



The California Managed Risk Medical Insurance Board

1000 G Street, Suite 450
Sacramento, CA 95814
Phone: (916) 324-4695
Fax: (916) 324-4878

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**REQUEST FOR INFORMATION (09-003)
June 22, 2010**

Federal Temporary High Risk Pool

The Managed Risk Medical Insurance Board (MRMIB) is releasing this request for information (RFI) for the purpose of receiving information and technical assistance from organizations, including joint submissions from partnerships of more than one organization, relating to the development and operation of a federal temporary high risk pool in California.

On April 29, 2010, Governor Arnold Schwarzenegger submitted a letter to the Secretary of the federal Department of Health and Human Services (DHHS), Kathleen Sebelius, announcing his intention to contract with the federal government to operate a temporary health insurance program for currently uninsured individuals with preexisting medical conditions. The Governor stated that his decision was based on his assessment that it is appropriate for the federal high risk pool program to be administered at the state level and the Secretary's assurances that 100 percent of the costs will be provided by the federal government for the duration of the program. Governor Schwarzenegger stated his intent was to implement the new federal program alongside California's existing high-risk pool, the Major Risk Medical Insurance Program (MRMIP), under the same governance and operational framework. The Governor tasked MRMIB with contracting with the federal government to implement the new federal temporary high risk pool. Authorizing legislation is currently pending in the Legislature.

Pending legislative authorization for MRMIB to enter into contracts or arrangements for operation of the new federal high risk pool, MRMIB is currently considering various options to secure the array of administrative and organizational services that would be needed to provide health care coverage to eligible high risk persons.

Through this RFI, MRMIB is seeking: (1) Information and background on a proposed program structure and design elements for a state-administered, federally funded temporary high risk pool; and (2) indications from RFI responders of their interest in contracting to perform the work described in this RFI. **Responses to this RFI must be received at the MRMIB office no later than 4:30 p.m. on June 25, 2010. The responses should be addressed to: Managed Risk Medical Insurance Board, 1000 G. St., Suite 450, Sacramento, California 95814, ATTENTION: Gina Van Nes. E-mail responses should be sent to gvannes@mrmib.ca.gov.**

Submission of a response to this RFI will not be required in order to submit a proposal for any vendor solicitation MRMIB may issue for services to administer and operate the federal high risk pool at a future date. Conversely, a response to this RFI will not be treated as a response to any later vendor solicitation MRMIB may issue.

I. 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 DHHS to carry out the program directly or through contracts with States or private, nonprofit entities. DHHS has stated a preference to contract with states that are willing to administer the program; for states that choose not to operate the program the federal government is required to establish a high risk pool to serve eligible persons in those states.

The federal high risk pool is a temporary program scheduled to be eliminated as of January 2014, along with other elements of health care reform which become effective in 2014. States will need to transition individuals enrolled in the temporary high risk pool to coverage in the health insurance exchange which is scheduled to become operational at that time.

On April 2, 2010, DHHS 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. On April 29, 2010, Governor Schwarzenegger notified Secretary Sebelius of his intention to have California administer the program at the state level.

DHHS released a solicitation for states governing state applications to operate a high risk pool, the full text of which can be found at: <http://www.hhs.gov/ociio/initiative/> and a model contract for states. The model contract is currently undergoing modifications by DHHS based on consultations with states interested in contracting to operate the federal program.

II. Information Request

MRMIB is seeking informative guidance on how and in what manner it might provide health care coverage to individuals eligible for and enrolled in a newly formed federal temporary high risk pool through a preferred provider organization (PPO) model.

MRMIB is interested in information on how it might obtain the eligibility and enrollment services, claims processing, provider network and benefit management services from one or two vendors who would provide or arrange for all of the necessary services and activities for the PPO coverage.

If MRMIB chooses to provide services through a PPO coverage model, the contracted services must meet the standards and requirements established by state law, requirements in the Affordable Care Act, the state solicitation for federal high risk pools and the terms of the contract negotiated between the State of California and the federal DHHS, as well as any other standards established by MRMIB.

