor shall operate a customer service call center that is appropriately staffed to the number of plan enrollees so as to provide prompt and accurate information and services to high risk pool program members.

2) The Contractor shall have the capability to provide customer service and plan enrollment information in languages other than English to meet the needs of the population anticipated to be served by the high risk pool program and must also make customer service and plan enrollment information available in formats that are accessible by people with disabilities.

A.4.5 The Contractor, at a minimum, shall operate a technical support center, which may include both a call center and an electronic/automated system, to respond to health care and pharmacy providers seeking information related to an enrollee's benefits, coverage determinations (including exceptions and prior authorizations) and enrollee appeals.

A.4.6 The Contractor shall be responsible for premium administration for the high risk pool program.

1) The Contractor shall calculate the appropriate premium amount, bill, and collect premiums from health risk pool program enrollees or enrollee's designee.

2) The Contractor shall use premiums collected and any interest earned on premiums held by the high risk pool program solely to offset the approved administrative expenses and high risk pool program enrollee claims for health services as included in this Contract.

A.4.7 The Contractor may develop and implement disease and utilization management that will assure high risk pool program enrollees have access to necessary health care services and prescription drugs via a provider network capable and available to deliver those services for high risk pool program enrollees in a cost-effective manner.

A.4.8 The Contractor shall develop and implement a system for processing and paying claims for health and prescription drug claims, including a point-of-sale claim system for prescription drugs.

A.4.9 The Contractor shall develop and implement a plan for marketing and outreach for the high risk pool program to make potentially eligible individuals and organizations and providers that interact with potentially eligible individuals aware of the high risk pool program and the coverage offered by the qualified high risk pool.

A.4.10 The Contractor shall establish procedures to identify and report to HHS instances where health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage (or discouraging enrollment in available coverage) in instances in which such individuals subsequently are eligible to enroll in the qualified high risk pool. Such procedures may include, but are not limited to:

1) Questions on the high risk pool application form to identify applicants (or their family members) that are employed, may have, or have had, access to other coverage including employment based group health coverage, or are getting assistance in the payment of premiums for the qualified high risk pool from employers or other sources.

2) Questions on the application form asking applicants to identify their most recent health coverage and the reasons for leaving or losing that coverage.

3) A requirement that enrollees report changes in their employment status (or that of a family member) during the course of enrollment.

A.4.11 The Contractor shall develop operating procedures to prevent, detect, recover (when applicable or allowable), and immediately report to HHS incidences of waste, fraud, and abuse and shall cooperate with Federal law enforcement authorities in cases involving waste, fraud, and abuse.

A.4.12 The Contractor shall establish and implement an effective system for routine monitoring and identification of compliance risks. The system shall include internal monitoring and audits to evaluate the high risk pool program, including any sub-contractors utilized by the program, in terms of compliance with HHS requirements.

A.4.13 The Contractor shall develop and implement a system for coordinating benefits for health and prescription drug claims with other payers as needed, such as Workers' Compensation.

A.5 PAYMENT TO CONTRACTOR

1) The Contractor will not be responsible for the costs of covered health insurance claims filed by enrollees in the State high risk pool program or for the administrative expenses of operating those programs to the extent that those claims and administrative expenses are in excess of the premiums collected by the State high risk pool program. The contractor will ensure that the claims and administrative expenses are incurred within the terms of the contract, and the claims and administrative expenses do not exceed any limits set by HHS. HHS will reimburse the Contractor for claims for covered services and for administrative expenses that are in excess of the premiums collected by the qualified high risk pool. Reimbursement for claims and administrative expenses is contingent on the extent that the Contractor complies with the terms of the contract, including the Contractor's responsibility to act in consultation with HHS to limit the amount of anticipated expenses to the available funds HHS allocates to the State to operate the high risk pool program.

2) The Contractor shall receive actual cost reimbursement payments from HHS for allowable and allocable administrative costs and claims costs incurred in the development and operation of the qualified high risk pool.

3) Invoices for Administrative Costs: The Contractor shall receive actual cost reimbursement, subject to limits and approval of HHS, for administrative costs associated with implementing the high risk pool program, including expenses directly related to the tasks outlined in A.5 as well as other expenses including, but not limited to the use of actuarial services, accounting and auditor fees, agent referral fees, assessment operations, bank charges, board of director expenses, staff salary and expenses, legal expenses, marketing and outreach, office rent, equipment and supplies, postage, and printing and other administrative costs as approved by HHS. On a monthly basis, the Contractor shall submit an invoice for administrative costs and shall include a Statement indicating:

a) The contract line item number

b) The administrative expenses of the Contractor;

c) The number of high risk pool program enrollees and the claims paid on behalf of high risk pool enrollees;

d) The amount of premiums billed and the amount of premiums collected.

The Contractor's invoice shall not contain personally identifiable information describing the enrollees in the qualified high risk pool.

4) Claims Costs: Funds associated with the claims payments will be placed in an account established with the Payment Management System (PMS). PMS is administered by the The Division of Payment Management (DPM), an office of U.S. Department of Health & Human Services' (HHS) Program Support Center, Financial Management Service (http://www.dpm.psc.gov). On a weekly basis, the Contractor shall submit a request for payment for the claims for review and approval, and shall include a Statement indicating:

a) The claims paid on behalf of high risk pool enrollees;

b) The number of high risk pool program enrollees;

c) The amount of premiums billed and the amount of premiums collected.

