Agenda Item 3
July 25, 2007 Meeting

Managed Risk Medical Insurance Board
June 20, 2007, Public Session

Board Members Present: Cliff Allenby, Areta Crowell, Ph.D., Sophia Chang, M.D., M.P.H., Richard Figueroa, M.B.A

Ex Officio Members Present: Warren Barnes (on behalf of the Secretary for Business, Transportation and Housing), Bob Sands (on behalf of the Secretary for California Health and Human Services Agency), and Jack Campana

Staff Present: Lesley Cummings, Denise Arend, Laura Rosenthal, Ronald Spingarn, Janette Lopez, Shelley Rouillard, Terresa Krum, Mary Anne Terranova, Ernesto Sanchez, Larry Lucero, Carolyn Tagupa, Alba Quiroz-Garcia

Also Present: Peter Davidson (PricewaterhouseCoopers), John Grgurina (Consultant to MRMIB), Peter Harbage (Harbage Consulting), Gwendolyn Leake Isaacs, Stuart Buttlaire (Kaiser), Maureen Sullivan (Local Health Plans of California), Cherie Fields (LA Care)

Chairman Allenby called the meeting to order.

REVIEW AND APPROVAL OF MINUTES OF May 16, 2007, MEETING

The Board approved the May 16, 2007 minutes as amended.

HEALTH CARE REFORM UPDATE

Ronald Spingarn, Deputy Director of Legislation and External Affairs, reported:

- Senate Bill 48, authored by Senator Perata, will be merged with Assembly Bill 8, authored by Assembly Member Nunez; the particulars of the merger are not known presently.
- Assembly Bill 2 (Dymally), the bill that provides additional funding for MRMIP, is also discussed in the context of the AB 8, because AB 8 will require a high risk pool in the long run.

There were no questions from the Board or public comments.

STATE LEGISLATION UPDATE

Mary Anne Terranova, Legislative Coordinator, presented a report summarizing legislation currently being tracked by MRMIB staff. There were no questions from the Board or public comments.

Assembly Bill 8 (AB 8) by Assembly member Nunez

Lesley Cummings, Executive Director, acknowledged the California HealthCare Foundation for making John Grgurina, consultant, available as part of a team to provide technical assistance to the Administration, the Senate and the Assembly, MRMIB and others working on health care reform efforts. She invited Mr. Grgurina to address the Board on the provisions of AB 8.

John Grgurina said that AB 8, as currently written, would:

- Establish an employer-based "pay or play" system designed to cover working Californians and their dependents through a purchasing pool;
- Mandate coverage for working persons, not dependents and not other individuals, either through an employer or the newly created pool;
- Expand Medi-Cal and Healthy Families coverage for children and their parents, and;
- Provide coverage to around 69 percent of the state's uninsured persons, per estimates from Dr. Gruber, whose work is being used by the Assembly, the Senate and the Administration;
- Make reforms in the individual and group markets.

He further explained provisions of the bill as follows:

<u>California Cooperative Health Insurance Purchasing Program (Cal-CHIPP)</u>

- Employers would decide to spend 7.5 percent or more of their payroll wages to purchase coverage for their full-time employees (30 hours a week or more) or pay 7.5 percent of their payroll wages to the state for coverage; they make a similar election concerning part-time employees;
- Certain employers are exempt from the fee: Those with fewer than two employees; small employers with a payroll of less than $100,000 per year; and any employer in business for less than three years;
- MRMIB would operate a purchasing pool (Cal-CHIPP), to provide coverage to those employees whose employers chose to pay the fee. It is expected to include three to four million lives; and
- MRMIB would determine employee's contribution levels and benefits provided by Cal-CHIPP.

Expanded Publicly-Funded Coverage:

- Income eligibility for the Healthy Families Program (HFP) would increase from 250% of the federal poverty level (FPL) for children to 300% FPL, regardless of immigration status. Income eligibility for Medi-Cal coverage for these children would be moved to 133% FPL (compared with 100% FPL proposed by the Administration); and
- Coverage for parents of children in HFP or Medi-Cal also would go up to 300% FPL; and
- MRMIB would create and oversee a premium assistance program for employees of playing employers who would otherwise be eligible for subsidized coverage in Cal-CHIPP.

Section 125 Plans

- All employers would be required to establish and maintain Section 125 plans for their employees, to be administered by MRMIB; the plans save federal and state income tax, FICA tax and Medicare tax on funds paid into these plans for employees and save FICA tax for employers.