MRMIB will establish specific requirements and standards for the provision of the PPO coverage as contract requirements for participating vendors. MRMIB has experience in providing health care services by contract with health plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) and will look to those standards as one resource for vendor contract standards.

IV. Potential Program Design

MRMIB is seeking information on a program design that relies on no more than two vendors to administer services and coverage to eligible persons enrolled in the new federal high risk pool. This request for information seeks information and recommendations for how to structure potential vendor services in a PPO arrangement that includes all of the following:

- 1) An eligibility and subscriber premium processing system for federal high risk pool enrollees.
- 2) An agreement where the federal high risk pool is a self-insured arrangement funded with premiums paid by subscribers and federal funds. There are no state funds or other funds available for this program;
- 3) Coverage for benefits to be determined by MRMIB consistent with federal requirements and state authorizing legislation. For purposes of this information request, responders should look to the benefits covered under the MRMIP PPO offered by Anthem Blue Cross (summary attached as Appendix A) with the following adjustments:
 - a) No annual cap on benefits and no lifetime limit; and,
 - b) \$1,500 calendar year deductible, except that coverage for preventive services will not be subject to the deductible.

The MRMIP PPO benefit includes a \$2,500 annual individual out-of-pocket limit and 15% coinsurance, with higher coinsurance for out-of-network services.

- 4) The potential enrollment for the new federal high risk pool in California is not known and actual enrollment will be subject to the costs of coverage and the federal funds available. At MRMIB's request, Pricewaterhouse Coopers (PwC) presented at the June 16, 2010 MRMIB meeting an estimate of potential enrollment based on specific assumptions and calculations.

Based on the PwC estimate, the potential enrollment could be approximately 25,000 on a monthly basis. The PwC estimate is attached as Appendix B.

IV. Services Anticipated

The DHHS solicitation establishes basic requirements states must meet in administering the federal high risk pool. MRMIB is interested in understanding how services might be provided through one or two potential contracted vendors. RFI responders may provide information on how the services could be provided through (1) one contract for an administrative vendor (AV) and a separate third-party administrator (TPA) or administrative services only (ASO) contract, or (2) one contract for both AV and TPA/ASO services.

Responders can provide information relating to one or both of the two vendor categories as they are outlined *for illustration purposes* below. MRMIB is interested in proposed arrangements that include all of the relevant services with no more than two vendor contracts for MRMIB to administer.

A. Administrative Vendor (AV) Services

The administrative vendor would be the entity responsible for eligibility and enrollment and first-line customer service. The AV would likely be contracted to perform the following services:

Eligibility Determinations

- Process applications for the program, including obtaining the name, address, date of birth and social security number of applicants;
- Provide to enrollees application forms, information brochures and enrollee communication materials, including materials in languages other than English;
- Verify citizenship and immigration status pursuant to federal eligibility requirements;
- Verify other program eligibility criteria, as determined by federal and state law and MRMIB's contract with DHHS, which will include, at a minimum, that an individual: (1) had no creditable coverage for at least 6 months, and (2) was denied health coverage by a health plan or health insurer, or was offered coverage where the premiums are in excess of a specified level determined by MRMIB;
- Enroll individuals and provide identification cards and basic program information to enrollees;
- Manage disenrollments for nonpayment, re-locations outside of service area, other coverage and death;
- Conduct and support marketing and outreach activities as determined by MRMIB;

- Administer a timely, first-level administrative appeal of eligibility determinations;
- Provide enrollment information to the contracted TPA/ASO contractor and enrollment reports to MRMIB as required; and,
- Administer any enrollment caps established by MRMIB to manage program funds.

Customer Service

Establish a customer service call center that is the single point of contact for program enrollees with questions or need for assistance, including appropriate translation and interpretation services. The AV would be responsible for working with any other contractors in the program to develop a process to answer all enrollee questions with only one call to the customer service center. The AV would also be responsible for development and administration of a web site accessible to enrollees and to the public.