The Contractor's request may not contain personally identifiable information describing the enrollees in the qualified high risk pool.

Upon approval, funds will be disbursed to the Contractor via electronic funds transfer.

5) HHS will reimburse costs incurred under the terms of this contract up to the amount allotted to the state, but shall not pay the Contractor a fee or profit for performing this contract.

6) The Contractor shall monitor the total expenses submitted to HHS, as well as the anticipated expenses of the high risk pool, in relationship to the total allotment of funds available to the Contractor's State. If the anticipated expenses of the high risk pool are projected to exceed the available HHS allotment of funds for the State, the Contractor shall make necessary adjustments to eliminate such deficit, in consultation with HHS.

A.6 PROMPT IMPLEMENTATION REQUIREMENT

The Contractor shall begin to accept enrollments into the qualified high risk pool and provide coverage to enrollees within a timeframe to be specified in the proposal and approved by HHS.

A.7 IMPLEMENTATION PLAN AND PROGRESS REPORTS

1) Within calendar 10 days of award of this contract, the Contractor shall submit to the HHS Contracting Officer Technical Representative (COTR) a project implementation plan that includes planning for each of the requirements in A.4 and highlights each step of implementation of this contract and that is consistent with the proposal submitted in response to this solicitation. The implementation plan, at a minimum, shall include specific dates on which the Contractor will:

a) Announce the availability of the plan to the public,

b) Begin accepting plan enrollments, and

c) Begin to cover the claims submitted by or on behalf of high risk pool program enrollees.

2) The Contractor shall submit progress reports to DHHS on the status of implementing and carrying out the high risk pool program. Reports should be submitted in a format to be provided by DHHS. The first progress report will be due 90 calendar days after the award of the contract. Subsequent progress reports will be due on the second Monday of January, April, July, and September in 2011, 2012, 2013, and on the second Monday of January 2014. At a minimum, progress reports shall include:

a) Evidence that the major milestones of the implementation plan have been met and clear identification of milestones yet to be met.

b) An updated timeline for implementing the program and meeting other identified milestones.

c) Risks and problems identified or encountered by the Contractor and mitigation strategies implemented to address those risks and problems.

d) A description of the enrollment into the high risk pool program, at least broken down geographically and demographically to describe whether the enrollees in the program are representative of the eligible individuals in the state.

e) The number of new enrollees into the program.

f) The number of individuals who have disenrolled from the program, including the reason for the disenrollments, if known.

g) The average length of enrollment in the program.

h) A breakdown of how enrollees satisfied the pre-existing condition requirement.

i) In the first progress report of each year, updated annual cost projections, based on actual expenditures and enrollment. If a shortfall is projected, a plan with specific cost-containment strategies will be submitted to HHS that assures high risk pool expenditures stay within allotment levels.

The quarterly reports shall not contain personally identifiable information about the enrollees in the high risk pool program.

3) The Contractor shall submit monthly reports to HHS, beginning on the 15th day of the month following the month of the effective date of the contract and continuing on the 15th day of each month until the expiration of the contract. Minimally, the monthly reports shall provide information on the previous calendar month of operations and contain a complete accounting of qualified temporary high risk pool expenditures and revenue, the total number of enrollees, the number of new enrollments and disenrollments, the average monthly premiums, and average out-of-pocket costs for enrollees. The Contractor must certify that all information submitted to HHS in these reports is true, accurate, and complete. The monthly reports shall not contain personally identifiable information about the enrollees in the high risk pool program.

4) On February 1, 2011 and each February 1 thereafter, the Contractor shall submit an independently audited financial report detailing the finances of the high risk pool program operated by the Contractor.

A.8 MEETINGS

The Contractor shall participate in monthly meetings or teleconferences with HHS to be scheduled by HHS through January 2011 and as may be necessary thereafter to provide for the exchange of information relative to the implementation of high risk pool programs.

A.9 DATA USE AGREEMENTS

The Contractor shall enter into and comply with provisions of data use agreements with HHS and other Federal agencies as may be required for the implementation of the high risk pool program.

A.10 TRANSITION TO HEALTH BENEFIT EXCHANGES

The Contractor shall be responsible for implementing HHS procedures to provide for the transition of eligible enrollees in high risk pool programs into qualified health plans offered through Health Benefit Exchanges as provided in the Affordable Care Act and assure that there is no lapse in coverage for the individual involved.

A.11 NON-DISCRIMINATION

The Contractor shall not discriminate based on race, ethnicity, religion, gender, age, or disability.

A.12 HHS RIGHT TO AUDIT

The Contractor agrees that HHS, other Federal agencies in the citizenship verification process, the Comptroller General, any Federal law enforcement agency, or their designee may evaluate, through inspection, audit or other means:

1) The quality, appropriateness and timeliness of services furnished to high risk pool enrollees under the Contract.

2) Compliance with HHS and other Federal requirements for maintaining the privacy and security of protected health information and other personally identifiable information of high risk pool enrollees, including, but not limited to the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, et seq.), Computer Matching and Privacy Protection Act of 1988, and The Privacy Act of 1974 (5 U.S.C. §552a).

