

**Managed Risk Medical Insurance Board
June 30, 2010, Public Session**

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

Ex Officio Members Present: Katie Marcellus
Ed Heidig

Staff Present: Lesley Cummings, Executive Director;
Janette Casillas, Chief Deputy Director;
Shelley Rouillard, Deputy Director for Benefits and
Quality Monitoring;
Teresa Krum, Deputy Director for Administration
Division;
Jeanie Esajian, Deputy Director for Legislative and
External Affairs;
Ernesto Sanchez, Deputy Director for Eligibility,
Enrollment & Marketing Division;
Seth Brunner, Senior Staff Counsel;
John Symkowick, Legislative & External Affairs;
Tony Lee, Manager in the Administration Division;
Amanda Evans, Manager in Financial Operations;
Randi Turner, Manager in the Administration Division;
Muhammad Nawaz, Manager in the Benefits and
Quality Monitoring Division;
Ruth Jacobs, Manager in the Benefits and Quality
Monitoring Division;
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;
Maria Angel, Executive Assistant to the Board and
the Executive Director; and
Claudia Ramos, Board Assistant

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

REVIEW AND APPROVAL OF MINUTES OF MAY 27, 2010 AND JUNE 16, 2010 PUBLIC SESSION

Chairman Allenby noted that staff would make some technical changes to the draft of the May 27 minutes and that the list of plans designated as the community provider plan would be corrected. The May 27 minutes were moved, and seconded. Chairman Allenby asked for any discussion. There was none. The Board unanimously approved the minutes as modified. Action on the June 16 minutes was put over to the next meeting.

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

High Risk Pool, including review of response to federal solicitation

Ms. Cummings reported that the Governor signed the bills authorizing the Board to operate a program to serve high risk people in California on behalf of the federal government. The bills have been chaptered as law. Ms. Cummings indicated that this accomplishment called for a cheer. Dr. Crowell and Mr. Figueroa concurred.

Ms. Cummings said the Board now has the authority to operate the program and the Board and staff are being pressed to implement it as quickly as possible so that the people of California have access to coverage. Staff is working at hyper-speed and has already issued a request for information from possible vendors, six of whom submitted responses. Staff wanted to ascertain who might be interested in serving as a vendor and in what configuration as the program requires the services of an administrative vendor, a third-party administrator, a PPO network, a claims adjudicator, a pharmacy benefit manager, a utilization review and disease management program and an independent medical review contractor. MRMIB staff has not previously conducted a solicitation for a self-insured administrative services only type of product, and feel some measure of anxiety about doing so given this lack of experience. However, the approach is a common one for employer and labor trust purchasers. Staff is talking to those who responded to the RFI to gain further information for the purpose of drafting a solicitation for vendors. Staff intend to bring the vendor solicitation documents to the Board on July 7. Concurrently, Deborah Kelch, from Kelch Consulting, and MRMIB staff are writing the response to the federal government's solicitation. Upon completion, the Governor's Office will forward the response to CMS. The Governor's Office provided a status report to the federal government on June 25 that is included in the Board packet.

Ms. Cummings reported that CMS has communicated that it would not be willing to approve a low-income subsidy program, so this will not be part of California's response despite the Board's interest. Chairman Allenby asked if the federal statute allows for a low-income subsidy. Ms. Cummings said her general reading of the law didn't seem to preclude a low-income subsidy. However, others have told her that it

does. Mr. Figueroa said the federal government is trying to maximize the number of people that can be enrolled and they would enroll fewer people if some of the funding was put into subsidies. Ms. Cummings said affordability also could have the effect of increasing volume in the pool. Dr. Crowell expressed disappointment that California would not be able to offer a low-income subsidy.

Ms. Cummings asked Ms. Rouillard to update the Board on some recent benefit suggestions.

Ms. Rouillard reminded the Board that it has been discussing a benefit design with a \$1,500 deductible. Staff suggest that the program also have a separate \$500 deductible for brand name drugs and minimal cost-sharing for generic drugs, like a \$5 co-payment, and \$15 for brand name drugs, after the \$500 brand name deductible is met. This population is likely to have high utilization of prescriptions, and a lower deductible threshold for brand name prescription drugs would give subscribers more affordable access than having first satisfied the \$1,500 deductible.