Premium Administration

Bill, collect and account for subscriber premiums as determined by MRMIB.

B. TPA/ASO services

The TPA/ASO contractor would be responsible for offering and managing a contracted provider network; processing and paying provider claims; utilization review and utilization management; benefit management and first-level appeals of coverage decisions; and responding to enrollee questions and complaints regarding the provision of benefits. The TPA/ASO would likely be contracted to provide the following services:

Provider Network

Offer a sufficient number and range of contracted providers in all 58 California counties so that all covered services are reasonably available and accessible to enrollees. The TPA/ASO would also likely be responsible for provider credentialing and provider quality monitoring.

The TPA/ASO would need to provide the methodology for ensuring the adequacy of the network, including the availability of providers appropriate to meet the needs of high risk individuals. MRMIB will look to Knox-Keene standards as one resource for actual vendor contract requirements, including provider network accessibility standards. For background purposes, Knox-Keene network accessibility standards can be found in the California Code of Regulations, Title 28, Section 1300.67.2 and 1300.67.21. Another resource for accessibility standards is the federal solicitation for a TPA/ASO to run the federal fallback high risk pool program. The federal TPA solicitation establishes the following network standards:

Federal Provider Network Standards TPA Solicitation for Federal Fallback	
Type of provider	No fewer than
Primary Care	
Urban	2 in 8 miles
Suburban	2 in 20 miles
Rural	1 in 30 miles
Hospital	1 in 30 miles
Specialists	
Urban	2 in 15 miles
Suburban	1 in 30 miles
Rural	1 in 60 miles

Technical Support

Operate a technical assistance center to respond to health and pharmacy provider inquiries about benefits and coverage, including prior authorizations, and enrollee coverage appeals. The TPA/ASO should provide for an independent external review of medical necessity determinations.

Customer Service

Coordinate with the AV to respond to enrollee inquiries and complaints through a single point of contact administered by the AV, and administer first-level appeals of benefit determinations.

Provider Fee schedule and Claims Payment

The TPA/ASO will propose a method of provider claims payment and reimbursement that includes a fully automated claim adjudication system, consistent with industry standards, and timely and accurate adjudication that complies with state and federal law. At a minimum:

- Automated eligibility verification;
- Benefit plan information stored on the system;
- Automatic calculation of deductibles, co-insurance, co-pays, and out-of-pocket limits;
- Individual claim history stored on the system and automatically updated;
- Ability to distinguish claims by diagnosis code;
- Automated calculation of cost containment provisions;
- Identification and collection of claim overpayments;
- Procedures for review of "medically necessary" determinations;
- Automated production of an Explanation of Benefits; and

- Automated tracking of individual deductible limits, annual individual out of pocket limits, and any other internal limits such as limits on days, sessions, visits, etc., consistent with industry standards.

Utilization Review and Disease Management

MRMIB will be looking to potential TPA/ASO contractors to include and administer utilization management, disease management and case management services appropriate for a high risk, high cost population.

Pharmacy Benefit Management

MRMIB will be looking for active administration and management of the pharmacy benefit for the high risk pool, including a point-of-sale capability. The pharmacy management component will likely include, at a minimum:

- Perform pharmacy claim processing and payment functions on behalf of the Plan from receipt of both paper and electronic claims, through final payment or denial on a fully automated claim adjudication system in a timely and accurate manner and all other necessary functions to assure timely adjudication of claims;
- Payment of benefits to eligible persons under a Plan;
- A formulary that assures therapeutic and economic value for enrollees and the Plan and covers all therapeutic diagnostic categories;
- Drug utilization review that will effectively and efficiently identify and address instances of potential fraud and abuse, as well as key prescribing and utilization patterns;
- Administration of pharmacy benefits shall at all times comply with all standards required under state and federal laws and regulations, in a manner consistent with industry standards for comparable commercial health insurance carriers, or health plan administrators, which may include a mail-in pharmacy service; and,
- Procedures to ensure that manufacturer rebates earned from prescriptions covered by the federal high risk pool shall accrue to the benefit of the federal program, and shall be separately tracked and credited.