Individual Insurance Market Reforms

- MRMIB would develop a list of conditions that would establish eligibility for the state's high-risk pool, which the Board would continue to oversee;
- MRMIB would develop a standardize health questionnaire that every carrier in the individual market would use;
- Carriers would be required to sell coverage, equivalent to that provided through the high-risk pool, to individuals in the private market who do not qualify for the high-risk pool.

Group Insurance Market Reforms

- Insurance rules will be established for employers with 51 to 200 employees like those for small employers; and
- Carriers would be required to spend at least 85% of their revenue on health care services, (similar to the Administration's proposal.)

Financing

Overall financing for AB 8, would include:

- $5 billion in employer contributions, as estimated by Dr. Gruber;
- $2.7 billion in individual and employee contributions; and
- Around $1 billion in federal funds from expanding the Medi-Cal and Healthy Families programs.

Cost Containment

- MRMIB would create uniform benefit designs to be offered through the purchasing pool on an unsubsidized basis. Carriers in the private market would also have to offer them.

Mr. Grgurnia presented a chart showing the different ways individuals might obtain coverage under AB 8. These included group coverage for persons either working for an employer that pays for coverage in the purchasing pool (Cal-CHIPP) or working for an employer who purchases coverage from a carrier. Individuals would obtain coverage through the individual market. Children along with eligible parents may be covered by public programs (such as Healthy Families or Medi-Cal) which would draw federal funds. In addition, childless adults may be eligible for subsidies for their coverage which would not draw federal funds.

He emphasized that that the Speaker was committed to offering subsidized coverage to lower-income persons who work for employers that provide coverage for their employees. This premium assistance feature of AB 8 is unique to the bill.

He reviewed some differences between the Senate and Assembly bills which included:

- Individual Mandate: SB 48 would mandate individuals above 400% FPL to obtain coverage; AB 8 would not. SB 48 would also exempt persons from the mandate if their cost for coverage is 5% or more of their family income. AB 8 requires employees to take up coverage.
- Premium Assistance: AB 8 would establish a premium assistance programs. SB 48 would not.
- Employer Exemptions: SB 48 would exempt self-employed persons from the coverage mandate. AB 8 would exempt businesses with under $100,000 payroll, businesses less than three years old and those with fewer than two employees.
- Individual Market Reforms: AB 8 would require MRMIB to develop a list of health conditions to be used by carriers in order for an individual to get covered in the high-risk pool. SB 48 would require guarantee issue of all products and allow persons under 400% FPL with certain medical conditions to apply to the high-risk pool where they could receive a discount on the cost for coverage in the pool.
- Employer Costs: SB 48 would authorize MRMIB to increase the amount paid for coverage by employers, currently set to start at 7.5% of their payroll, either in the private market or through a pool. AB 8 would require legislation to change employers' costs for coverage.

Board Members' Questions and Comments: Dr. Crowell asked what provisions the legislature is making to fund start-up costs. Mr. Grgurina said that this is under discussion. Dr. Crowell noted that the legislature often creates programs that are expected to be operational from their first day without having the necessary resources allocated. Mr. Grgurina said that another timing issue concerns phasing in the pay-or-play requirements as over 250,000 employers don't provide coverage today and bringing on that number of employers at once could be challenging. He emphasized that the legislative leadership is sincerely

interested in creating an approach that MRMIB is able to implement and that the technical assistance team's role is to help achieve this goal, particularly with figuring out how to establish parameters that minimize adverse risk selection issues for the Board's programs. Dr. Crowell acknowledged that many people are working hard to make the proposal work.

Dr. Crowell, Dr. Chang and Mr. Allenby thanked Mr. Grgurina for an excellent presentation.

STATE BUDGET UPDATE

Terresa Krum, Deputy Director for Administration, reported that the May revision for MRMIB was adopted by the legislature as proposed and there is nothing remaining in conference committee regarding MRMIB's budget.

FEDERAL BUDGET AND LEGISLATION

SCHIP Reauthorization Update: Ronald Spingarn, Deputy Director of Legislation and External Affairs, presented two handouts – a letter from Governor Schwarzenegger to members of Congress supporting reauthorization of the State Children's Health Insurance Program (SCHIP) and a side-by-side summary of three major bill related to SCHIP authorization authored by Senator Hillary Clinton/Representative John Dingell; Senator Jay Rockefeller/Senator Olympia Snowe and Representative Rahm Emanual/Representative Jim Ramstad.

