

**Managed Risk Medical Insurance Board
June 16, 2010, Public Session**

Board Members Present: Cliff Allenby (Chairman)
Areta Crowell, Ph.D.
Richard Figueroa

Ex Officio Members Present: Katie Marcellus, representing the CHHS Agency
Jack Campana representing the HFP Advisory Board
Tim LeBas, representing the BT&H Agency

Staff Present: Lesley Cummings, Executive Director;
Laura Rosenthal, Chief Counsel;
Shelley Rouillard, Deputy Director for Benefits
and Quality Monitoring;
Terresa Krum, Deputy Director for Administration
Division;
Jeanie Esajian, Deputy Director Legislative and
External Affairs;
Ernesto Sanchez, Deputy Director Eligibility,
Enrollment & Marketing Division;
Seth Brunner, Senior Staff Counsel;
John Symkowick, Legislative and External Affairs;
Loressa Hon, Manager in the Administration Division;
Tony Lee, Manager in the Administration Division;
Thien Lam, Manager for Eligibility, Enrollment, and
Marketing Division;
Kathi Dobrinen, Manager in the Eligibility, Enrollment
and Marketing Division;
Randi Turner, Manager in the Administration Division;
Ruth Jacobs, Manager in the Benefits and Quality
Monitoring Division;
Sarah Swaney, Manager in the Benefits and Quality
Monitoring Division;
Lilia Coleman, Policy & Operations Manager, Benefits
and Quality Monitoring Division;
Mary Watanabe, Research Program Specialist;
Anjonette Dillard, Manager in the Eligibility, Enrollment
and Marketing Division;
Juanita Vaca, Research Analyst II;
Larry Lucero, Manager in the Eligibility, Enrollment
and Marketing Division;
Darryl Lewis, Manager in the Eligibility, Enrollment
and Marketing Division;
Maria Angel, Acting Executive Assistant to the
Board and the Executive Director; and
Elva Sutton, Board Assistant.

Chairman Allenby called the meeting to order at 10:05 a.m. The Board then went into Executive Session. It reconvened for public items at 11 a.m.

REVIEW AND APPROVAL OF MINUTES OF MAY 13, 2010 AND MAY 27, 2010 PUBLIC SESSIONS

Chairman Allenby asked for a motion to approve the May 13 minutes. A motion was made and seconded. Chairman Allenby asked for any discussion. There was none. The Board unanimously approved the minutes.

The Minutes of the May 13, 2010 Public Session are located at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Public_5-13-10_Final.pdf

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

Lesley Cummings reported that staff is working on its response to the federal solicitation to operate the Federal Temporary High Risk Pool (FTHRP) and hoping to submit it in the next couple of weeks. CMS has asked California and other states that have yet to submit their solicitation response to turn in something in writing by June 25th as it has to figure out where CMS will be providing coverage via the “federal fall-back.”

Ms. Cummings reported on her recent attendance at a meeting of the National Association of State Comprehensive Health Insurance Plans (NASCHIP) where she was able to learn what other states are planning with regard to the federal temporary high risk pool (FTHRP). Some states reported their intention of letting the federal government operate their states’ program. States that are planning to contract with the federal government to operate the program themselves are building on their existing structures and relationships with existing contractors. California will not be able to do that as existing contractors are not interested in participating. Staff are working to develop an alternate approach.

She noted that the Board packet contains a letter of support that Governor Schwarzenegger sent to the authors of the two state bills that would give the Board the authority to operate a program.

Ms. Cummings reported that at staff’s request PricewaterhouseCoopers (PwC) has been analyzing benefit packages and estimating the number of people that can be enrolled. It is important for staff to get a sense of the Board’s views on benefit packages because the benefit package is an essential component for conversations with potential vendors. There is no law yet enacted. Thus, the Board has no authority to authorize contracts but it would still be valuable to get a sense of the Board’s views on several benefit design issues. Ms. Cummings apologized that the Board had not received the analysis in advance, but staff are having to move quickly for this project and Mr. Davidson only finished the document last night.

Pete Davidson of PricewaterhouseCoopers (PwC) presented his analysis to the Board. In addition to benefit options and enrollment estimates, the document also addresses the reserve requirements that might be necessary under the program.

Mr. Davidson noted that there is still uncertainty in terms of what the program is going to look like, such as the actual benefit design and some of the specifics, such as deductibles and co-insurance, as well as a number of other benefit details that could move rates and premiums in the report by a few percentage points.