Performance Measurement/Quality Improvement

The TPA/ASO will likely be required to conduct performance measurement and quality improvement activities to meet federal contract requirements and standards set by MRMIB.

Fraud Prevention and Detection

The federal state high risk pool solicitation and model contract impose on states the responsibility to actively engage in fraud prevention and detection and

MRMIB will be looking to the TPA/ASO vendor for activities and programs to meet the federal requirements.

Coordination of Benefits

MRMIB will look to the TPA/ASO to coordinate benefits with other sources of coverage that may be available to enrollees, such as workers' compensation coverage.

VI. Information to Submit:

MRMIB is seeking responses to this RFI that include:

- Recommendations and suggested parameters for the program structure and design based on the illustrative guidelines in this RFI and the federal solicitation for state high risk pools;
- Vendor organizational models and business arrangements, including the number and type of contractors and subcontractors that might be engaged to administer the program and the functions and activities each would perform;
- Any specific strategies or suggestions for program administration or program efficiencies;
- Indications of interest by responders in contracting to perform the work described in this RFI, including any information about responders' business capabilities that may be helpful to MRMIB in assessing the availability of experienced and qualified vendors to administer the federal high risk pool; and,
- Any other information, recommendations or resources responders determine would be helpful to MRMIB in developing the federal temporary high risk pool for California.

VI. Timelines

Upon enactment of authorizing legislation, MRMIB will be moving to establish the new federal high risk pool as soon as practical. Responders should include information on the timelines to accomplish initial program start-up and meet contract requirements. Strategies to implement the program on the shortest possible timeline and an estimated timeline will be welcome. The Board intends to begin coverage **no later than September 2010**.

Anthem Blue Cross PPO

Summary of Benefits

Type of Service	Description of Service	What You Pay Participating Provider	What You Pay Nonparticipating Provider
Annual Deductible	The amount that you must pay for covered services except for preventive care services before the plan will cover those services at the copayment or coinsurance amount	\$500 per member (Subscriber only)	\$500 per family (Subscriber + 1 or more dependents on the same policy)
Copayment/ Coinsurance	Member's amount due and payable to the provider of care	See Below	
Yearly Maximum Copayment/ Coinsurance Limit	Member's annual maximum copayment/coinsurance limit when using participating providers in one calendar year	\$2,500 per member (Subscriber only)	No yearly maximum copayment/coinsurance limit for nonparticipating providers. You pay unlimited coinsurance.
		\$4,000 per family (Subscriber + 1 or more dependents on the same policy)	
	If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the member's responsibility and do not apply to the yearly maximum copayment/coinsurance limit		
Annual Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$75,000 in one calendar year for a member		
Lifetime Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$750,000 in a lifetime for a member		
Preventive Care Services**	Services Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Human Papillomavirus (HPV) Screening Test, Ovarian and Cervical Cancer Screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Infections (STI) Tests, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain Immunizations for Children and Adults, and Disease Management Programs	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospital Services	Inpatient medical services (semi-private room)	15% of negotiated fee rate	All charges except for \$650 per day
	Outpatient services; ambulatory surgical centers (No benefits are provided in a noncontracting hospital or noncontracting dialysis treatment center in California, except in the case of a medical emergency)	15% of negotiated fee rate	All charges except for \$380 per day
Physician Office Visits	Services of a physician for medically necessary services	\$25 office visit	50% of customary and reasonable charges and any in excess
Diagnostic X-ray and Lab Services**	Outpatient diagnostic X-ray and laboratory services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Prescription Drugs	Maximum 30-day supply per prescription when filled at a participating pharmacy	\$5 for generic drugs \$15 for brand drugs	All charges except 50% of drug limited fee schedule for generic or brand name drugs
	60-day supply for mail-order	\$5 for generic drugs through mail service prescription drug program (WellPoint NextRx SM) \$15 for brand drugs through mail service prescription drug program (WellPoint NextRx SM)	
Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy** and Maternity Care	Inpatient normal delivery and complications of pregnancy	15% of negotiated fee rate	All charges except for \$650 per day for hospital services
	Prenatal ** and postnatal care	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Ambulance Services	Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	15% of customary and reasonable charges and any in excess
Emergency Health Care Services*	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional, and supplies	15% of negotiated fee rate	15% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours
Mental Health Care Services*	Inpatient basic mental health care services up to 10 days each calendar year	15% of negotiated fee rate and all costs for stays over 10 days except for SMI and SED services.	All charges except for \$175 per day up to 10 days. In addition, all costs for stays over 10 days except for SMI and SED services.
	Outpatient basic mental health care visits up to 15 visits each calendar year *Unlimited inpatient days and outpatient visits for Severe Mental Illnesses (SMI) and Serious Emotional Disturbances (SED) in children.	15% of negotiated fee rate for 15 visits per year. All costs for over 15 visits except for SMI and SED services.	50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits except for SMI and SED services.
Home Health Care	Home health services through a home health agency or visiting nurse association	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for members who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	Skilled nursing care	Not covered unless Anthem Blue Cross recommends as a medically appropriate more cost-effective alternative plan of treatment	
Infusion Therapy*	Therapeutic use of drugs or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	You pay all charges in excess of \$500 per day for all infusion therapy related administrative, professional, and drugs
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	You pay all charges except for \$25 per visit