3) The facilities of high risk pool programs to include computer and other electronic systems.

4) Any books, contracts, computer or other electronic systems, including medical records and documentation of sub-contractors related to the HHS Contract with the high risk pool program.

A.13 RECORD RETENTION

The Contractor is required to retain records that the Contractor or sub-contractors create, collect or maintain while participating in the high risk pool program for at least six years following termination. This retention period may be extended by the Secretary if a qualified high risk pool's records relate to an ongoing investigation, litigation or negotiation by the Secretary, the Office of the Inspector General, the Department of Justice or a State, or such documents otherwise relate to suspicions of fraud and abuse or violations of Federal or State law. The Contractor shall return or destroy protected health information created or received in the Contractor's capacity in operating a high risk pool program under this contract.

A.14 DISPUTES

This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613). Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under the disputes clause contained in Appendix 3 of this solicitation.

SECTION B –OTHER PROVISIONS

B.1 DESIGNATION OF CONTRACTING OFFICER TECHNICAL REPRESENTATIVE (COTR)

HHS will designate an HHS COTR who will be responsible for monitoring the Contractor's progress in the implementation of the high risk pool program, interpret the Statement of Work and any other technical performance requirement, perform technical evaluation as required, and assist in the resolution of technical problems encountered during performance. HHS may change its COTR designation.

B.2 REGULATORY GUIDANCE

HHS will provide guidance on regulations that it may promulgate that will govern requirements and operations of high risk pool programs. Contractors must follow such guidance for the duration of the contract, as well as other applicable laws and regulations.

B.3 MONITORING OF AVAILABLE FUNDS

HHS will monitor the total expenses paid to the Contractor in relationship to the total allotment of funds available to the Contractor's State and will work with the Contractor to develop mitigation strategies should the actual or projected expenses reimbursable under this contract and through the high risk pool program be projected to exceed the total funding allotment available for the State. If HHS determines that the amounts available for the payment of expenses of the high risk pool will be less than the projected amount of such expenses, the Contractor shall make necessary adjustments to eliminate such deficit, in consultation with HHS. Nothing in this provision relieves a contractor of the obligation to monitor and report its expenditures or to permit expenditures beyond the amount specified in the contract.

B.4 TERMINATION OF CONTRACT

(1) HHS may terminate a contract with the Contractor if the Contractor fails at any time to maintain compliance with any element or requirement of its contract with HHS, or if entity is at any time out of compliance with any provision of this part. The entity will be notified in writing of any contract termination.

(a) Should a Contractor receive notice from HHS that HHS intends to terminate the contract under the terms of B.4(1), the qualified high risk pool will have 30 days to cure its failure(s) that were the basis for the termination and to notify HHS in writing at the address specified in the notification letter. HHS will review the correction and notify the entity in writing of its decision to either find the contractor has cured its failure(s) or to proceed with the termination.

(b) If the contract is with multiple States, each State will be individually notified of the termination. Any correction of the deficiencies must be submitted jointly and on behalf of all of the affected States.

(2) HHS, by written notice, may terminate this contract, in whole or in part, when it is in HHS's interest. If this contract is terminated, the rights, duties, and obligations of the parties, including compensation to the Contractor, shall be in accordance with Part 49 of the Federal Acquisition Regulation in effect on the date of this contract.

SECTION C – PROPOSAL PROCESS

The Department of Health and Human Services is seeking proposals from States to establish and administer temporary high risk health insurance pool programs to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013. Only States or their designated entities are eligible to submit proposals and States are required to submit proposals according to the process described under "Instructions to Proposers" in Section C.2. HHS will award one contract to operate a high risk pool program in each State that submits a qualifying proposal in response to this solicitation.

C.1 PROPOSAL PROCESS

The following chart depicts the key dates and steps in the proposal process for this solicitation.

PROPOSAL AND REVIEW PROCESS	
DATE	**MILESTONE**
April 2, 2010	HHS issues letter to States seeking from each by April 30, 2010 a State a Notice of Intent relative to the operation of high risk pool programs.
April 22, 2010	HHS holds a call with States to review the anticipated requirements of the contract solicitation.
April 30, 2010	Deadline from April 2, 2010 letter for States to send HHS a Notice of Intent that they intend to submit a proposal to operate a high risk pool program.
May 10, 2010	HHS issues a solicitation for States to submit proposals to operate high risk pool programs.
June 1, 2010	Deadline for State submission of proposal for HHS evaluation and contract awards by July 1, 2010.
July 1, 2010	HHS awards contracts to States that have submitted acceptable contract proposals by June 1, 2010, to operate high risk pool programs.

Questions from Proposers

Proposers may request clarifications of this solicitation, including the requirements and the proposal process, using the following procedures:

- Submit questions in writing, through an email or Word attachment to an email. Include in the email the point of contact's name, email address, phone number, and name of the State.
- For each question, please reference the section number referenced in the question.
- Questions should be sent via email to highriskpools@cms.hhs.gov.