The Governor's letter states his support for allocating $50 billion for SCHIP, obtaining federal matching funds for legal immigrants, and establishing state flexibility for determining benefits to be provided to persons in SCHIP and for verifying documentation status. Ms. Cummings praised the Governor for a fabulous letter not only in terms of the level of funding needed, but also for advocating for changes needed to get more federal funds for California and simplifying eligibility processes for the program.

MRMIB staff has been working on a detailed, technical summary of the SCHIP bills and has met with Department of Health Care Services (DHCS) staff to begin to coordinate a potential response from California once it is clearer which provisions will be moving forward. Current word is that there may be a markup in one to three weeks.

Analysis of SCHIP Funding and Policy Issues: Lesley Cummings, Executive Director, introduced Peter Harbage and praised the California HealthCare Foundation for funding him as a consultant to examine issues, including the funding formula, likely to impact California regarding SCHIP reauthorization.

Mr. Harbage presented and discussed handouts/slides providing background on SCHIP funding issues, emphasizing that the Dingell/Clinton, referred by many as making SCHIP into an entitlement, and Rockefeller/Snowe (a bipartisan bill) as the two most significant ones today. [Note: These are available on the MRMIB website under what's new/SCHIP funding – www.mrmib.ca.gov].

- The most important issue Congress will decide is the size of the national allotment. Many are talking about a$50 billion national allotment, but the more likely number will be closer to $30 billion. Not putting enough money nationally into the program could create momentum to actually roll back coverage.
- California should evaluate the impact of lowering income eligibility to 200% FPL. While this provision is not in either bill, the concept is being pushed by the Bush administration and many Republicans. A family at 200% FPL in California has a greater need for help than in another state with a much lower cost of living.
- Both bills have enrollment bonuses which he explained. They have been touted as innovative and interesting, but it is not clear that they will work, and certainly not for California.
- The entitlement approach of the Dingell/Clinton bill is not likely to move forward given the high cost.
- The Rockefeller/Snowe bill would allocate $58.4 billion nationally over five years and, according to the authors, California would receive $1.28 billion in 2008. The bill has many moving parts but the main ones are "the coverage factor" and "the uninsured child factor". Both are weighted in the allocation formula for each state. The coverage factor uses each state's 2007 allotment and grows it forward using national medical inflation and national child population growth. Funds would be rebased every other year for each state. The uninsured child factor allots funds based on each state's share of uninsured children. Due to the formula, it is really difficult to know what allotments will look like in the future, as they are, in large part, based on both state and national data which is not currently available.
- Issues that warrant further examination in the Rockefeller/Snowe bill are:
    - How base-year allotments are calculated. Basing allotment on a state's projections of its future spending would likely reduce the money available to other states. Additionally, there is no requirement to reconcile any projections that a state may use to actual growth
    - Use of data for national child growth instead of state-specific child growth data. Nationally, there is around three percent positive growth, but some states, like Maine and Montana, has negative growth.
    - Growth in the states' population of pregnant women is not being considered at all which could really disadvantage California.

- The Senate and House both expect to have committee markups of their respective bills by mid-July.
- If there is no agreement on the issues there may be a continuing resolution to provide a short-term fix to the situation.

Mr. Harbage indicated that he would continue working with Lesley Cummings and Ron Spingarn on SCHIP issues.

Board Members' Questions and Comments: Mr. Allenby thanked Mr. Harbage and said we still have a ways to go on this subject. Dr. Crowell said the paper is very thorough and asked Mr. Harbage if he is working with advocates on SCHIP issues. Mr. Harbage said that the California HealthCare Foundation doesn't lobby but that the information he has produced is being made widely available. Ms. Cummings said that Mr. Harbage will be going to Washington, DC, to educate people about his work. Dr. Crowell asked if Mr. Harbage has a recommendation regarding their future cost projections being used as a basis for their allocation, which seems unfair. Mr. Harbage said that there is not even a requirement that states reconcile their expenditures and that one of the papers he produced and handed out addresses this issue.

HEALTHY FAMILIES (HFP) UPDATE

Enrollment and Single Point of Entry Reports
Ernesto Sanchez reported that enrollment was nearly 815,000 at the end of May. Languages spoken by applicants include: 47% Spanish, 44% English; and almost 7% Chinese, Vietnamese, Korean (Asian languages). There were no comments or questions from the Board or the public.

Administrative Vendor Performance Report
Ernesto Sanchez reported that the vendor met all standards. There were no comments or questions from the Board or the public.