Chairman Allenby asked what benefit plan Mr. Davidson had used to conduct his analysis. Mr. Davidson replied that he used individual plans that are selling in the market today but made certain modifications to make the comparisons easier to understand. For example, he added in a maternity benefit to plans that didn't have them.

Ms. Cummings indicated that staff had asked Mr. Davidson to take the MRMIP benefit package, remove the annual cap, keeping maternity benefits, and then analyze various cost-sharing alternatives.

Mr. Davidson indicated that this resulted in a full array of services. The benefit options that he reviewed were variations in cost sharing, including deductible levels and co-insurance and out-of-pocket limits.

To estimate the number of people that can be covered, PwC modeled a number of different scenarios based on how quickly people enroll in the program, what sort of a ramp up there might be, subscriber turnover, the types of people choosing to enroll and the costs that might be associated with them, premium levels that will vary and reserves. The assumptions used in the model will be refined as work moves forward and the Board should expect these numbers to move as work progresses.

Premium development is an area of great potential flexibility; PPACA requires that FTHRP premiums be no greater than 100 percent of standard average premiums. However, there is no standard definition of "standard." For purposes of this analysis, he used a different definition of standard than is used in MRMIP. In MRMIP, the standard is developed by the health plans that first choose a base plan under some basic guidelines and then make actuarial adjustments to arrive at a MRMIP type product. For purposes of the FTHRP analysis, PwC (rather than the health plan) selected the base plan, PwC surveyed health plans to obtain information on the top selling plans in the individual market because these plans typically don't have significant levels of adverse selection and have an average rate level. PwC picked a couple of plans as the baseline, made actuarial adjustments based on PwC's proprietary models, and came up with the relative benefit values that are shown in Table 1 based on various benefit designs.

Ms. Cummings asked Mr. Davidson to explain to the Board the differences in the top three plans listed in Table 1.

Mr. Davidson said the first row was MRMIP priced at 125% of the standard average premium (as done under the MRMIP way) – which is the requirement for the program. State law requires that the rates for MRMIP reflect a 25 percent “risk load.” The pricing includes the MRMIP annual benefit limit of \$75,000. The last column in the row shows the premium that a 50-year-old person residing in the Bay Area would pay for coverage in Anthem Blue Cross -- a \$915 monthly premium. This is right out of the MRMIP brochure. The second row shows the MRMIP rate without the 25% risk load (in other words at 100%). The far column shows that eliminating the 25 percent risk load brings down the premium to \$730 per month for the hypothetical 50-year-old Bay Area resident. This row also continues the \$75,000 annual benefit limit. The third row and all of the rows below are based on the modeling of the PwC designed base plan.

Chairman Allenby asked what accounted for the significant difference in the premiums listed in Table 1. Board Member Figueroa also asked what caused the gap between the MRMIP premium(s) and the other options.

Mr. Davidson responded that the MRMIP option with no limits, which is essentially using exactly the MRMIP benefit design but taking off the \$75,000 annual max and the \$750,000 lifetime maximum, was the factor.

Ms. Cummings indicated that she still didn’t understand. If one begins with MRMIP and removes the \$75,000 benefit cap, the cost should increase, not decrease.

Mr. Davidson replied that it was because he used the PwC designed base plan rather than the one used by health plans in MRMIP. MRMIP offers a plan that doesn’t exist in the commercial market so there is a great deal of subjectivity involved in rate-setting. In MRMIP, health plans chose a base plan that is costlier because there is a higher rate of risk assumed for a product with a low deductible. People with high health care needs will generally gravitate toward the richer benefit plans. It seems to be fairly clear that there is still some adverse selection in the base plans that the plans are starting within MRMIP. The PwC model is less expensive because it is based on products that have a lower risk mix. The Board has the flexibility to take this approach in the FTGRP.

Board Member Figueroa said that in the instructions to a vendor on how to price, the plan would be told to use the approach PwC has outlined.

Board Member Crowell asked Mr. Davidson to explain the reason that plan option 6 in Table 1 has the same benefit value as MRMIP currently. Mr. Davidson said it was essentially the tradeoff between the out-of-pocket and the deductible on the front end versus the benefit caps on the back end. Board Member Crowell said it was an informative point to show what it takes to bring them to the same value.

Mr. Davidson said there are some nuanced benefit decisions that could move the values a few percentage points in order of magnitude.

Board Member Figueroa noted that the plans presented still might not match the big sellers in the market which might have higher deductibles or co-pays. But he said he was aware that the design had to factor in the federal \$5,000 maximum on out-of-pocket costs.