HHS Point of Contact for Solicitation

Prior to the contract award, HHS points of contact for all inquiries and submission of required documents from potential proposers shall be:

For policy and program development questions:

Kevin Simpson
410-786-0017

Linda Anders
410-786-0459

Email: highriskpools@cms.hhs.gov

For proposal submission questions:

Jacquelyn Carey (primary)
301-443-6557

David Snight (secondary)
301-443-6557

HHS Qualifications to Proposal Process

This solicitation does not commit HHS to pay for any cost for the preparation and submission of a proposal. HHS reserves the right to amend or cancel this solicitation.

C.2 INSTRUCTIONS TO PROPOSERS

States shall use the following process to submit proposals in response to this solicitation. States are advised that the information in their proposals, and any subsequent written clarifications provided in response to HHS' request will be referenced in the contract with HHS.

1) The State must submit comprehensive information to support the proposal. Proposals shall have three sections:

a) Certification
b) Technical Approach
c) Cost Proposal

2) Certification -In preparing the signed certification, please print out the certification provided in Appendix 2 of this solicitation and submit an original document signed by the Governor or official designated by the State's response to the HHS April 2, 2010 letter.

3) Technical Approach – Using each requirement for the proposal outlined in Section C.4 below, States shall provide a description of the proposed program, demonstrating how it meets the qualifications described in Section A of the Statement of Work. In preparing the Technical Approach section of the proposal, respond to the requirements in Section C.4 of this solicitation. Please repeat each proposal requirement as stated, followed by your response. Provide complete answers. If you have additional information that you would like to provide, please include it as an appendix to your proposal, and cross-reference its relationship to the information requested. If the approach plans to use sub-contractors, identify the name of the organization(s) and the role(s) to be filled by the organization(s) that are proposed as sub-contractors.

4) Cost Proposal – In preparing this section of your proposal, submit the information in the required formats specified in Section C.5 of this solicitation. Provide complete answers. If you have additional information you would like to provide, please include it as an appendix to your original proposal, and cross-reference its relation to the information requested.

5) Proposal Format – States shall submit both written and electronic versions of their application to HHS.

All copies and the original proposal should be in 3-ring binders. Tab indexing should be used to identify all major sections of the proposal. Page size should be 8.5 by 11 inches, with one inch margins, and the pages should be numbered. Type size should not be less than 12 point with a space and a half between lines. HHS requires that one original and two copies of the proposals be delivered.

In addition to submitting written versions of the proposal, States must email to HHS a zip file of the certification and proposal (in a format compatible with MS Office 2007). The Cost Proposal shall be in Excel.

Both written and electronic versions of the proposal shall have, on the first page, the following:

Name of this RFP, i.e. "Solicitation for State Proposals to Operate Qualified High Risk Pools"

The State's name, contact's name, address, email, and telephone and facsimile numbers

If applicable, the designated nonprofit entity's name, contact's name, address, email, and telephone and facsimile numbers

Names, titles, emails, and telephone and facsimile numbers of persons authorized to negotiate on the State's behalf with the Government in connection with this solicitation.

The rest of the required sections shall be in the following order:

a) Certification
b) Technical Approach
c) Cost Proposal

7) Submitting the Proposal – States should deliver written proposals to the address below:

Department of Health and Human Services
Program Support Center
Strategic Acquisition Service
Division of Acquisition Management
Parklawn Building, Room 5-101
5600 Fishers Lane
Rockville, MD 20857

The electronic version of the proposal shall be sent via email to highriskpools@cms.hhs.gov and to pscacquisitions@psc.hhs.gov concurrently.

8) Deadline for Submission – HHS will begin to review proposals upon submission. HHS must receive completed proposals by June 1, 2010 from States intending to establish qualified high risk pools on July 1, 2010.

9) Withdrawal of a Proposal – A State (or States) may withdraw a proposal at any time before the contract is signed and becomes effective. Proposal withdrawals shall be submitted in writing to the HHS contact noted above, and are effective upon receipt.

10) Amendments to an Proposal – States may submit modifications to their proposals at any time before the proposal deadline or, upon the request of HHS, up to the effective date of the contract, whichever comes first.

11) Protection of Confidential Commercial Information – If any information within a submitted proposal (or attachments thereto) constitutes and is clearly labeled by the proposer as a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), then such information will be protected from release by HHS under 5 U.S.C Section 552(b)(4).

12) Certification Instructions – After submitting the proposal, States must notify HHS in writing if they become aware of changes to the certification provided (see Appendix 2), including:

- Any information in the proposal that is not true, correct, or complete
- There are any changes that may jeopardize the proposers ability to meet the qualifications and fulfill the Statement of Work of the proposed contract

Changes to the information furnished in this proposal must be reported promptly to the designated point of contact for the solicitation listed in C.1.

13) Multi-state proposals - If two or more States elect to join together to establish and operate a single qualified high risk pool that covers enrollees in each State, a single proposal may be submitted. The proposal, however, must:

- Be jointly certified by the governors or independent insurance commissioners of each State.
- Include all of the information described in this section.
- Separate the requested proposal elements (to the extent applicable) by State.

C.3 SUMMARY OF QUALIFICATIONS

This is a non-competitive solicitation seeking proposals from States who will be awarded contracts to establish and administer temporary high risk health insurance pool programs to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013. Each State-submitted proposal that meets those requirements will be eligible for award of a contract.