Ms. Cummings asked if this policy was acceptable to the Board. Chairman Allenby and Dr. Crowell both said they liked the idea. Mr. Figueroa asked that staff also look into tiering of drugs, a standard practice in the industry because paying for brand name non-formulary drugs can be very expensive. Dr. Crowell cautioned that the program should be structured in a way as to not be discriminatory against any particular type of patient with unique needs. Mr. Figueroa agreed. Ms. Rouillard reminded the Board that the maximum annual out-of-pocket that subscribers would pay is \$2,500, which means only an additional \$500 in out-of-pocket costs after both deductibles were met.

Mr. Figueroa said the separate brand name drug deductible makes prescription drugs more available than they were in the previous configuration because generics would be available with little or no co-pay, and brand name drugs would be available at a lower threshold of deductible. Ms. Cummings noted that a number of other states have established a separate drug deductible in their proposals.

Ms. Cummings asked Mr. Sanchez to brief the Board on several eligibility issues with which staff has been wrestling. Mr. Sanchez said staff has been using the MRMIB website to manage some of the interest and provide bulletins and updates to interested parties. There is a link on the MRMIB home page for the temporary federal high risk pool under "What's New" and a new email box for persons who would like to get an application for the federal high risk pool when it becomes available. The website is also a place for interested persons to find updates on progress toward implementation.

Mr. Sanchez reviewed various approaches the Board could take on the application, ranging from a supplement to the state high risk pool application to one integrated application to two totally separate applications. Staff recommendation is to do the supplement, at least initially, because it will be the fastest and easiest to produce. The supplement would include a comparison chart to show applicants the differences between what the state and federal programs provide and the eligibility rules to qualify

for each. Ms. Cummings added that the rates would also be provided. She also added that in the longer run she would like to develop one joint application. Mr. Figueroa, Dr. Crowell and Chairman Allenby indicated that beginning with the supplement recommended by staff would be fine.

Mr. Sanchez said staff also wanted Board input on various eligibility criteria the federal high risk criteria would have. The first is that applicant be a U.S. citizen, national, or be a lawfully resident alien. Staff recommends initially using a verification process like that used in the Healthy Families Program, which requires submission of either a birth certificate or immigration documentation with the application. In the longer run, staff could explore the feasibility of using the Social Security Administration (SSA) verification system now used by the Medi-Cal program. Medi-Cal has found that when it has a Social Security number, there is a 95 percent match rate. The SSA system does not presently cover lawfully present individuals, but the Department of Homeland Security is expected to be providing that type of information in the future.

Another eligibility criterion that must be demonstrated is that an applicant has not had creditable coverage for 6 months. Staff suggest that the application include questions asking when the applicant last had coverage and also include a signed declaration that the applicant had not had creditable coverage for 6 months prior to application and that the information they have provided on the application is true and correct.

The third criterion that must be demonstrated is that the applicant has a pre-existing condition that makes the applicant medically uninsurable. Staff recommends using the same process now used in MRMIP: Submission of a letter of rejection from a carrier issued in the last 12 months. Mr. Sanchez indicated that staff are aware that in past legislative efforts to obtain funding for MRMIP, there had been discussions of requiring more than one letter of rejection. However, staff believe that one rejection is a sufficient demonstration and requiring more would be burdensome. Chairman Allenby concurred.

Mr. Sanchez also suggested that that a person be eligible if he or she can demonstrate that an insurer offered coverage at a rate higher than the MRMIP PPO rate. Mr. Figueroa asked how many MRMIP subscribers gain eligibility through that latter alternative. Ms. Cummings said approximately 11 percent.

Mr. Sanchez said another eligibility criteria for MRMIP that the Board may want to consider for the new federal high risk pool is involuntary termination for reasons other than nonpayment or fraud. It is not an area staff has decided on, but wanted to raise to the Board as to whether it should be suggested to the federal government as an eligibility criterion. Ms. Cummings said she wondered under what circumstances one could be involuntarily terminated. Mr. Figueroa said this was a vestige of pre-HIPAA, pre-conversion regulation days, where employers just dropped coverage, thereby involuntarily terminating employees. It wasn't fraud, it wasn't nonpayment, the employer just stopped offering coverage. Now there is a more regulated process for coverage conversion. This is a vestige of a different time. Mr. Sanchez noted that said the Board did not think this criterion was needed.

Mr. Sanchez said California is expected to submit its response to the federal solicitation in early July. That means a contract with the federal government must be finalized quickly. California will benefit from work already done by other states in negotiating contract provision changes with the federal government. Staff anticipates bringing the solicitation for contractors to administer the program and provide health care services to the Board on July 7. A bidders' conference would follow a few days later, with responses due a couple of weeks later. The overall goal is to begin accepting applications in August with coverage beginning in September. Board members concurred that this is the goal, noting that it was a lot to accomplish. Mr. Figueroa said it will be interesting to see what vendors propose to the Board.