Enrollment Entities (EEs)/Certified Application Assistants (CAAs) Reimbursement Report
Larry Lucero reported that $4.2 million was paid out the first six months of the fiscal year; there has been a steady increase in the number of CAAs which now number 17,500; and there has been excellent growth with web-based training. There were no comments or questions from the Board or the public.

Kaiser Report on Behavioral Health Utilization
Shelley Rouillard, Deputy Director of Benefits and Quality Monitoring, reminded the Board that last September a UCSF representative presented findings to the Board from their study on the carve-out of coverage for serious emotional disturbances (SED). The study was conducted to examine whether mental health services were being under-utilized by children in the Healthy Families program.

The report noted that Kaiser Permanente:

- Doesn't refer suspected SED cases to the counties, but rather handles those cases in their own.
- Doesn't report SED data to MRMIB which contributed to the under-reporting in the Healthy Families program, overall.

At staff's request, Kaiser representatives are here today to share their information about behavioral health utilization within Kaiser.

Ms. Rouilllard introduced Gwendolyn Leake-Isaacs, Managing Director of the Medi-Cal Strategy and State Program, Southern California Region; and Dr. Stuart Buttlaire, Regional Behavioral Health Services Director for the Permanente Medical Group.

Ms. Isaacs and Dr. Buttlaire presented and discussed a handout, reporting that:

- More than 95% of the care provided to Kaiser members is provided within the organization;
- Decision-making about care is made by providers;
- Kaiser is truly and integrated delivery system;
- 5.3% of Healthy Families members at Kaiser use psychiatric or behavioral health services;
- Additional features at Kaiser, not reflected in the report data, include a number of programs for parents and kids, their training of pediatricians in administering and prescribing ADHD medication; their mental health providers and professionals actually provide services in pediatrics in consultation with pediatricians.
- The chart details diagnoses they believe are SED conditions.
- The Welfare Code that defines SED is not a clinical document, a main reason for confusion about the variation in reporting among health plans.
- Around 3.3% of their Healthy Families members have SED conditions. These children may receive outpatient individual treatment, including intensive outpatient services, in addition to group treatment, medication, visits and family appointments.
- The behavioral health system was not designed for Healthy Families members in particular but rather for the broad Kaiser membership. Their providers do not know who is enrolled in Healthy Families and who is not.
- Kaiser refers children to outside services if they need a lot of long-term or residential care or if they fall under AB 3632 and need that level of care.
- Kaiser did a data run and noticed some HFP subscribers exhausted their inpatient benefit and yet Kaiser continued to treat them. When the providers were surveyed about why they retained the children in inpatient services, some replied that they were unaware that the

children were Health Families and some said they had been unable to get the child into treatment with the county in a timely fashion.
- Another barrier to access in all systems is that there are very few child psychiatrists.

Board Members' Questions and Comments: Dr. Chang asked does how the percent of Healthy Families children with SED's relate to the overall population. Dr. Buttlaire said he did not know but will look into it.

Dr. Crowell thanked Dr. Buttlaire and Ms. Isaacs for their presentation and said she would like to see ongoing basic contact reports as part of what the Board receives from the rest of the plans. Dr. Buttlaire agreed. Dr Crowell was pleased about the percentage of children overall in Healthy Families getting mental health services in Kaiser; that it comes closer to the epidemiological expectation than the Board has seen in other plans. The higher rate reflects favorably on the integrated nature that the Kaiser system tries to develop. She said there are some advantages to county SED systems – one is that they connect many kids with outside services better than do many private care systems which may lack time or energy to do this. Sometimes the lack of awareness between plans and providers is an impediment which MRMIB staff are working on addressing. Dr. Buttlaire agreed.

Dr. Buttlaire said that plans have to provide benefits consistent with the requirements of Assembly Bill 88, signed into law in 1999, regarding mental health parity. Counties are exempt from it. He said that plans are providing more services in some cases than counties are providing. Eating disorders are an example of a condition that could lead to a dangerous gap in service because of this. Dr. Crowell agreed.

Dr. Crowell said that substance abuse utilization information was not in their report. Dr. Buttlaire said they have to look at that. He indicated that Kaiser has two levels of care – services for people who have lower level problems and those who need their chemical dependency recovery program for more intensive care. He said they will report on that the next time. Ms. Cummings said there are consultants working on a report regarding substance abuse utilization and information provided by Kaiser will be in that report. Dr. Buttlaire agreed that Kaiser would provide data for the report.