HHS will review the proposals to ensure that each one has been submitted by a State and that any designation of a nonprofit as a contractor to operate the high risk pool program is accompanied by copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation.

HHS will not score proposals in comparison to one another and no scoring scale will be used by proposal reviewers. Reviewers will evaluate whether the proposal addresses each element of the prompts in Section C.4 and whether the responses in the proposal fully comply with the requirements in the Statement of Work.

HHS will review proposals to verify that the cost estimates contained in the Cost Proposal are actuarially sound, given a comparative cost analysis of currently operating State high risk pool programs and considering costs associated with the start-up of the pools to be created under contracts awarded through this solicitation. HHS will also review cost estimates in the Cost Proposal in comparison to the available funding allocated to the State based on a formula used by HHS for the initial estimated allocation of available funds.

HHS will promptly contact States if reviewers identify elements of the proposal that are missing, incomplete, or that do not appear to fully comply with the requirements in the Statement of Work. States will be given an opportunity to submit amended proposals that comply with those requirements.

C.4 TECHNICAL APPROACH CONTENT

Please respond to the following questions regarding your State's proposed high risk pool program. You may submit additional information that demonstrates your proposal meets and/or exceeds the requirements of the Statement of Work outlined in Section A.4 and Summary of Qualifications found in Section C.3.

C.4.1 Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services.

If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation.

As part of the technical approach, the State or its designated entity may subcontract with either a for-profit or nonprofit entity.

C.4.2 In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

1) Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

2) Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

3) How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

4) Describe how the qualified high risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

5) Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.

6) If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

7) Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.10.

C.4.3 Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

1) How will the qualified high risk pool develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?

2) How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?

3) Describe the process that the qualified high risk pool will use to confirm that an enrollee is a citizen or national of the United States or an alien lawfully present in the United States.

4) Describe the enrollment process that the qualified high risk pool proposes to use.

5) Describe the disenrollment process that the high risk pool plan proposes to use.

C.4.4 Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.

C.4.5 Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

C.4.6 Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

C.4.7 If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.8 Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.9 Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

C.4.10 Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.

C.4.11 Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.12 Describe the system for routine monitoring and identification of compliance risks.

C.4.13 Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.5 COST PROPOSAL

States must submit their estimated costs associated with operating high risk pool programs. The state estimates should cover the duration of the program and demonstrate that the high risk pool funds will be available every year for the life of the program. The estimates in the cost proposals will be the basis for negotiating and determining the payment rates under this contract. States must submit their projected costs estimates and the assumptions used to develop these estimates using Tables 1, and 2 provided below. The cost estimates submitted in these tables will be subject to review and negotiation by HHS for the purposes of determining the total amounts payable under the contract. Proposers should be prepared, upon request, to provide HHS with documentation to support the development of the estimates and data in Tables 1 and 2. The data submitted shall be subject to audit by HHS or by any person or organization that HHS designates.

Table 1

HHS intends to pay Contractors reasonable, allowable costs associated with initial administrative expenses for the initial period of performance of high risk pool programs. Given the nature of initiating a new high risk pool program or building upon an existing program during this start-up period, HHS intends to reimburse Contractors for reasonable, allowable administrative costs associated with developing the high risk pools pursuant to the contract that are not tied to specific enrollment and claims estimates until December 31, 2010.

HHS anticipates that, over the life of the program, the total administrative costs of the program will not exceed 10% of the total claims costs of the program, as identified in Table 2 below.

Using Table 1, proposers should itemize anticipated administrative costs for each calendar year of the program's operation. The projected administrative costs should be broken down using the categories provided. Proposers should itemize any other categories of anticipated administrative expenses not identified in a category already provided in Table 1.

Table 2

Table 2 provides a template for summarizing the projected administrative and claims expenses that high risk pool programs anticipate for 2010 – 2014, based on the number of people that the States anticipate enrolling in the programs during that time. Proposers should provide projected average enrollment numbers for each calendar year, beginning with the partial year 2010 and going through 2013. States should use the projected administrative costs detailed in Table 1 to calculate the total projected administrative costs for each year. States should indicate the total projected premiums that the high risk pool program will collect in each year as well as the projected total claims.

If States choose to offer more than one plan option to individuals eligible for the high risk pool program, States should list the anticipated number of enrollees, premium revenue, and claims expenses for each plan option separately using the format provided in the template provided for Table 2.

As part of the cost proposal, States should include their strategies for limiting program costs to the anticipated allocations available for each State.

Budget Narrative

State shall provide a budget narrative as part of the cost proposal. The budget narrative should provide an explanation of each of the administrative costs identified in Table 1, including the basis of the cost estimates and indication of any sub-contracting arrangements the State intends to make to acquire administrative services.

States are also required to include an attestation from a certified actuary as to the actuarial soundness of the projections in the cost proposal, as those projections relate to the anticipated enrollment levels, premium revenue, and claims costs identified for each plan option identified by the State in Table 2. If the State proposes cost limiting strategies (such as enrollment limits) to keep the total program costs within the amount supported by premiums and available Federal funds allotment for the state, the State should describe those strategies in the Budget Narrative.