Dr. Crowell asked if the federal government has approved any state plans yet. Ms. Cummings replied that it has. Dr. Crowell asked how long that process took. Ms. Cummings said it was within the 30 days the federal government had committed to as a turn-around time. Mr. Figueroa concurred with the prior staff comment that California would profit from the fact that CMS has already worked out a number of issues and improved its model contract as it has negotiated with other states. He remarked that staff would be working on parallel tracks, one the agreement with the federal government and the other agreements with program vendors. Dr. Crowell asked if he really thought CMS would provide a rapid response. Mr. Figueroa replied that he was sure they would be pretty quick.

Dr. Crowell indicated that she assumed that the Board could not sign a contract with selected vendors until the contract with the federal government had been signed. Ms. Cummings indicated that she was correct.

Chairman Allenby asked if there were any other questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience.

Linda Leu of Health Access offered her congratulations to the Board on the signing of the two bills and the new authority to operate the federal high risk pool in California. The Board should prioritize a marketing and outreach plan, which is required by the federal application. The Board has never advertised MRMIP, but it should advertise the new plan to Californians who are medically uninsurable that help is here. Marketing should include various forms of low-cost media, as well as outreach. Health Access urges the Board to undertake a vigorous effort, including reaching out to physicians and hospitals, as well as insurance brokers, small businesses and community groups. Health Access is willing to work with MRMIB staff and also suggested the use of new media, reaching out to various reporters and columnists who cover not only healthcare, and also personal finance. Health Access believes that coverage from a high risk pool is not just about staying healthy; it is also about not going broke when a person gets sick; that message needs to get out.

Mr. Figueroa commented that he is very aware and appreciative of the input that Health Access and others provide through the NAIC Consumer Representative Council. It is good to hear the consumer point of view.

Chairman Allenby asked if there were any other comments from the audience. There were none.

The documents on Federal Budget and High Risk Pool, Request for Information is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_063010/Agenda_Item_4a_Federal_Budget_High_Risk_Pool_RFI.pdf

STATE BUDGET UPDATE

Terresa Krum reported that there was nothing to report on the budget.

STATE LEGISLATION

John Symkowick reported that the Board's packet contains a copy of the support letter for SB 227 and AB 1887 that MRMIB submitted.

He drew the Board's attention to several other bills; those concerning creating of a health insurance exchange, and those implementing the 1115 Waiver that Director Maxwell-Jolly had discussed with the Board at a prior meeting. He pointed out that one of the exchange bills, AB 1602 (Perez) prohibits lifetime benefit limits and restricts annual benefit limits. The annual benefit restrictions would appear to limit the Board's flexibility in the administration of MRMIP. Staff has brought this issue to Agency's attention and hope that amendments will exclude MRMIP from that provision.

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

Documents on State Legislation are located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_063010/Agenda_Item_6_SB227_AB1887_Support_Letter.pdf

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Evaluation of Children on the Wait List

Mr. Sanchez presented a report to the Board on what happened to children who had been placed on a waiting list during the period (July 17 through September 17 of 2009) when the Board suspended new enrollments into HFP because of funding shortages. Staff worked with Maximus to develop the report. Some report findings include: 43 percent of the children on the wait list were later enrolled in the Health Families Program; 35 percent were denied enrollment in HFP and were never admitted to the program (32 percent of whom were denied because of missing information). Applicants would have received a letter indicating what was missing on their application, and Maximus would have made up to five phone calls trying to get that additional information.

Chairman Allenby pointed out that even if the missing information had been provided, the children might not have been eligible. Mr. Sanchez concurred.

Chairman Allenby asked what the normal rate of denial was. Mr. Sanchez replied that in the prior 12 months, 54-55 percent of children screened through the application process were deemed eligible and enrolled in the program. However, the quality of applications submitted prior to the imposition of the waiting list was likely lower than average because families rushed to submit their applications trying to beat the deadline. The average length of time spent on the wait list was 83 calendar days. The report also covers the percentage of applications that were assisted and demographic information on wait listed children.

Normally, when an application has missing information, applications are resubmitted within two to three months and an eligibility determination can be made. That was not the case with the wait list applications. Staff is partnering with the California Health Care Foundation and the University of Cincinnati for a survey of all families placed on the wait list to try to determine what happened during the two months that the waiting list was in place and the subsequent processing that took place to see why these families did not resubmit applications.