Public Comment: None

Approval of Proposed Community Provider Plan (CPP) Regulations
Carolyn Tagupa reported that last July MRMIB staff presented an analysis of the CPP designation process. In September, staff responded to subsequent input from stakeholders and made recommendations approved by the Board. These were used to draft changes to CPP regulations. The changes include:

- Specify that hospital outpatient clinics are included if they provide at least 15 services to children in Medi-Cal.
- Divide the weighting factor for the clinic score in half, applying half of the original weight of the weighting factor of 45 percent based on the number of clinics in accounting as was done in the past. And the remaining portion of the weighting factor would be applied based on the number of services provided by the clinics.
- Change the individual score for the number of services attributed to CHDP providers in a county so that it is divided by the total number of services provided by all the traditional and safety-net CHDP providers in that county.
- Allow HFP plans, as well as providers, to request changes to the list during the November appeal period.

She reported that prior to this meeting staff sent a copy of the proposed regulations to all HFP participating plans and any others that submitted written comments last summer. These were sent out on June 1st. Staff recommends that the Board adopt these proposed changes.

Ms. Rouillard pointed out that the Board members had in their packet a letter HealthNet has submitted with their comments on the proposed regulations as well as the staff issue paper distributed in September.

Public Comment: Leah Morris, HealthNet, congratulated the Board for hiring Ms. Rouillard. She noted that HealthNet participates in the CPP program. Health Net believes that additional changes to regulations are needed, including: Setting a minimum number of services for other clinics in addition to a minimum of 15 services for community hospital based clinics; focusing clinics more on primary care providers and preventative services, possibly only including providers who do CHDP services; refining the lists of providers available to contract with managed care plans; cleaning up duplicate providers on the provider lists, and; altering the CHDP provider calculation with consideration given to language she has provided to address this issue.

Ms. Rouillard said that she has worked for one month at MRMIB and needed Ms. Tagupa help with responding to some comments. MRMIB staff does not have a problem applying the 15 service minimum standard to other clinics as it may address another issue some plans raise regarding out-of-county clinics that appear on lists of providers for a specific county. Ms. Tagupa added that it also may address optometry and methadone clinics.

Maureen Sullivan, Local Health Plans of California, said that her comments echo HealthNet's regarding the inapplicability of including optometry and methadone clinics. LHPC also believes that out-of-county providers should not be counted if they serve in-county plan beneficiary. They support the proposed change to the clinic scoring methodology and encourage MRMIB to base the

entire score on the number of services provided to children divided by the number of clinics as this is more accurate.

Cherie Fields, LA Care, supports the Local Health Plans of California's comments. In addition LA Care supports removing providers from the lists when appropriate and defining a process for removing providers from the list based on demonstrated proof that they are no longer in practice.

Ms. Tagupa stated that staff has not found a way to use the data provided by the Department of Health Care Services to identify which clinics are primary care clinic. Ms. Rouillard added that there is no way to know which clinics would contract with managed care plans and that staff do the best they can to eliminate duplicate providers from the lists and will continue to improve. Staff has not had a chance to figure out the solution to the CHDP provider percentage and will continue to look at this.

Mr. Allenby asked for the regulations to be brought back to the next board meeting. Ms. Rouillard noted that proposed regulatory changes normally go twice to the board but because of the need to obtain Office of Administrative Law (OAL) approval in time for the beginning of the next CPP process, the board needs to act today on the changes. Mr. Allenby asked if the regulations could be approved dependent upon staff working out a resolution with interested parties. Ms. Rosenthal said that a contingency in adopting regulations is not allowed. Mr. Allenby said that due to deficiencies in the proposed regulatory structure, the Board wants to try to move forward and not miss the OAL cycle. Ms. Cummings said that an issue paper on this topic was produced six months ago and suggested that the Board let staff look at the unresolved issues for another round of regulatory changes. Mr. Allenby agreed.

Ms. Morris suggested that a surrogate marker – the provision of CHDP services – be used to identify primary care providers, and entities be allowed to submit documentation to MRMIB to verify if they contract or not with a managed care plan and those that do not contract be removed from the provider list. She said that they and LHPC are willing to live with the current CPP structure for another regulatory cycle. She said that the numerator and denominator are inconsistent and unclear in calculating in- and out-of county service provision; the denominator should reflect service in-county, and if it to reflect out-of-county statewide services then the denominator should reflect out-of-county statewide services.