After review and potential negotiation between HHS and the proposer, the amount of projected costs to be reimbursed to high risk pool programs under these contracts will be the total of administrative and claims expenses, minus the premiums collected by the high risk pool programs. Each contract will contain a "not to exceed" amount available under the contract corresponding to each State's allotment. HHS will continually monitor actual State expenses in comparison to the cost estimates contained in the Cost Proposal and will negotiate with States to amend contracts accordingly to keep total program costs within the amount of funding available from the Federal funding allotment.

Maintenance of Effort Description and Table

The budget narrative should contain a separate section that describes how the State proposes to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. A State should provide a narrative description of its maintenance of effort strategy and also provide a table identifying State allocated funds and other current State high risk pool program revenues that supplemented premiums paid by current state high risk pool program enrollees in 2009. The narrative and accompanying table should demonstrate how the State will maintain that level of support of its state high risk pool program.

Cost Proposal Tables

Tables 1 and 2 are templates that States should follow in detailing program costs as part of the Cost Proposal.

Table 1
Administrative Costs

The administrative costs projected in Table 1 should include all administrative costs that the State anticipates during each calendar year from 2010-2013.

Administrative Costs					
Cost Category	**Annual Administrative Costs**				
	2010	**2011**	**2012**	**2013**	**2014**
Marketing and Outreach					
Member Materials					
Customer Service					
Provider Relations					
Information Technology					
Eligibility/Enrollment					
Premium Administration					
Claims Processing**					
Appeals/Reconsiderations					
Legal Services					
Accounting Services					
Actuarial Services					
Procurement					
Personnel Expenses					
Overhead*					
Other Administrative Costs*					
TOTAL					

*Provide a detailed description of costs included in this category of administration costs
**Including prescription drug point of sale claims

Table 2
Administrative and Claims Costs

Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010					
Plan Option 1					
Plan Option 2					
2010 TOTAL					
2011					
Plan Option 1					
Plan Option 2					
2011 TOTAL					
2012					
Plan Option 1					
Plan Option 2					
2012 TOTAL					
2013					
Plan Option 1					
Plan Option 2					
2013 TOTAL					
2014 TOTAL					
TOTAL					

Notes:

- State should list total administrative costs for each calendar year. Administrative costs do not need to be broken down for each plan option if multiple plan options are offered.
- States may offer one or more plan option. State may add additional plan options following the format in template Table 2.
- Claims against Federal Fund Allotment for each year and for the total contract equal the total administrative and claims expenses, minus the premium revenue.
- The projected total for the term of the contract should not exceed the provided Federal fund allotment.
- States must attest to the actuarial soundness of the projects contained in this table in the budget narrative section of the Cost Proposal.

APPENDICES

Appendix 1	**Timelines for Deliverables**
Appendix 2	**Proposal Certification**
Appendix 3	**Disputes**

APPENDIX 1 – TIMELINE FOR DELIVERABLES

Deliverable	ITEM (Task #)	DUE DATE
Project Implementation Plan	A.7	Within 10 calendar days of Date of Contract Award
Quarterly Progress Reports	A.7	Quarterly, beginning 90 calendar days after Date of Contract Award
Monthly Reports	A.7	Monthly, beginning 30 days after Date of Contract Award
Audited Financial Report	A.7	Annually, beginning on February 1, 2011

APPENDIX 2 – PROPOSAL CERTIFICATION

I, (Name and Title), attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware of any information in this proposal that is not true, correct, or complete, I agree to notify the Department of Health and Human Services (HHS) immediately and in writing.

I authorize HHS to verify the information contained herein. I agree to notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with Stated Federal requirements. I further agree to immediately notify HHS if, despite these attestations, I become aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

Authorized Representative Name (printed)	Title
Authorized Representative Signature	Date (MM/DD/YYYY)

APPENDIX 3 – DISPUTES

a) This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim.

(e) For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under the contract, and comply with any decision of the Contracting Officer.

PRICEWATERHOUSECOOPERS

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Direct fax (813) 329-8798

to: **Lesley Cummings** date: **May 7, 2010**

from: **Pete Davidson** subject: **Comparison of MRMIP Premiums and Potential Federal High Risk Pool Premiums**

You have requested that we analyze how Major Risk Medical Insurance Program (MRMIP) premiums may compare to premiums that will be offered in California under the temporary Federal High Risk Pool (FHRP). This memo presents our initial analysis.

Background
From an April 2, 2010 letter issued by U.S. Department of Health and Human Services (HHS) Secretary Sebelius to the state governors and insurance commissioners, the following is known about allowable plan designs and determination of premiums in the FHRP:

- Benefits/Coverage Must Have:
  - An actuarial value of at least 65 percent of total allowed costs;
  - An out-of-pocket limit no greater than the applicable amount for high-deductible health plans linked to health savings accounts, described in section 223(c)(2) of the Internal Revenue Code of 1986 (that is, $5,950 for an individual in 2009); and
  - No pre-existing condition exclusions.
- Premiums Must:
  - Be established at a standard rate for a standard population (that is, not exceed 100 percent of the standard non-group rate); and
  - Not have age-based rate variations greater than 4 to 1.

