Arnold Schwarzenegger, Governor

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July 9, 2007

The Honorable Senator Sheila Kuehl
Chair, Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

RE: Support for AB 2 (Dymally) – Health Care Coverage

Dear Senator Kuehl:

The Managed Risk Medical Insurance Board (MRMIB) **supports provisions of AB 2 (Dymally), set to be heard July 11th in the Senate Health Committee,** that for the first time would ensure long term, stable, adequate funding for the Major Risk Medical Insurance Program (MRMIP). As amended July 5th, the bill includes these provisions as well as new provisions that would establish insurance rules for covering persons in the individual market. These rules are designed to reduce the number of medically uninsurable persons. The Board supports this goal, but has not has the opportunity to review and analyze the particulars as proposed in the July 5th amendments. We look forward to working with the author further as the Board reviews the approach of the bill in greater detail.

Major Risk Medical Insurance Program (MRMIP)

MRMIP is California's high-risk pool, providing health coverage to persons determined by health plans/insurers to be "medically uninsurable," meaning they were denied coverage because of a health condition or other underwriting practices.

California has an estimated 400,000 persons who are denied coverage in the individual market. MRMIP served 7,855 persons in May 2007. In addition, 6,000 persons who had been in the MRMIP are receiving coverage from the Guarantee Issue Pilot (GIP) temporarily program, created by AB 1401 (Statutes of 2002, Chapter 794) which will end January 1, 2008.

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Pool Financing

Presently, subscribers pay 62 percent of the pool costs, paying premiums that are 125 to 137.5 percent of what they would pay in the private market for the same coverage. A state appropriation of $40 million pays for the costs exceeding subscriber premiums. MRMIP can only enroll the number of people that the Board's actuaries estimate can be served with the $40 million. The capped funding has, unfortunately, routinely required the program to limit enrollment. For much of its history, it has had significant waiting lists. As a result, many persons most in need of health coverage and willing to pay a high price for it could not purchase it.

Removal of the Annual Benefit Limit and an Increase in Lifetime Benefit Limit

Due to the current capped appropriation for MRMIP, the program imposed an annual $75,000 limit and $750,000 lifetime limit on benefit for enrollees. This cap allows MRMIP to use funds to enroll more people instead of paying higher catastrophic care costs. A negative consequence of this has been that MRMIP enrollees pay more and receive lower benefits than they would if they could obtain coverage in the commercial market.

A recent report, "Major Risk Medical Insurance Program: Benefit Design Review," indicates that this benefit cap is the lowest in all of the nation's high-risk pools. In addition, California has not been eligible to receive federal high risk pool funding due to its annual benefit limit. Thus, the state forfeited its chance at receiving a share of $75 million available to states in 2006 due to the state's annual benefit limit.

Last, although few subscribers have costs exceeding the $75,000 benefit limit, those who do reach or exceed it are usually financially devastated. As echoed in a principle adopted by the Board (Attachment 1) the program's structure of benefits should be compatible with the medical needs of the population.

AB 2 would eliminate the $75,000 annual benefit cap, increase the lifetime benefit from $750,000 to $1 million, and would provide the necessary funding to make these benefit changes. The Board's consulting actuary, PriceWaterhouse Coopers, recently indicated that removal of the cap would cost the state approximately $5.7 million and increase subscriber premiums by 7% to 15%.

Guaranteed Issue Pilot (GIP) Project for Insurer Participation in Costs

AB 1401 (Statutes of 2002, Chapter 794) temporarily expanded financing for coverage of medically uninsurable persons by bringing in some carrier dollars to establish a Guaranteed Issue Pilot (GIP) project. Specifically, the pilot, scheduled to expire January 1, 2008: (1) requires MRMIP to disenroll subscribers after 36 consecutive months and (2) gives disenrolled subscribers the right to purchase insurance products

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in the individual market. Losses (costs over subscriber premium) are shared equally between insurance carriers and the state. MRMIB must use the $40 million in MRMIP funds to pay the state's share of costs, as noted above, for nearly 6,000 persons in the GIP. Nearly 2000 people who were disenrolled from MRMIP due to the provisions of AB 1401 did not enroll in GIP coverage or did not remain enrolled likely due to the higher cost.