Ms. Cummings explained that it is services, not children because MRMIB doesn't get an unduplicated count. She explained that the Chief Counsel advised her to ask staff to write the language now and bring it back to the Board later in the meeting for review and/or approval. She noted that the changes being presented to the Board had been discussed at several Board meetings; this is not an expedited process. She believes MRMIB should move ahead and

make the changes about the 15 services now with a clarification if it is needed, and wait until next year if more changes are needed.

Ms. Sullivan said that she has worked with for the LHPC for two months and would appreciate more time, not necessarily another regulatory cycle, to clarify some issues.

Mr. Allenby instructed everyone to come back to this issue later in the meeting.

At the end of the meeting, Ms. Rouillard read the following language for the Boards consideration for approval:

Subsection (c)(2):

The clinic list shall include all community clinics, free clinics, rural health clinics, community hospital based outpatient clinics and county-owned and -operated clinics located in the county which were so identified by the MediCal program as of October 1st of that year and which were identified on the MediCal paid claims tape as having provided at least 15 services in the state fiscal year that ended immediately prior to the most recently ended state fiscal year.

For each clinic the list shall indicate a percentage which shall be equal to A) one divided by the number of listed clinics in the county; multiplied by 0.225; plus B) the number of MediCal-funded services provided by the listed clinic divided by the number of MediCal-funded services provided to children by all listed clinics in each county; multiplied by 0.225."

Subparagraph (e)(1):

The CHDP percentage is calculated by summing the number of CHDP services provided within the county to all children as identified by the plan pursuant to d.1., and dividing this sum by the number of services provided by all CHDP providers in that county; and multiplying that number by 0.35.

Motion: A motion was made and seconded. There was no additional discussion and the motion passed unanimously.

Approval of Rural Health Demonstration (RHD) Project Proposal Solicitation for 2007-08 and 2008-09: Alba Quiroz-Garcia presented an update on revisions being made to the RHD solicitation presented at the last board meeting. The changes were: an increased focus on adolescent care as a result of learning of the adolescent health survey results; clarification that mobile vans are not a fundable item, and; including more detail about the process MRMIB will undertake negotiating contracts for these projects.

Board Members' Questions and Comments: Dr. Chang complimented the changes proposed. Ms. Cummings said Dr. Crowell had earlier asked to add mental health services to the adolescent health services category – so this should be included.

Motion: Dr. Crowell moved that the changes be approved as amended. Dr. Chang seconded. No one in the public or on the Board had any additional comments. The motion passed and was approved.

Encounter Data Project Update: Ms. Rouillard said this was her first big project since working for MRMIB. The Board has indicated an interest in learning more about utilization of services within the Healthy Families program, the focus of a project that has been around for a while. The MAXIMUS contract includes a provision requiring that MAXIMUS establish an encounter claims database and data warehouse to receive, store, maintain, and analyze claims data from health and dental plans. The purpose is to understand overall utilization of services by health plan and, possibly by provider and the cost of the services by provider type, for the most prevalent health conditions. The thought is that this information may be useful down the road as part of a pay-for-performance reimbursement model.

Staff learned that claims/encounter data are generally generated in two formats – the "837", which is HIPAA-compliant, and the DHS format used by Medi-Cal managed care plans. Staff surveyed participating plans and found that 7 of 21 plans, including Kaiser and Blue Cross, the two biggest ones, are able to submit in the 837 format – this included almost two-thirds of the program's enrollment. Nine plans, representing around 30% of the program's enrollment, submit data using the DHS format and, at some point, need to be HIPAA-compliant. Five plans, including Blue Shield, don't use either format.

MAXIMUS representatives said their preference is to use only one format – the 837 – but this would limit ability to look beyond the plans that use this format. So, staff has asked MAXIMUS for a cost proposal to accommodate two formats, and expect a proposal later from MAXIMUS.

Board Members' Questions and Comments: Dr. Crowell said to keep working on the project.

CHIM

County Buy-In Update: Janette Lopez, Deputy Director of Eligibility, reported that the Legislature authorized MRMIB to establish, at no cost to the state, a county buy-in program so that counties that do not presently have Healthy Kids programs could pay MRMIB to provide coverage. First Five funded staff for the project. There were many challenges, one of which was Proposition 86 which would have eliminated the need for the project. In addition, a solution needed to be found to address the concern of health plans about California Children's Services. Staff came up with the idea of using reinsurance and checked with counties about it. During the survey of counties, staff found a decline in interest

from counties to participate in the program altogether, and it did not appear to be viable.