Mr. Davidson replied that many of the big sellers in the commercial market don't have maternity benefits and also have significant front-end expenses on pharmacy, which were removed in the PwC analysis process.

Ms. Cummings noted that the products sold in the individual market are intended for people with little or no need for health care and questioned why these were appropriate products for a population with medical needs.

Board Member Figueroa noted that the table showed that there seemed to be little effect on premium price of increasing deductibles and co-pays. Mr. Davidson explained that the premium amounts are primarily affected by the out-of-pocket factor. The out-of-pocket amount for options 1-4 was \$2,500. It doesn't take long to get to the out-of-pocket limit. A relatively high percentage of subscribers reach that point.

Board Member Figueroa noted that the difference between option 4 and option 5 is only \$15. Mr. Davidson said this is because the benefit plan is very rich. Additionally, the deductibles in the options modeled are lower than those in the commercial market, which don't contain maternity coverage and have more services subject to the deductible.

Ms. Cummings opened a discussion with the Board on the number of products that MRMIB should offer in the FTGRP. She suggested that the Board limit the offering to one product. This would allow for a quicker start. She reminded the Board that actuaries have informed the Board in the past that multiple products result in risk selection in the pool which produces higher overall costs for the pool.

Chairman Allenby recalled that that was the experience in the Health Insurance Plan of California (HIPC) program, which had EPOs and PPOs. Ultimately the risk that accrued to the PPOs led them to ask for high rates. Finally, the HIPC had to eliminate the participation of the EPOs and PPOs.

Ms. Cummings repeated her recommendation that the pool offer one product. The Board could decide later if it should add any additional products.

Board member Crowell commented that she couldn't see why the Board would want to do anything other than offer one product. The Chairman concurred. Ex-Officio Member Campana cautioned about making changes to the program after it begins, saying there is going to be a great deal of change in health care anyway during a relatively short period of time. Chairman Allenby noted that FTGRP is only a short term filler before the Exchange opens in 2014.

Board Member Figueroa said it makes sense to start FTGRP in California with one plan, but the Board also needs to look at what the demand is, how quickly it fills up, and the price sensitivity. No one knows what the demand will be and the Board wants to ensure the entire federal allocation is used in California. He suggested that the Board remain open on the issue of offering multiple plans and re-visit the issue fairly soon after the program is implemented.

Noting the Board's agreement that, at least initially, FTGRP would offer only one product, Ms. Cummings then indicated she would like to get a sense of the Board on which option in the PwC analysis made the most sense to them.

She asked Deborah Kelch, of Kelch Associates, to describe what she had seen in reviewing other states' responses to the federal solicitation.

Ms. Kelch said most states are choosing one product with deductibles of \$1,000 to \$1,500, and out-of-pocket maximums in the \$3,000 range. She cautioned that she hadn't expected to talk to the Board on the topic and she was not familiar with the proposals in detail.

Chairman Allenby said that given the time constraints to start the program, it needs to be simple and straight forward. As time progresses, options may expand or change. Board Member Figueroa said he agreed with the Chairman's assessment.

Ms. Kelch added that based on past work and discussions of increasing MRMIP's up-front costs to keep premiums down, the PwC analysis is interesting in that there is not a lot of distinction among the premiums that one would expect to see. Conventional wisdom and history would lead one to expect a much greater difference and that given the relatively small numbers of Californians that would be served, usage is not a factor either.

Mr. Davidson clarified that the pricing was modeled on what an average person's costs would be under these separate benefit scenarios. He said the pricing reflects richer benefits and higher co-pays. He said a health plan pricing the plan would take into consideration anticipated selection and that would create a bigger difference in pricing. The pricing offered by PwC strictly reflects the differences in benefit value, not the behavior of people as they choose which plan they want to go into.

Ms. Kelch said that in past work on MRMIP there had been a lot of discussion about the need for the MRMIP product to be more like the market and have more up front cost sharing. She noted that the different levels of deductible appeared to have very little effect on premium in the PwC analysis.

Mr. Davidson replied that if he were to price the products using the same approach that a health plan would, which is anticipate selection, there would be a wider range of rates. But the PwC approach strictly reflects the differences in benefit value, not the behavior of people as they choose which plan they want to go into. Ms. Kelch noted that there are significant differences in pricing for a \$500 versus a \$5,000 deductible product. But only part of the price difference is because of coverage.

Another big part is who will pick that plan and what their expected health care costs are. When you're talking about differences for the same population, this high risk pool population, you don't accrue those same, huge differences.