Chairman Allenby asked if there were any questions or comments. Hearing none, he asked if there were any questions or comments from the audience.

Ms. Cummings noted that the Board received a letter last night from the Community Health Council (CHC) that noted they had undertaken a survey. Ms. Cummings urged stakeholders to provide information for Board meetings at least a day in advance, and indicated that she had no context for the survey CHC conducted. Chairman Allenby said the Board and staff should take a look at that survey. Dr. Crowell noted that the Council said they would come to the Board to present their findings.

Mr. Figueroa asked whether the Board had ever discussed a stop-the-clock letter from CMS or HHS on HFP, related to last year's premiums. Ms. Cummings said she did not think the Board has ever discussed it. She said one has recently been received and staff responded to it already, saying the premium increases were enacted prior to health care reform legislation enactment and therefore not affected by the maintenance of effort (MOE) requirement of CHIPRA.

Mr. Figueroa asked if the letter sheds light on how CMS will interpret the CHIPRA maintenance of effort provision. Ms. Cummings said that it did as it was the first articulation by CMS that it would view an increase in premiums as a barrier to enrollment, and therefore precluded by the CHIPRA MOE. This had not been certain. The CHIPRA MOE provision was modeled on a similar provision for Medi-Cal in ARRA, and CMS had interpreted premium changes to be a barrier to enrollment. But because many CHIP programs have premiums, some thought that CMS might have a more nuanced interpretation. Raising the issue in the stop-the-clock letter is definitely a signal.

Chairman Allenby asked if there were any other questions or comments.

Kelly Hardy with Children Now and the 100 Percent Campaign asked if the public could get a copy of CMS' letter. Ms. Cummings said the letters are public and it would be posted on the CMS website. She asked Mr. Sanchez to find out if MRMIB's response was posted on the CMS website yet. MRMIB sent it to CMS two days ago.

Ms. Hardy also commented that HFP enrollment has still not recovered from the wait list period. Prior to imposition of the wait list enrollment was around 922,000 children. During a time of recession families need the program more than ever. Children Now and the 100 Percent Campaign are working with everyone to make sure the money is there so that more children can be enrolled and HFP can sail, rather than slide, into health care reform. Chairman Allenby thanked Ms. Hardy for her organization's efforts.

The document on the Wait List Evaluation Report is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_063010/Agenda_Item_7a_2009_HFP_WaitList_Eval_Report_and_Letter_from_CHC.pdf

Authorization of 2010-11 Vision Plan Contract Extensions and Amendments

Janette Casillas requested the Board to approve the resolutions which authorize the Director to enter into vision contracts with Safeguard Vision, Vision Service Plan, and IMED Vision Care for the 12-month period beginning October 1. She noted that both the Senate and Assembly Budget Committees rejected the Governor's proposal to eliminate vision benefits. Staff proceeded with negotiations because of timelines necessary to conduct open enrollment. The negotiations are complete. However, if changes occur due to subsequent budget negotiations, the issue will be brought back to the Board.

Chairman Allenby said the Board and staff are doing the best they can under the circumstances. He said the motion would be to approve the resolutions included in Agenda Item 7.b authorizing the Executive Director to contract with Safeguard Vision, Vision Service Plan and IMED Vision Care. The motion was seconded.

Chairman Allenby asked if there were any questions or comments. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The motion was approved unanimously by the Board.

The resolutions can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_063010/Agenda_Item_7.b.pdf

The Vision Plan Coverage Areas Grid is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_063010/06.30.10_2010-11_HFP_VISION_Coverage_Areas_BOARD_GRID-FINAL.pdf

CHIP Reauthorization Implementation

Ms. Cummings said there was nothing new to report on CHIPRA Implementation.

Approval of Extension of Interagency Agreement with the Department of Health Care Services for funding of the Single Point of Entry

Chairman Allenby indicated that the motion before the Board was to approve the resolution included in Agenda Item 7.d to extend the Interagency Agreement with the Department of Health Care Service for funding of the Single Point of Entry.

Chairman Allenby asked if there were any questions or comments. Hearing none, he asked if there were any questions or comments from the audience. There were none.

It was moved, seconded and unanimously approved by the Board.

Chairman Allenby asked if there was anything else to come before the Board.

Ms. Cummings said there was not. Chairman Allenby adjourned the meeting at 11:25 a.m.