New proposals in the Senate and Assembly and from the Governor all seek to cover all children in a state program. So, staff has asked First Five for a new interagency agreement to fund staff both at MRMIB and at the Department of Health Care Services to develop a plan to cover all children. Staff expects there will be many issues from the Healthy Kids programs about moving kids from local programs to a state program. Staff needs to assess how to transition these kids. First Five will be taking the staffing proposal to their July board meeting. Staff will be closing the county buy-in program and begin working on these new endeavors.

AB-495 Contract Extensions for San Mateo County, the City and County of San Francisco, and Santa Clara County: Terresa Krum asked the board to continue the contracts with the counties already participating in AB 495. The original 2-year contract allowed for two 1-year extensions, and this would be the first one.

Motion: Dr. Crowell made a motion to approve and it passed unanimously.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report: Ernesto Sanchez reported that over 1,100 new moms enrolled in May. There were no comments or questions from the Board or the public.

Administrative Vendor Performance Report: Ernesto Sanchez reported that the vendor met all standards. There were no comments or questions from the Board or the public.

2007-08 Plan Contract Extensions: Terresa Krum asked the Board to extend the 2007 AIM contracts one more year. The original 3-year contracts allowed for a 1-year extension. Ms. Chang made a motion to approve and it passed unanimously.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report: Ernesto Sanchez reported that 438 new persons enrolled in May, bringing enrollment to over 7,800. There were no comments or questions from the Board or the public.

Administrative Vendor Performance Report: Ernesto Sanchez reported that the vendor met all standards. Last month the vendor had failed to meet one, but it was corrected this month. There were no comments or questions from the Board or the public.

MRMIP Semi-Annual Estimate: Ms. Cummings said this is the biannual process the Board uses to establish the MRMIP's enrollment cap due to its limited state funding. The period for this estimate is July 1, 2007 to June 30, 2008. She introduced Pete Davidson, PriceWaterhouse Coopers to present the estimate and recommendations for the enrollment cap. Mr. Davidson recommended increasing the cap to 12,752 from 9,182 currently and said this won't have an immediate effect as current enrollment is still below the current cap.

Board Members' Questions and Comments: Dr. Crowell said the Board's big concern is that policies cost too much for consumers to buy them and wanted to know what changes might be made to improve affordability. Ms. Cummings said that this will be addressed in a presentation to be made by Peter Harbage.

2007-08 Plan Contract Extensions: Terresa Krum asked the board to extend four MRMIP contracts for one additional year. The original 3-year contracts allow for two 1-year extensions and this would be the second extension.

Motion: Dr. Crowell made a motion to approve and it passed unanimously.

Benefit Design Report: Ms. Cummings reminded the board that MRMIB received federal funds to address issues related to helping California to comply with federal guidelines to qualify MRMIP for federal funds. Some of these funds were used to hire Harbage Consulting to examine benefit design issues. She then introduced Peter Harbage who presented preliminary findings from his research. His final report will be made at the July 25 Board meeting.

Peter Harbage noted that he had previewed his findings two meetings ago. He then reviewed his draft report and slides/handouts. To prepare for writing the report he talked with a number of people around California, including representatives of the four participating health plans, and representatives from risk pools in five other states. His interviews focused on care/disease management, deductibles, market trends and other relevant information. All states had disease management (DM) programs – two of them mandated DM services for their high risk pool enrollees.

In California, Contra Costa and Kaiser have mature DM programs. Blue Cross (BC) and Blue Shield (BS) representatives said they offer DM to other enrollees, but not to persons enrolled through the MRMIP. So, all California plans have the capacity to provide DM services to persons in MRMIP, but follow up is needed to ensure that BC and BS implement such programs. The plans did not have much information about the impact of DM services on patient health or outcomes. Other states seemed to have more data about this, but none indicated a documented return on their investment in the programs. Research, including a report by Dr. Robert Berensen from the Urban Institute included as part of the report, indicates that DM programs may or may not save money, and

they are usually done for quality of life and health status rather than for cost savings.

Mr. Harbage said plans use case management for persons with co-morbidities. California plans' practices appeared to be consistent with other states' practices in terms of the criteria used to identify patients would benefit from these programs. He found that MRMIP plans practices regarding pharmaceutical management and benefits management practices were also consistent with practices in other states.

One area of benefits management where California is anomalous is in maintaining a $75,000 annual benefit cap. This was the lowest such cap in the nation. A few have $100,000 annual caps but many have no annual caps and just lifetime caps.