Remaining questions regarding FHRP benefits and premiums include:

- Specifics of allowable FHRP benefit plan designs;
- The process by which health plans' Individual product standard risk premiums will be adjusted to reflect the FHRP benefit designs;
- Whether FHRP premiums will be averaged across health plans for each benefit design or whether each health plan will offer its own premium rates; and
- How adjustments related to the limit in age-based rate variation will be applied.

It is also unclear the extent to which these types of issues will be prescribed by the federal government as opposed to allowing the states to make these determinations.

Analysis

As an initial step in analyzing the potential impact to MRMIP and demand for the FHRP program, you asked that we compare current MRMIP premiums to those that would be offered under the FHRP for a plan design similar to the MRMIP plans but without MRMIP's annual and lifetime benefit limits ($75,000 per year, $750,000 lifetime). To produce the comparison, two adjustments to the MRMIP premiums are necessary to develop theoretical FHRP premiums:

1. An adjustment to MRMIP premiums to reflect differences in annual/lifetime benefit limits; and

2. An adjustment to reflect that FHRP premiums will be offered at 100% of the standard risk rate, while MRMIP premiums are offered at 125% to 137.5% of the standard risk rate (all MRMIP rates are currently at 125% of the standard risk rate).

Under the MRMIP program, health plans are instructed to develop MRMIP plan premiums by selecting one of their Individual benefit plans similar in design to the MRMIP plan and applying actuarial adjustments to the premiums for differences between the Individual plan and MRMIP plan benefits. The most significant adjustment in these calculations is typically the adjustment for differences in the annual and lifetime maximum benefit, since the vast majority of Individual plans have annual limits of at least $1 million and no lifetime limit. In the 2010 MRMIP rates prepared by the health plans, adjustments reflecting the difference between the annual/lifetime maximums in the selected base Individual plan and the MRMIP plan ranged from -7.5% to -22%, with a weighted average of approximately -16%.

Assuming that an appropriate average reduction due to differences in annual/lifetime benefit maximums is 16%, the benefit value of the FHRP plan described above is approximately 19% higher than the MRMIP benefit [1 / (1 - 0.16) = 1.19]. Therefore, assuming the increase in premiums is equal to the increase in benefit costs the theoretical FHRP premium relative to MRMIP premiums can be estimated as follows:

$$\text{FHRP Premium} = \text{MRMIP Premium} \times 1.19 \times 100\%/125\%$$

$$= \text{MRMIP Premium} \times 0.952$$

In other words, the FHRP premium for a benefit plan that mirrors MRMIP's plan designs but with an annual benefit limit of at least $1 million and no lifetime limit is estimated to be approximately 5% less than current MRMIP premiums, on average, given that premiums will be set at 100% of standard rather than 125%. Alternative estimates, based on the application of either the minimum or maximum adjustment applied by the plans in the 2010 MRMIP rate calculations (-7.5% or -22%) rather than the average adjustment, suggest that an average FHRP premium in this scenario may range from 14% less to 3% more than MRMIP premiums.

Please keep in mind that these are rough estimates, and since the adjustments for benefit limits developed by the health plans may be affected by interactactions with other benefit differences (e.g., deductibles, coinsurance, copays, etc.), it may be appropriate to request that the health plans provide their own estimates of the impact on rates due solely to differences in benefit limits. Additionally, future Individual plan rate revisions are likely to impact the results of this analysis, though the extent is unclear.

* * * * *

Please call me at 415-498-5636 if you have any questions regarding this analysis.

Temporary Federal and State High Risk Pools Administrative Services and Administrative Options Comparison

I. Background

On March 23, 2010, President Obama signed the Patient Protection & Affordable Care Act (PPACA) into law (H.R. 3590). The Act contains a provision (Section 1101) requiring the federal government to establish a temporary federal high risk pool no later than 90 days after enactment and ending of December 31, 2013. On April 2, 2010, Kathleen Sebelius, Secretary of Health and Human Services (HHS) issued a letter to governors and state insurance commissioners asking each State to indicate its interest in administering the temporary high risk pool.

On April 29, 2010, Governor Arnold Schwarzenegger sent a letter to Secretary Sebelius indicating California's intent to contract with the federal government to operate a temporary health insurance program for currently uninsured individuals with preexisting medical conditions. On May 10, 2010, the HHS agency released the application solicitation to establish the temporary federal high risk pool program which includes an initial submission deadline of June 1, 2010 for contracts to be awarded on July 1, 2010.

Governor Schwarzenegger's letter indicated that California would operate the temporary high risk pool alongside the State's high risk pool under the same governance and operational framework. The Managed Risk Medical Insurance Board (MRMIB) administers California's high risk pool, Major Risk Medical Insurance Program (MRMIP). In order to meet the aggressive federal time, MRMIB has begun the process of evaluating the PPACA and the solicitation requirements.

This issue paper first begins to evaluate the operational framework options to administer the new pool and the existing experience level of each option for the necessary administrative services. In evaluating the administrative options, staff has created two comparison tables which include required administrative services and important administrative services (not required for start-up). Secondly, it begins to compares the existing MRMIP administrative services with the administrative services staff believes will be necessary to successfully implement the temporary federal high risk pool. We believe that the comparisons and the included information will help begin the discussions and assist the Board in its deliberations on the most effective and efficient way to implement the new temporary federal high risk pool.