* For exact terms and conditions of coverage, you should refer to your Evidence of Coverage booklet.

** These preventive care services are covered even if you have not met the calendar year deductible and do not apply towards the deductible.



PricewaterhouseCoopers LLP
3 Embarcadero Center
San Francisco, CA 94111
Direct phone (415) 498-5636
Direct fax (813) 329-8798

to: **Lesley Cummings**

date: **June 15, 2010**

from: **Pete Davidson**
Sandi Hunt

subject: **Initial Modeling Results of
Federal High Risk Pool Coverage**

As you requested, we have developed initial estimates of the number of people that could be covered under the temporary Federal High Risk Pool (FHRP) in California. We modeled a range of benefit designs, average premiums, and average claims costs in the preparation of the allowable enrollment estimates. As many details of the program design have yet to be specified, broad actuarial assumptions were necessarily applied.

Assumptions

Benefit Plans

The following table summarizes the benefit plans that you asked us to analyze. The estimated actuarial benefit values of each of these plans relative to the MRMIP (Major Risk Medical Insurance Program) PPO benefit plan are also presented. The relative actuarial values provide a comparison of the relative richness of the plan benefits. Note that there are a number of benefit design elements that have not yet been specified that may impact the relative benefit values once decisions are made.

Table 1
Benefit Plan Summaries and Relative Benefit Value

Plan Description	Calendar Year Deductible	Enrollee Coin-surance	Enrollee Out of Pocket Limit	Annual Benefit Limit	Lifetime Benefit Limit	Relative Benefit Value	Illustrative Rate 50 year old-SF
MRMIP-125%	\$500	15%	\$2,500	\$75,000	\$750,000	1.00	\$915
MRMIP-100%							\$732
MRMIP no limit	\$500	15%	\$2,500	N/A	N/A	1.18	\$635
Plan Option 1	\$1,000	15%	\$2,500	N/A	N/A	1.09	\$585
Plan Option 2	\$1,000	20%	\$2,500	N/A	N/A	1.07	\$580
Plan Option 3	\$1,500	15%	\$2,500	N/A	N/A	1.06	\$575
Plan Option 4	\$1,500	20%	\$2,500	N/A	N/A	1.05	\$570
Plan Option 5	\$2,500	20%	\$5,000	N/A	N/A	1.02	\$555
Plan Option 6	\$2,500	30%	\$5,000	N/A	N/A	1.00	\$545

Notes: 1) Rates offered to MRMIP enrollees include a 25% risk load. The rate associated with plan description MRMIP-100% excludes the risk load.