The point is in MRMIP, if we were to say \$500 deductible, we're going to raise that to \$1,500 or \$2,000, or whatever it might be, the plans, of course, would have to choose a different base plan. They would not be able to choose a \$500 deductible plan as their base, they'd have to choose something that's closer to the products in the table.

And so, some of the selection that's built into the \$500 deductible rates that are offered in the market goes away and that rate comes down more than just the pure benefit value.

Board Member Crowell said that the significant point is to choose a product that gets more people in sooner and gives them coverage. The goal is to maximize use of the federal funds.

Mr. Davidson reviewed that part of his analysis in which he had estimated enrollment. He enumerated the assumptions behind the analysis:

- 1) All FTGRP slots will be full on day one of the program, which he estimated to be on September 1;
- 2) Slots are always occupied: as quickly as any subscriber disenrolls, there will be another subscriber to replace him/her;
- 3) The age distribution in FTGRP will be similar to that of MRMIP. This trends toward an older population and also fits within the age band required by federal law. Adjusting the age distribution can have a major effect on premium. For example, if he used the average California statewide distribution average premiums would decrease by 15 to 20 percent;
- 4) To estimate claims costs, PwC looked at a combination of MIP and GIP costs, made benefit adjustments to what may be offered and trended those forward to 2010, with an assumption of a \$1,000 per member, per month claim cost. PwC modeled average claim costs that were 20 percent higher and 20 percent lower, and those contributed to the high and the low ranges in Table 2. For MRMIP, with the annual limit of \$75,000, 2009 claim costs were \$760 per member per month. For GIP (Guarantee Issue Program), with an annual limit of \$200,000, the claims cost in 2008 (the most recent data available) are more than \$1,100 per member per month;
- 5) In terms of trends for premium and claim costs, PwC assumed an increase of ten percent per year.

Ms. Cummings commented that the 10 percent limit on administrative costs for FTHRP is of total program costs, not only of claims costs, as PwC had assumed. This will make a slight difference in the PwC analysis.

Mr. Davidson discussed the outcomes of his analysis as it is laid forth in Table 2 of the document. It shows that there is not a tremendous amount of variation in the numbers of people that can be served by the program. The estimate is basically between 24,000 and 26,000 people. The various cost sharing options moved the number of slots by 200 or 300 people, an insignificant variance in his mind.

Mr. Davidson proceeded to discuss the portion of his analysis that estimated the number of people who could be served if the state offered a low-income subsidy program. Ms. Cummings reported that the state has not made a decision to include such a program, but for purpose of PwC's analysis she had asked Mr. Davidson to presume a program in which 30% of the slots/month would be offered to lower income people at a lower price, 70% of the standard premium. If the slots didn't fill, then they would be offered to other applicants. This additional component increases the administrative complexity of the program, but it deals with the concern that the program be affordable for lower income people while limiting the program's cost exposure.

Board Member Crowell asked Ms. Kelch if any other states are proposing low-income subsidy programs. Ms. Kelch replied that the only one that she could recall was Pennsylvania, which provides a low-income subsidy for individuals at 200 percent of the federal poverty level or below. In that state, the average premium is \$486, with low-income subscribers paying \$186. Ms. Cummings said the state of Washington also proposed a low-income subsidy program, as did the state of Oregon. However, she did not have details of the programs in those states.

Chairman Allenby said the Board has raised the issue, but has never had the resources to implement such a policy. It is appropriate to have the insurance be as affordable as possible and affordable related to a person's ability to pay. The Board should continue to keep that on its agenda and plan, if possible, to implement the subsidy. Board Member Crowell agreed. The Chairman noted that having such a program does increase administrative complexity. Ms. Cummings replied that staff would build on the processes developed over the years for the Healthy Families Program. The Chairman commented that HFP does use income for eligibility determination, but it does not admit only a limited number from income groups.

Board Member Figueroa asked if the federal fall-back plan for states not operating their own risk pool would contain a low-income subsidy. Ms. Cummings said that there would not be a low-income subsidy program in the federal fall back. Some states have said they don't expect much take-up of the risk pool if they are not allowed to offer a low-income subsidy.

Ms. Cummings indicated that the Board also needed to discuss the issue of an appropriate reserve. She noted that the federal government has said that two years into the program, CMS will review state expenditures and reallocate funding from under-spending to over-spending states. MRMIP has not been able to maintain a reserve, despite the advice of its actuaries, because reserves get swept up to ameliorate state funding problems. But the state will not be able to sweep up FTHRP funds, making a reserve possible. By obligating the federal funds as they come in, this should allow the program to maintain a reserve, which has not been possible with MRMIP.