II. Comparison of Administrative Options and Existing Experience Level

Required Administrative Vendor Functionalities:

Required AV Functionality	MRMIP	HFP	Experience Advantage
Potential scalability of AV services to serve potential eligible population (est. 400,000 to 600,000 individuals)	Maybe	Yes	HFP
Citizenship/Immigration status eligibility verification process	No	Yes	HFP
Preexisting condition eligibility verification process	No	No	Neither
Period of un-insurance eligibility verification process	No	Yes	HFP
Appeals process in compliance with federal requirements	No	Yes	HFP
Multi-Lingual application and correspondence	No	Yes	HFP
Monthly enrollment reconciliation process	No	Yes	HFP
Develop and administer program website	No	Yes	HFP
Premium billing and collection system	Yes	Yes	Both
Call Center (Multi-lingual)	Yes	Yes	Both
Case management	Yes	Yes	Both
Electronic data transmission to health plans	Yes	Yes	Both
Health plan invoicing and capitation payment systems	No	Yes	Both
Administer payments to insurance agents and brokers	Yes	Yes	Both

Maintain PO Box and dedicated fax capacity	Yes	Yes	Both
Mail room processing	Yes	Yes	Both
Welcome letter for new subscribers and denial letter for ineligible applicants	Yes	Yes	Both
Respond to written inquiries within 20 calendar days	Yes	Yes	Both
Administer enrollment wait list process to keep expenditures within allocated funds	Yes	Yes	Both
Administer disenrollment process including HIPAA notices	Yes	Yes	Both
Administer disenrollment survey process	Yes	Yes	Both
Administer annual open enrollment process	Yes	Yes	Both
Administer fiscal systems including maintenance and reconciliation	Yes	Yes	Both
Turnover requirements to transition subscribers into the Insurance Exchange by 1/1/14	Yes	Yes	Both

Important Administrative Services

Important AV Functionality (Not Required for start-up)	MRMIP	HFP	Experience Advantage
Application missing information follow-up processes	No	Yes	HFP
Remote access to data systems for MRMIB	No	Yes	HFP
Imaging of incoming and outgoing correspondence	No	Yes	HFP

Auto dialer systems for outbound follow-up telephone calls	No	Yes	HFP
Automated application tracking for MI process and appeal disposition tracking systems	No	Yes	HFP
Multiple premium payment modalities	No	Yes	HFP
Technical experience in working with DHCS ITSD (MEDS interface) for citizenship/immigration status Verification	No	Yes	HFP

III. Comparison of Existing MRMIP Administrative Services and Necessary Administrative Services

Bolded items are new administrative services that are not part of existing MRMIP services

MRMIP Existing Administrative Vendor Services	Temporary federal High Risk Pool (Required and Important AV services)
Mail room processing	Mail room processing
Complete application processing and eligibility determination	**Imaging of incoming and outgoing correspondence**
Incomplete application mail back with cover letter (no missing information follow-up process)	Application processing and eligibility determination
Welcome letter for new subscribers and denial letter for ineligible applicants	**Missing information follow up process including MI letter and telephone calls**
Administration of post-enrollment waiting period	Welcome letter packet for new subscribers and denial letter for ineligible applicants **including referral to other coverage programs**
Premium billing and collection processing	Premium billing and collection processing
Develop and produce program application and brochure (English only)	Develop and produce program application and materials (**multiple languages to comply with federal requirements**)
Call Center (8:30 am to 7:00 pm M-F)	Call Center (**8:00 am to 8:00 pm M-F, possible weekend hours**)
Maintain PO Box and dedicated fax line	Maintain PO Box and dedicated fax **server**
Respond to written inquiries within 20 calendar days	Respond to written inquiries within 20 calendar days
Case management for subscribers	Case management for subscribers

Electronic data transmission to health plans (834, 820 and 837 transactions)	Electronic data transmission to health plans (834, 820 and 837 transactions)
Administer enrollment wait list process to keep expenditures within allocated funding	Administer enrollment wait list process to keep expenditures within allocated funding
Administer disenrollment process including HIPAA notices	Administer disenrollment process including HIPAA notices
Administer annual disenrollment survey process	Administer annual disenrollment survey process
Administer payments to insurance agents and brokers	Administer payments to insurance agents and brokers
Administer fiscal systems including maintenance and reconciliation	Administer fiscal systems including maintenance and reconciliation
Administer state monthly reporting requirements	Administer state **and federal** monthly reporting requirements
	Develop and implement monthly enrollment reconciliation process for health plans
	Develop and implement online eligibility verification system for health plans
	Develop and implement internet provider network information service system for applicants
	Develop and implement remote access to HR pool data systems for MRMIB
	Develop and implement citizenship/immigration status eligibility processes (manual and automated)
	Develop and implement preexisting condition list for eligibility determination process
	Develop and implement administrative verification systems for eligibility determination process (SSA, & HLS)
	Develop and implement eligibility appeals process that complies with federal requirements
	Develop and implement HR pool website
	Develop and implement multiple premium payment modalities
	Develop and implement plan capitation invoicing and payment systems

IV. Next Steps

Begin discussion with Administrative Vendor options on ability to meet the requirements and timelines for the new temporary federal high risk pool.