2) The base benefit plan used by participating plans for pricing the MRMIP benefit differs from the base benefit plans used by PricewaterhouseCoopers to price the "MRMIP no limit" plan and Plan Options 1-6. It is likely that the base benefit plan used to price the MRMIP benefit reflects adverse selection.

Average Premiums

Premiums for the FHRP are to be no more than 100% of standard average premiums for Individual coverage, however there is no universally accepted definition of standard average premium. The average premiums used in the modeling were developed by analyzing premiums for a large California health plan's top selling benefit plans in 2009 and early 2010, and applying actuarial benefit adjustments to convert the rates for those plans to rates for the requested plan options shown in Table 1. We also applied a 5% risk load to the rates to reflect our understanding of the average underwriting rate-up applied by the health plan in their sold rates.

FHRP premiums are expected to vary by age band, and we developed age rates based on relative age rates used by the health plan in its Individual products. Assuming premiums will vary by age band, the average premium is very sensitive to the assumed age distribution of FHRP enrollees. We assumed that the age distribution of FHRP enrollees will be similar to that in MRMIP, resulting in an average premium of approximately \$450 per month in 2010. For comparison, the 2009 average MRMIP premium excluding the 25% risk load was approximately \$430 per month. We also estimated the average premium using the age distribution of California's uninsured population (~\$350 per month) and California's overall population (~\$390 per month). We did not explicitly apply these alternative average premium assumptions, but our modeling included scenarios in which the average assumed premium approximated these levels.

We assumed that FHRP premiums would be reset each January 1, and that the average premium increase would be 10% per year.

Average Claim Costs

Average claim costs are based on historical claim costs observed in the MRMIP and GIP (Guaranteed Issue Pilot Program), adjusted for differences in benefits and claim trends. The most recent available claim cost data indicates that average MRMIP enrollees cost approximately \$760 per month in 2009 and average GIP enrollees cost \$1,125 per month in 2008. For modeling purposes, we assumed a base claim cost for FHRP enrollees of \$1,000 per month in 2010. Claim cost trends are assumed to be 10% per year.

Average Administrative Costs

We assumed administrative costs equal to 10% of claim costs.

Federal Funding

We assumed that California would receive \$761,000,000 in federal funding for the excess of claim and administrative costs over enrollee premiums between program implementation and program termination (December 31, 2013).

Enrollment and Disenrollment Patterns

For modeling purposes, we assumed that the FHRP program would enroll the total number of people supported by the federal funding on the first day of operation, which is

assumed to be September 1, 2010. We further assumed that disenrollees would immediately be replaced by new enrollees.

Modeling Results

We modeled a number of scenarios using the base assumptions described above, as well as higher and lower average premiums (+/- \$50 PMPM) and average claim costs (+/- 20%). Additionally, we modeled the impact of potential premium subsidies for low income enrollees. The results of the modeling are summarized below.

Table 2
Estimated Average Enrollment Supported by Federal Funding

Plan Description	No Low Income Premium Subsidy			30% Premium Subsidy Provided to 30% of Enrollees		
	Low	Base	High	Low	Base	High
Plan Option 1	17,000	23,950	40,650	16,350	22,600	36,450
Plan Option 2	17,250	24,350	41,300	16,650	22,950	37,050
Plan Option 3	17,400	24,550	41,600	16,750	23,150	37,350
Plan Option 4	17,650	24,850	42,150	17,000	23,450	37,850
Plan Option 5	18,200	25,650	43,500	17,500	24,200	39,000
Plan Option 6	18,400	26,000	44,050	17,750	24,500	39,500

There remain substantial uncertainties regarding the FHRP program design and operation that may have significant impacts on average premiums and claim costs, which directly affect average subsidy requirements and the number of people that can be covered. As these elements are further developed, we expect to revise the assumptions and update the modeling results.