Chairman Allenby said a rational reserve is appropriate, and staff will have to figure out how to create one. Mr. Davidson said he wasn't sure how a claim for the reserve could be advanced as the federal solicitation requires that invoices be submitted for claims already paid. Ms. Kelch noted that in its response to CMS, Alaska had proposed that its program would not be operational until three months of reserve had accumulated from federal funds and all up-front costs had been paid. Also, Alaska's claims payment method is one in which they process claims, ask for federal funds, and once the federal funds are in their account, then pay those claims. CMS has not responded to this proposal.

Chairman Allenby said another plan to consider would be to receive the allocation and then pay out claims. Mr. Davidson asked if what the Chairman meant was an approach in which the total allocation of \$762 million is divided by the number of months the program will be operating and get a monthly payment up front. Board Members Allenby, Figueroa and Crowell expressed support for this approach.

Noting that enrollment impacted expenditures of federal funds, Ms. Cummings asked to return to the discussion to enrollment numbers. She asked Mr. Davidson to elaborate on his analysis explaining his low, base, and high estimates. She indicated that the goal should be to enroll as many people as possible without having to arrive at the need for a waiting list.

Mr. Davidson explained that the low base assumes that premiums, on average, will be \$50 per member per month less and claim costs will be 20 percent higher than the base \$1,000 assumption. The low estimate is a pessimistic assumption while the high estimate is based on optimistic assumptions

Board Member Figueroa said the Board will know more when it decides what the actual benefit package looks like. Mr. Davidson agreed. Ms. Cummings said the real story will come in when the Board gets claims data. Mr. Davidson said that the Board would not get a lot of claims data initially because of the deductible. Subscribers have to incur expenses up to the deductible before they submit claims. In the first month or two of enrollment, the program may not see any claims and if the program starts at a later point in 2010, subscribers only have three or four months to reach their annual deductible. Board Member Figueroa expressed confusion on the point, noting that there were a number of benefits that were not subject to the deductible. Mr. Davidson acknowledged that this was so. Preventive care is not subject to the deductible and typically anything with copayments is not counted toward the deductible.

Mr. Davidson said the specific design elements of the FTGRP plan in California need to be nailed down before the premium estimates can be tightened up.

Ms. Cummings said that it was not critical for the Board to decide whether to embrace the low, moderate, or high enrollment estimate at this meeting. Chairman Allenby agreed but noted that the Board has to start the process and this is as reasonable a place to start. With Ms. Kelch's help the Board will learn what other states are doing and then can pick and choose those things which make most sense to the people of California who are going to purchase this plan.

Ms. Cummings said although the Board does not yet have the authority to enter into a contract to run FTGRP, staff need to be able to talk to potential vendors in order to be prepared to implement the program quickly once the authority is conferred. To do so, staff need to know the Board's views on the benefit package for the program as this is an essential building block. She asked the Board to express its views on which of the products was the appropriate one to offer in the pool. Board Member Figueroa added that the federal government is looking for MRMIB to provide a general idea of the benefit package within the next week or two.

Board Member Crowell expressed strong support for a low-income subsidy program, noting that affordability is a major barrier to purchasing coverage. She asked whether limiting the subsidy program to 30% of the slots was the right amount.

Board Member Figueroa suggested that the Board opine on a plan option first and consider the subsidy issue after that.

Ex-Officio Member Campana asked if the Board could look at the subsidy issue in six months or a year down the road.

Board Member Figueroa said the federal government does not have a subsidy in the fall-back plan and doesn't contemplate having one. The Board does not know if the federal government will allow any of the states to offer a low-income subsidy.

Ms. Cummings said that staff was not looking for direction on the subsidy issue at this meeting. Staff is looking today for the Board's preference for one of the benefit options in PwC's document.

Chairman Allenby noted that the premium that a subscriber would pay given a \$1,000 deductible, co-insurance of 20 percent and out-of-pocket limit of \$2,500 is significantly less in the federal product than in the MRMIP PPO (\$580 compared to \$915 for a hypothetical 50-year-old Bay Area resident). And the federal product is superior to the state product.

Ms. Cummings noted that the analysis that PwC provided today indicates that MRMIB could provide a lower premium than it had previously expected. Mr. Davidson indicated that this was because of the flexibility provided under the

federal solicitation to compute the standard rate. Targeting the standard rate to actively marketed plans reduces the cost of the product associated with adverse risk. If MRMIB were to offer these plans through MRMIP, premiums would be higher and the plans would develop rates based on something that has more risk than what the Board chose as its starting base plan. There is a desire to move toward affordability and by taking out the excess risk, this contributes to lower premiums.