Though additional funding from carriers allowed the Board to eliminate the wait list for several years, insurer costs are not currently equitably spread across carriers in the market. These costs are primarily paid by one insurer who carries a disproportionate share of GIP subscribers. In 2006, costs again outstripped funding and the program developed a waiting list of over 1,000 individuals. SB 1702 (Statutes of 2006, Chapter 683) appropriated an additional four million dollars in state funds to MRMIP and permitted the program to clear its waiting list.

When the GIP sunsets January 1, 2008, carrier dollars subsidizing losses for the eligible population will decline rapidly; furthermore, as a result of the sunset, the program will stop disenrolling 36-month subscribers at the end of September, 2007. These changes will greatly increase pressure on the state's capped appropriation. It will be only a matter of time until there is another waiting list for those most in need of coverage through the program.

AB 2 would provide the necessary funding to eliminate any potential for a waitlist for persons to receive coverage through the MRMIP.

Affordability of Coverage

It also appears that the cost of coverage in MRMIP has become unaffordable as prices in the individual market have increased dramatically, especially for persons in state risk pools. For the first time in MRMIP's history, the program is now filling available slots. Current enrollment is below the "enrollment cap" and the program is not netting new enrollments on a monthly basis. Annual surveys consistently point to price as a key reason for voluntary disenrollments. By law, MRMIP prices are based on – and must exceed – market rates by 125% to 137.5%. Therefore, as the price of coverage in the individual market increases, so has the price of coverage in MRMIP. Cost for coverage in MRMIP for a 50-year old, range from $4,842 to $9990 per year in Los Angeles to $5219 to $12,536 per year in San Francisco.

There is evidence that high risk pools may be able to stem enrollment losses and maintain affordable coverage by providing subsidies to lower income persons. Thirty-three other states have high-risk pools. Ten of these – Wisconsin, Connecticut, New Mexico, Tennessee, Oregon, Colorado, Washington, Montana, Minnesota and Maryland – provide subsidies for lower income persons to help them afford coverage in these high risk pools. While enrollment has been flat and in some cases declined slightly in many

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states' high risk pools, those states with low income subsidy programs are among those that have had growth in their enrollment.

AB 2 would make coverage more affordable for persons who most need it by allowing the Board to subsidize premiums for lower-income persons and by reducing the cost of premiums in MRMIP from 125% to 137.5% to 110% of comparable coverage in the private market.

Many of the Provisions of AB 2 are Consistent with the Board's Principles

Many of the provisions of AB 2 are consistent with principles the Managed Risk Medical Insurance Board, adopted March 22, 2006. Attachment 1 summarizes major principles and how AB 2 addresses them.

Market Reforms

As noted previously, the July 5th amendments to the bill address broader reforms to the commercial market. These recent amendments are likely to reduce the number of medically uninsurable persons in California, an admirable goal in line with the Board's principles. However, also as previously noted, these processes have not yet been reviewed by the Board.

AB 2 in the Context of Larger Health Reform Efforts

The legislature is considering major proposals for health care reform. The Governor's comprehensive proposal would eliminate the need for a separate program for medically uninsurable persons as it would guarantee health coverage for persons now considered "high risk" and nearly all other persons in California.

AB 8 (Nunez) would significantly reduce the number of medically uninsured people, but would not eliminate the need for MRMIP. Similar to AB 2, it would require MRMIB to develop a list of medical conditions that would allow persons to be automatically eligible for MRMIP and would also require carriers to fund the cost of the MRMIP.