He indicated that to finalize the report he would continue mining data from other states' care management programs.

Board Members' Questions and Comments: Dr. Chang asked what the impact would be on enrollment caps of raising the benefit cap, given the limited state funding available for MRMIP. Mr. Davidson of PwC said it was hard to know for certain given that it would require obtaining information from participating plans about their products in the individual market. However, based on information plans submitted this last year, he estimated that eliminating the benefit cap would increase costs by 7% to 15%. This would reduce the number of enrollment slots by 800 to 1200 (out of the newly recommended cap of 12,700 slots). He also indicated that eliminating the benefit cap would result in increased premium costs to subscribers. Dr. Crowell noted that if California eliminated the benefit cap California would qualify for federal high risk pool grant funds. Mr. Allenby clarified that there is currently no federal money budgeted for such grants, however.

Mr. Allenby asked for clarification about the process for the Board to consider altering the benefit caps. Ms. Cummings and Ms. Rosenthal indicated that staff could bring proposed regulations to the Board at the July Board meeting. Ms. Cummings reiterated Mr. Davidsons' observation that doing so would increase subscriber premium costs, which, Mr. Davidson reiterated, would be between 7% to 15% higher.

Mr. Allenby asked what the impact would be if, in addition, the Board were to establish a deductible for coverage. Ms. Cummings reminded the Board that existing statute and regulations authorize the Board to establish up to a $500 deductible. Mr. Davidson reported that with both a $500 deductible and elimination of the $75,000 annual benefit cap, there would be a net increase on 1% to 2% in premium costs.

Chairman. Allenby requested that staff bring the Board options on these issues for the July Board meeting.

Ms. Cummings noted that the Board had just approved a contract extension with the MRMIP health plans and Peter Harbage had recommended that the two plans that do not provide disease management services for MRMIP subscribers begin to do so. She asked the Board if it wanted to reconsider its earlier motion in light of later discussion and decisions made as to whether it wants disease management services to be required in contracts with health plans participating in the MRMIP. Ms. Rosenthal noted that resolutions give the Executive Director authority to make contract amendments. The Board directed staff to ensure that all MRMIP plans were providing disease management services to program subscribers.

Returning to report findings, Mr. Harbage went on to discuss the issue of high deductible coverage. He noted that there has been recent growth in high deductible health plan enrollment in the nation at large. – two to three million persons nationally enroll. In terms of high risk pools, California is an outlier. Every other state has a deductible option. Minnesota and New Mexico actually offer up to a $10,000 option. Seventeen states offer deductibles in the $200 to $800 range; but there are many states that go higher than that. Dr. Chang asked if states are offering a menu of deducible choices, which Mr. Harbage confirmed affirmatively.

The report presents arguments both for and against high deductible approaches, which Mr. Harbage indicated he is generally disinclined to. Generally, high cost-sharing and higher out-of-pocket costs are off-set by lower premiums. So, some persons are better off even though there is resulting financial pressure on the pool due because of lower subscriber premiums. He opined that because of very aggressive underwriting practices in California's individual market, some of the people in MRMIP might actually be relatively healthy and could financially benefit from the lower premiums of higher deductible coverage. However, the costs for the pool overall would remain the same, meaning that greater state subsidy would have to replace the loss of subscriber premium.

Mr. Allenby thanked Mr. Harbage for his report.

REVIEW AND APPROVAL OF INTERAGENCY AGREEMENTS

<u>Department of Health Care Services: Provides State and Federal (Title XIX funding for functions at the Single Point of Entry</u>
<u>Motion:</u> Dr. Chang made a motion to approve and it passed unanimously.

<u>First 5 California: Provides Funding for Staff to Work on Health Access and Reform Issues for Children</u>

Motion: Dr. Chang made a motion to approve and it passed unanimously.

CalOHI: Provides Funding for Continued Implementation of the Health Insurance Portability and Accountability Act
Motion: Dr. Chang made a motion to approve and it passed unanimously.

University Enterprises, Inc: Extension of the Contract to Provide Student Assistants through the California State University, Sacramento
Motion: Dr. Crowell made a motion to approve and it passed unanimously.

Announcement:
Dr. Crowell said this summer marks the fifth anniversary of Lesley Cummings as Executive Director and of Cliff Allenby's return as Board chair. She thanked both Ms. Cummings and Mr. Allenby for their service.

The meeting was adjourned at 1:40 p.m.