Chairman Allenby said the assumptions could be right or wrong and there is a good chance they will hit fairly close.

Board Member Figueroa said the \$2,500 deductible is too high and the \$500 is too low. There aren't many 85/15 plans around anymore in the market. Generally, plans are more like 80/20. It doesn't appear to make that much difference under the co-insurance side; 20 percent or 15 percent. In terms of the overall premium, it looks like it is a \$5 difference. Mr. Davidson noted that the major effect on costs was the \$2,500 out of pocket limit.

Board Member Crowell asked Mr. Figueroa why he thought a \$500 deductible was too low. He replied that there is a lot of uncertainty about how the program will unfold, it may not be possible to have a low income subsidy program and the product has to be affordable for the general population. To achieve that, the product has to have a higher deductible.

Chairman Allenby asked if there were any questions or comments.

Board Member Figueroa commented that the federal government's product is unknown and could require deductibles at levels associated with Health Savings Accounts. He asked if other states were proposing a \$500 deductible. Ms. Cummings said there are other states proposing a \$500 deductible, but these states also have more than one product and are building on their existing state high risk pool structure.

Chairman Allenby asked Ms. Cummings what option she favored. She replied that she did not feel that she had a definitive answer but that if pressed she would select the \$1,000 deductible plan with 15 percent coinsurance and a \$2,500 out-of-pocket limit as she thought it provided less of a barrier to accessing care. She noted that the difference in premiums for deductibles ranging from \$1,000 to \$2,500 was only \$40 according to the PwC analysis. But she reminded the Board that data from the last Fact Book on MRMIP subscribers had shown that there was a wide array of claims costs/subscriber. Mr. Figueroa commented that the subscribers had also expressed interest in lowering their premiums by having access to a higher deductible plan.

Chairman Allenby proposed that the Board start with the \$1,000 deductible option because that gets more of the target population into the program. Board Member Crowell indicated that she favored the \$500 deductible.

Board Member Figueroa remarked that he believes that there will be a broader range of premiums than is apparent in the PwC report. Given that, he favored a \$1,500 deductible with 15 percent coinsurance and out-of-pocket limit of \$2,500.

Ms. Cummings suggested that the Board might consider giving Board Member Figueroa's view deference since in addition to his position on the Board, he is the person that the Governor designated to work with the federal government on the issue. Mr. Figueroa replied that he was speaking only as a Board member.

Ms. Kelch asked about the discussion over coinsurance and what ratio was most common -- 80/20 or 85/15. Board Member Figueroa said the industry standard used to be 90/10, where the insurer pays 90 percent and the subscriber pays 10. MRMIP is 85/15 and the commercial market is at 60/40 or 70/30. Ratios much above 15 or 20 percent constrain access.

Board Member Figueroa again emphasized that he expected a broader array of premiums. Mr. Davidson asked him to explain. Mr. Figueroa said that if one arrayed two plans' premiums for the same thing, there would be a much broader range than is shown in the PwC document. Mr. Davidson replied that this would be true if one looked to a market premium for two plans. The PwC analysis reflect only actuarial benefit differences not selection differences.

Ms. Kelch remarked that the discussion was about the method the Board would ultimately use to establish premiums.

Ms. Cummings said with the availability of federal funds, she suggested the Board's methodology should favor the course that results in the more affordable premium.

Mr. Davidson said there is a direct tradeoff between the premium charged and the number of people that can enroll in the program.

Board Member Crowell said she was reconciled to a deductible above \$500 given the exclusion of all preventive services and the fact that they are not subject to co-pays.

Chairman Allenby said that the sense of the Board was for Option 3: \$1500 deductible, 15% co-insurance and \$2500 out of pocket maximum. He noted that this issue was a starting point and the Board would have many more issues to address.

Ms. Cummings thanked the Board for their guidance and thanked Peter Davidson who has been working hard on MRMIB requested analyses because he is aware of the short timeframes.

The documents on Federal High Risk Pool can be found at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_4.a_Federal%20Budget-High_Risk_Pool.pdf

STATE BUDGET UPDATE

Ms. Krum provided a handout that corrected the budget numbers staff had given the Board at the last meeting.

She reported that there are three issues currently in conference. The first is that the Assembly adopted budget bill language regarding a CHIPRA proposal that required a legislative report and limited funding for that item to only what was federally required. This was rejected by the Conference Committee.