The Board is hopeful that the Governor and the Legislature will be able to enact major health care reforms this year that improve options for medically uninsurable persons and extend coverage to the uninsured. At minimum, MRMIP needs stable funding and affordable coverage until the implementation date of the larger reforms. Whether there remains a long term need for MRMIP will depend on the details of any reforms enacted. The coverage MRMIP provides will be needed at least for several more years and, depending on the reforms enacted, may be needed for the foreseeable future.

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We urge you to support adequate financing for affordable coverage for the medically uninusurable by voting for passage of AB 2 (Dymally).

If you have any questions, please contact Ronald Spingarn, Deputy Director of Legislation and External Affairs, at (916) 324 – 0571 or RSPINGARN@mrmib.ca.gov.

Sincerely,

Lesley Cummings
Executive Director

cc: All Senate Health Committee Members
Senate Health Committee Consultant, Peter Hansel
Assembly Member Mervyn Dymally
Deborah Kelch, Assembly Health Committee
Sherrie Lowenstein, Department of Managed Health Care
Jennifer Kent, California Department of Health and Human Services Agency
Kimberly Belshe, California Department of Health and Human Services Agency
Ana Matasantos, Office of Governor Arnold Schwarzenegger

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AB 2 (Dymally)
As Amended July 17, 2007

Insurers in all markets must either sell individual coverage on a guaranteed issuance basis with community rating (no health, age, family size or geographic variation) or elect to pay a fee to help finance the high risk pool.

Plans must make their election annually and notify the Board by February 1 of each year, beginning in 2008.

Individual Market Rules for Insurers Paying the Fee

- List of Conditions: By 9/1/08, MRMIB would develop a list of medical conditions to determine a person's eligibility for MRMIP. The purpose of the list is to identify the 3% to 5% of people who are the most expensive to treat.

- Health Questionnaire: By 9/1/08, MRMIB would design a health status questionnaire designed to identify persons with the list of conditions established above. Carriers would be required to use this standardized questionnaire. They cannot ask for any additional health history information. Persons with conditions on the list are "automatically eligible" for MRMIP and would be referred there.

- Benefits: By 9/1/08, the regulators (Director of the Department of Managed Health Care and the Commissioner of Insurance) will jointly establish 5 classes of benefits that carriers must guarantee issue and renew.
    - Each class is to reflect a reasonable continuum between the class with the lowest and highest benefits, and each class should have an increased level of benefits.
    - Each class must have one baseline HMO and one baseline PPO.
    - The regulators must assure reasonable benefit variation.
    - Subscribers can change classes of benefits, as follows:
        - During the month of birth, the subscriber can change one level up.
        - Movement to a lower class can be at any time.
        - After a significant life event, (such as divorce, death of spouse, adoption), subscriber may move up to a higher class.

- Rates: Rate variance is allowed for age, family size and geographic regions, (all as determined by the regulators). Carriers are also allowed to provide health improvement discounts.
    - The regulators are encouraged to look to the rating rules for the small group market when determining the number of variables by category.
    - Carriers are specifically precluded from adjusting rates for risk selection.

- Guaranteed Issuance: By 1/1/09, carriers would have to sell coverage on a guaranteed issue/renewal basis to any person that does not have one of the conditions on the list. Any person that does have such a condition would be referred to the high risk pool.

MRMIP

- Eligibility: By 1/1/09, Eligibility for MRMIP will be restricted to person with conditions on the list MRMIB develops.
  - Those presently enrolled in MRMIP are allowed to remain in the program.

- Benefits:
  - Effective 1/1/08, MRMIP coverage
    - Could not have annual benefit limit on total coverage.
    - Would have at least a $1 million lifetime benefit.
    - Would have out-of-pocket maximums of $2,500 per person and $4,000 per family in aggregate deductible and co-payment costs.
    - Must require 6-month exclusion for pre-existing health conditions.