Disclaimer

In developing this report, PricewaterhouseCoopers LLP ("PwC") relied on data and other information provided by the State. We have not audited or verified this data or other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. This report has been prepared pursuant to an exclusive client relationship to assist the California Managed Risk Medical Insurance Board ("MRMIB") in its development of the Temporary Federal High Risk Pool. It is not intended or necessarily suitable for any other purpose. The Services and deliverables are not intended for a third party's use, benefit or reliance, PwC disclaims any contractual or other responsibility or duty of care to others based upon these Services or deliverables, and, accordingly, this information may not be relied upon by anyone other than the MRMIB for whom this report was prepared.

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Please call Pete at 415-498-5636 or Sandi at 415-498-5365 if you have any questions regarding this analysis.

Status Report California Federal Temporary High Risk Pool

June 25, 2010

As stated by Governor Arnold Schwarzenegger in his April 29, 2010 letter to Secretary Sebelius, California intends to establish a state-level federal temporary high-risk pool (FTHRP). The federal Department of Health and Human Services Office of Consumer Information and Oversight requested this update from California on the status of that effort.

California will operate the FTHRP using a model similar to the state's current high risk pool program, the Major Risk Medical Insurance Program (MRMIP), which is operated through a public-private partnership with contracted vendors supervised and monitored by the Managed Risk Medical Insurance Board (MRMIB).

California will contract with one or more vendors to provide administrative services and to perform third party administrator (TPA) activities. California developed and disseminated a Request for Information (RFI) seeking input and technical assistance from vendors interested in providing services to operate the FTHRP (RFI attached). Submissions responsive to the RFI are due by close of business on June 25, 2010. Subject to state legislative authorization, California intends to issue vendor solicitations for the administrative vendor (AV) and/or TPA services.

Enabling State Legislation

The Governor has tasked MRMIB to establish and administer the new FTHRP. State legislation authorizing MRMIB to establish the program is pending in the Legislature and has been moving through the legislative process on an expeditious timeline. Legislation is likely to be passed and signed into law in the immediate near term.

Benefits in the Federal High Risk Pool

Pending legislative authorization, MRMIB has been doing analysis and focused activities to structure a workable program and prepare a response to the federal solicitation. To that end, at the June 16 MRMIB meeting, the Board discussed and gave staff an initial outline of the benefits for a new high risk pool to facilitate vendor negotiations, actuarial analysis and other staff work.

The Board asked staff to work with a Preferred Provider Organization (PPO) benefit design, with a \$2,500 annual individual out-of-pocket limit (\$4,000 family) and 15% coinsurance, with higher coinsurance for out-of-network services. The overall benefit design will likely be very similar to the Anthem Blue Cross PPO offered in the current high-risk pool (benefit summary attached) with the following adjustments:

- a) No annual cap on benefits and no lifetime limit; and,
- b) A \$1,500 calendar year deductible, except that coverage for preventive services will not be subject to the deductible.

Federal High Risk Pool Premiums

MRMIB is working with Pricewaterhouse Coopers (PwC) to conduct preliminary actuarial analyses and develop some assumptions for further review on potential premium rates in the new high-risk pool. Attached is a summary of the PwC estimate, which includes the assumptions and methodology used in the development of current estimates of premium rates for the California program. PwC is currently in the process of gathering additional information on standard premium rates for similar plans in the California market, which will form the basis for final recommended premiums for the FTGRP. Based on the assumptions, PwC estimates a representative premium for a 50-year old subscriber in San Francisco to be approximately \$575 as of June 1, 2010.

Timeline

California is committed to developing a timely solicitation response and detailed proposal to the federal government by no later than early July 2010. California anticipates that the new program will begin accepting applications from individuals in August with coverage beginning in September 2010.

Attachments

MRMIB Request for Information dated June 22, 2010
Benefit Summary: Anthem PPO benefits summary, California MRMIP
Pricewaterhouse Coopers Memo on Expected Premiums in FTGRP