The second issue was related to emergency regulation authority advanced as part of the CHIPRA trailer bill language. The Senate had rejected the language as being too broad. Based on additional work by the Department of Finance and Ms. Rosenthal, staff was able to propose slightly revised language that was adopted by the Conference Committee.

The third and still open issue relates to the proposed premium increase. Both houses rejected the proposal. The Senate assumed that General Funds would replace the savings and the Assembly assumed that it would transfer hospital fees from Medi-Cal to cover that cost.

Staff applied for a start-up grant related to CHIPRA and the prospective payment system. CMS recently notified MRMIB that it would receive a grant of up to \$500,000. Written confirmation is pending.

The Board congratulated staff on receipt of the grant.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The document on the State Budget Update is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_4.a_Federal%20Budget-High_Risk_Pool.pdf

STATE LEGISLATION

Mr. Symkowick presented analyses of the two bills that would establish the high risk pool that the Board has been discussing, AB 1887 and SB 227. The bills are sponsored by the Governor. AB 1887 provides the funding structure for the pool. It was voted off the Assembly Floor on a 76-10 vote Monday. The Senate Health Committee will hear that bill today at 1:30 p.m. SB 277 provides MRMIB with the authority and responsibility to administer the pool. It specifies that the Board must ensure that only federal funds are expended to provide coverage to pool subscribers. The vote yesterday in Assembly Health Committee was 18-0 for passage. Mr. Symkowick reviewed the details of the analyses with the Board.

Mr. Symkowick asked if there were any questions. There were none.

Ms. Cummings said staff was recommending that MRMIB support the legislation. Chairman Allenby replied that it was appropriate to do so.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The State Legislation Documents are available at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_5_State_Budget_Update.pdf

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Report

Thien Lam reported that at the end of May, there were more than 877,600 children enrolled in the Healthy Families Program. More than 25,400 of these children were new subscribers. There were no notable changes to subscribers enrolled in the top five counties in Southern California and no significant changes to the subscribers' demographic information. The vast majority of applicants' spoken language continues to be English and Spanish, which represents more than 91 percent of HFP families.

The single point of entry processed more than 2,600 applications. Nearly 27 percent of them were assisted by CAAs (certified application assistants). More than 70 percent of the applications were forwarded to the Healthy Families Program.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

Administrative Vendor Performance Report

Ms. Lam reported that the administrative vendor continued to meet all 18 areas of performance, quality and accuracy standards. She asked if there were any questions from the Board.

Board Member Crowell expressed concern that enrollment was still far below its peak and said it was discouraging. Ms. Lam said staff is working with the administrative vendor to create social media outreach, such as through Facebook and Twitter. These efforts are in the process of being implemented by this summer.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The updates on the Enrollment and Administrative Vendor Reports are located at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_7.a_HFP_Enrollment_Report.pdf

and

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_7.b_HFP_Adm_Vendor_Perf_May_2010_Summary.pdf

Correction to the Community Provider Plan Designations for 2010-11

Mary Watanabe reviewed a document that reported on the correction to the CPP designations presented at the prior meeting. The change impacts the final score for Glenn, Humboldt, Imperial and Inyo County. The correction impacted the CPP designation only in Glenn County, which will continue to be Anthem/Blue Cross EPO.

Chairman Allenby said the motion would be to approve the revised 2010-2011 Community Provider Plan designations listed in Attachment One to Agenda Item 7d. He asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

A motion was made, seconded and the board unanimously approved the revised plan designation.

The Updated CPP Designation for 2010-11 is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_7.d_Correction_to_2010-11_CPP_Designation.pdf

Authorization of Consultant Contract to Implement CHIPRA Quality Standards

Shelley Rouillard reported that CHIPRA includes requirements that states develop and implement a quality assessment and improvement strategy, and contract with an external quality review organization for their CHIP programs. The David and Lucile Packard Foundation has provide MRMIB a grant, which will be matched with federal funds, to hire a consultant to help with this process. Staff issued a solicitation in February and received five proposals. Staff has analyzed the proposals and would like to proceed with developing a contract with one of the proposers.

Chairman Allenby said the motion would be to approve the resolution included in Item 7.e authorizing the Executive Director to enter into a consultant contract to implement the CHIPRA quality standards. He asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The motion was moved, seconded and unanimously approved by the Board.