  - By 1/1/09 MRMIB is to establish the scope and content of adequate major medical coverage offered by the MRMIP, including:
    - Guidelines, as appropriate, for disease management, case management, care management or other cost containment strategies that also ensure high-quality health care services.
    - Benefits and co-payments, out-of-pocket costs and deductibles appropriate for medically uninsurable and high-risk persons (determined by the Board) compatible with comprehensive products in the individual market, at minimum equal to coverage by health plans licensed by the DMHC plus prescription drug coverage.
    - Lower subscriber cost-sharing for primary and preventative health services, and for medication to treat chronic health conditions.

- Subscriber Premiums: Subscriber premiums would be reduced over time as follows:
  - By 1/1/11 premiums would decrease from 125% of comparable coverage in the private market (as they are under current law) to 120%. The amount would decline again to 110% by 1/1/12.
  - Additionally, MRMIB is authorized to establish a special subsidy program for low income persons.

- Subsidy Financing: The bill
  - Expresses the Legislature's intention that by 1/1/09 the program has sufficient funds, from a combination of public and private sources, to provide coverage without having to establish a waiting list.
  - Deletes provisions of existing law that require the Board to administer the program within the limits of the state appropriation for subsidy funds.
  - Maintains the $40 million in Proposition 99 funds as an ongoing source of subsidy funds.
  - Provides for financing of MRMIP costs through *carrier fees.*
    - The Board is to establish program costs and the level of fees to be paid by carriers who have elected to be payers. Program costs are to include providing covered benefits to all prospective eligible persons. Fees will be on a covered lives basis and based on a carrier's relative number of lives. Carriers begin paying fees 1/1/09.
    - The Board is authorized to adjust the fee if program costs exceed projected costs.

- Carriers make their pay election annually and notify the Board by February 1 of each year, beginning in 2008. The Board notifies the regulators which carriers have chosen to pay and the amount of the fee owed.
- By March of each year, beginning in 2008, carriers have to report information on their covered lives to MRMIB.
- The regulators will collect the fees. The regulators are to send the funds to MRMIB within 30 days of receipt. Carriers may remit owed amounts on a quarterly basis.
- By June of each year, MRMIB must produce a report showing the share of the program's cost for each health plan and insurer.

Return of the GIPers

By January 1, 2008 those persons enrolled in the guaranteed issue pilot project (GIP) would be transferred back to the MRMIP program.

To assist in this transition, MRMIB is required to notify all persons who have been or will be disenrolled to GIP that they can reenroll in MRMIP and may do so through an abbreviated process.

Advisory Committee to MRMIB

- MRMIB is to appoint an 8-member (unpaid) advisory committee to advise the Board on the following subjects:
  - Policies, regulations and operations related to the carrier fee.
  - MRMIP's budget and the appropriate amount for the carrier fee. This includes any adjustments the Board may make to the fee if program costs exceed estimates.
  - Recommendations to improve the quality and cost effectiveness of program operations.
  - The standardized questionnaire that MRMIB is to develop.
  - The types of information MRMIB will collect from carriers so that MRMIB can discern how to allocate fees based on covered lives.

- Committee composition would be:
  - Four plan and insurer representatives, including at least one each that is a payer (not providing coverage to individuals);
  - Two representatives of medically uninsurable consumers;
  - One physician and surgeon;
  - One representative of the business community, and;
  - Ex-officio (non-voting) members: the two regulators or their designees.

- The committee will meet quarterly, unless the Chair decides that a meeting is not needed.

- The committee is to submit recommendations to the Board in writing and the Board is to consider them at its next meeting. If the Board rejects a recommendation, it must communicate to the committee in writing.

MRMIB Report to the Legislature:

- By July 1, 2011, MRMIB must report to the Legislature on the implementation of the new law.
  - The report is to include information on the number and type of people in the program, program costs and revenues, average per capita and annual increases in subscribers' costs, the later compared with the individual market.
  - It is also to include an implementation and transition plan for an alternate approach to providing quality coverage for high risk persons.
    - Options to be considered include a reinsurance mechanism or risk-adjustment, or both.
    - The transition plan is to presume a change to the new system by January 1, 2012.
    - The plan is to include estimated costs and expected fees per covered life.