The Resolution on Consultant Contract to Implement CHIPRA Quality Standards is found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_7.e_6-16-10_Meeting_Quality_Assurance_Standards_Resolution.pdf

Update on the Oral Health Quality Improvement Project

Ms. Rouillard said the California HealthCare Foundation has provided funding for the Oral Health Quality Improvement Project which will address quality concerns the Board has with the dental plans, particularly the capitated plans. The project should begin around July 1.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

Update on Advisory Committee on Quality

Ms. Rouillard updated the Board on the work of the Advisory Committee on Quality, which met on June 3. Meeting attendance was good, with about 13 members in person or on the phone. The Committee heard updates on the budget, the Benefits Research Project that Ms. Kelch has been conducting, the new regulations on mental health parity and the extension of the HFP benefit year, the pilot projects for the CCS redesign that the Board heard about from Dr. Maxwell-Jolly last month, the impact on Healthy Families of healthcare reform, and the quality assurance standards just discussed. The committee's next meeting will be on August 26. At that time, the quality consultant will be on board and the Committee will assist in determining what the quality strategy ought to be. Members who originally agreed to serve for a year have agreed to continue for this year and the following year to participate in the quality strategy development.

Chairman Allenby asked Ms. Rouillard if the Committee members expressed a reaction to the Department of Health Care Services' proposal for a waiver. Ms. Rouillard said the waiver as a whole was not discussed, although the pilot projects were. There was interest in having Healthy Families' kids participate in the pilot projects to the extent they are approved by the federal government and implemented by CCS.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

Update on Encounter Data Project

Ms. Rouillard said the last time the Board was updated on the Encounter Data Project was last January. The project was on hold for a year, but it is now on track as CHIPRA now gives the Board legal authority to collect encounter and claims data.

Ms. Cummings noted that trailer bill language has been adopted by both the Assembly and the Senate that allows the Board to collect encounter and claims data for three-and-a-half years prior to the implementation date of CHIPRA.

Ms. Rouillard said staff was in the final stages of completing a number of things that need to occur before Maximus can start receiving the test data. These are to execute trading partner agreements between the plans and Maximus; execute three-month contract extensions between MRMIB and the plans that include the encounter data language, particularly for the five pilot plans; and a contract amendment executed between MRMIB and Maximus that details how the data will be collected and made available to MRMIB. She indicated that these tasks should be completed by the end of this month so that Maximus can begin receiving data from at least the pilot plans in July. System testing also must take place after the data is received, which will occur by the end of the year.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

CHIP Reauthorization Implementation

Ms. Cummings said there was nothing to report beyond the grant award Ms. Krum mentioned during the budget update.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Kathi Dobrinen reported that as of May, there were 871 new subscribers enrolled in the program, bringing current enrollment to 6,748 women. The majority of subscribers continue to be Latina. The percentage of enrollment in specific counties did not experience any notable changes with Los Angeles, San Diego and Orange counties remaining the top three counties representing enrollment. These counties reflect approximately 51 percent of the AIM population. The health plans that subscribers enrolled in did not significantly change compared to last month.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The AIM Enrollment Report is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_8.a_AIM_Enrollment_Report.pdf

Administrative Vendor Performance Report

Anjonette Dobrinen reported that the administrative vendor continues to meet all of the seven areas of performance, and quality and accuracy standards in processing

applications and making eligibility determinations, assisting applicants and subscribers through the toll-free line, and translating subscriber enrollment information.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The AIM Administrator Vendor Performance Report is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_8.b_AIM_Adm_Vendor_Perf_May_2010_Summary.pdf

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Ms. Dillard reported that as of June 1, enrollment was at 6,923 and there were 64 people on the waiting list. Enrollee demographics remain comparable.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

The MRMIP Enrollment Report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_9.a_MRM_IP_Enrollment_Report.pdf

Update on Enrollment Cap and Waiting List

Ms. Dillard said as of this week, the wait list total was 47. The wait list is open and enrollment slots have been made available to individuals for an effective date of August 1.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

MRMIP Update on Enrollment Cap and Waiting List is found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_9.b_MRM_IP_Enrollment_Cap_Waiting_List.pdf

Administrative Vendor Performance Report

Ms. Dillard reported that the performance standards for the application and call centers continue to be met. A total of 4,482 calls were received during the reporting period.

Chairman Allenby asked if there were any questions or comments from the Board. There were none. He asked if there were any questions or comments from the audience. There were none.

MRMIP Admin Vendor Performance Report is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061610/Agenda_Item_9.c_MRMIP_Adv_Vendor_Perf_for_May_2010.pdf

Having no further business to come before the Board, Chairman Allenby adjourned the meeting at 12:35 p.m.