



The California Managed Risk Medical Insurance Board

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MEMORANDUM

DATE: October 9, 2012
TO: MRMIB Members
FROM: Jeanie Esajian 
Deputy Director for Legislation and External Affairs
SUBJECT: MRMIB Media Report for September – October 2012

The last month was a light media period with regard to media requests of MRMIB. Reporting was devoted to the transition of Healthy Families Program subscribers to Medi-Cal and the Governor's signature of AB 1526, which provides premium relief for subscribers of the Major Risk Medical Insurance Program.

If you have any questions or comments regarding these articles, please feel free to contact me at (916) 324-0571 or at jesajian@mrmib.ca.gov.

October 04, 2012 - Capitol Desk

Ambitious Transition Plan for Healthy Families

by David Gorn

State officials this week submitted a four-phase strategic plan to eventually move 875,000 children from the Healthy Families program into Medi-Cal managed care plans.

Health care advocates have expressed some reservations and concerns about the transition. State officials have said they're confident they're ready to meet the deadlines that have been set for it. The new plan hopes to simultaneously improve quality of care for children and save the state money.

It will happen quickly. On Jan. 1, the state plans to launch the first phase of the transition, shifting 415,000 of the Healthy Families kids to a managed care plan.

There's a lot that goes into that kind of move, and the state needs to spend the proper time to make that transition go smoothly, according to Kelly Hardy, director of health policy for Children Now.

"Honestly, it looks like we need more time to work together to make sure these kids are taken care of," Hardy said. "This is a good start, but more time is needed to do this right, rather than rushing the transition."

Hardy emphasized that her group and other children's advocacy groups are all committed to making the transition work, and she was reluctant to offer any criticism. But she looked at the mountain of work ahead, at everything that needs to come together in less than three months, and the prospect is daunting, she said.

"The amount of time we have is the amount of time we have," she said. "But providers and families aren't even known yet, the provider rate isn't known yet, some of the pieces of information are not yet out there."

The project also still needs federal approval, and the state hopes to get that soon, preferably before the Nov. 1 deadline to start sending out notices to beneficiaries.

According to Norman Williams, director of public affairs for the Department of Health Care Services, the other details are being worked out now, so that a final version can be sent to CMS as soon as possible.

"We expect to finalize the adjusted provider rates in the next few weeks," Williams said. "We will then submit them to CMS for final approval."

The transition will be worth the effort being put into it now, Williams said.

"Through the transition we intend to create one program for all children in California in families who meet the eligibility requirements," Williams said, which is for children in families up to 250% of federal poverty level.

He added, "These children will still receive comprehensive care, but it will be provided via Medi-Cal. The transition helps the state as we prepare for health care reform in 2014. It largely simplifies coverage options and provides additional benefits and lower costs for children at certain income levels. We will also achieve administrative efficiencies, General Fund savings, and provide a more consistent health plan contracting process while increasing plan accountability to provide high-quality services to children."

Williams said that mailings to eligible beneficiaries will be sent out in each of the four transition phases. "The letters are currently under development and are being coordinated with the Managed Risk Medical Insurance Board," Williams said.

The children are at the center of the transition and all of the planning has been done with them in mind, Williams said.

"The state is prepared to implement this transition," he said. "We will do it carefully, taking about nine months to transition all of the 875,000 children to Medi-Cal. Medi-Cal contracts with almost all of the Healthy Families' plans and providers, so children will continue to receive the same high level of access to quality primary and specialty care. The goal is to ensure children are able to stay in the same plan and see the same provider."

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October 02, 2012 - Topic: Health Care Reform

Gov. Brown Signs, Vetoes Health Care Reform-Related Measures

Recently, Gov. Jerry Brown (D) signed several bills into law that implement health care reform in California, the *Sacramento Business Journal* reports.

Bills Signed by Brown

The bills include:

- **AB 1083**, which implements new insurance rules for small businesses, including a rule that small business owners cannot be subject to additional premium hikes based on their employees' health;
- **AB 1453 and SB 951**, which require insurers to cover a minimum set of benefits in their health plans (Robertson, *Sacramento Business Journal*, 10/1);
- **AB 1526**, which allows the Managed Risk Medical Insurance Board to subsidize premiums for program members at no less than 100% of comparable rates for the individual insurance market and prohibits the amount of subsidies from affecting the calculation of premiums (**AB 1526 bill text**, 9/30);
- **AB 1761**, which prohibits individuals or entities from falsely representing themselves as the California Health Benefit Exchange;
- **AB 174**, which provides funding for the Office of System Integration to establish data sharing between the Employment Development Department, the Franchise Tax Board, specified health agencies, and county departments and agencies to verify eligibility for state health programs;
- **AB 441**, which requires transportation planning to include health criteria to help facilitate healthier communities;
- **AB 792**, which requires that consumers be given information about their coverage options under the insurance exchange when they file a job change, separation, divorce, adoption or other life changes; and
- **SB 1410**, which clarifies the process under which consumers appeal denial-of-care decisions.

Bills Vetoes by Brown

Brown also has vetoed certain health reform-related bills, including:

- **AB 1461 and SB 961**, which would have prevented insurers from denying coverage or discriminating against patients with pre-existing conditions and would have phased in new rules for individuals who purchase insurance on their own; and
- **SB 970**, which would have allowed individuals to use a single portal to apply for both social services and health programs (*Sacramento Business Journal*, 10/1).

Comments on Vetoes

Brown said that he vetoed AB 1461 and SB 961 because they would have forced health insurers to carry out a provision in the federal health reform law even if federal officials decide to change the law.

In his veto message, Brown wrote, "Without the strong foundation that federal law provides, a state-level mandate on insurers alone could encourage healthy people to wait until they got sick or injured before purchasing coverage," adding, "This would lead to skyrocketing premiums, making coverage more unaffordable" (Yamamura, *Sacramento Bee*, 10/2).

In a news release, Anthony Wright, executive director of Health Access, said, "We are deeply disappointed that Gov. Brown vetoed the two bills opposed by insurers that would implement key Affordable Care Act

consumer protections," adding, "It is imperative these bills are redone in a legislative special session as soon as possible, in order for Californians to get the benefits of reforms scheduled to start in January 2014."

Meanwhile, Patrick Johnston -- president and CEO of the California Association of Health Plans -- said that health plans are concerned about a "piecemeal approach" of enacting only some of the changes to the state's insurance marketplace included in the ACA (*Sacramento Business Journal*, 10/1).

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Governor signs key health reform bills, vetoes others

Sacramento Business Journal by Kathy Robertson, Senior Staff Writer

Date: Monday, October 1, 2012, 6:57pm PDT



Kathy Robertson

Senior Staff Writer- *Sacramento Business Journal*

Email

Gov. Jerry Brown has signed key legislation to implement health care reform in California, but he vetoed two important measures to reform the individual market.

He also left hanging whether individuals will be allowed to use one portal to apply for both social services and health programs when a new insurance exchange launches in 2014.

The vetoes increase the stakes of a special legislative session Brown already agreed to call in December to deal with complex state and federal issues related to health reform.

"We are deeply disappointed that Gov. Brown vetoed the two bills opposed by insurers that would implement key Affordable Care Act consumer protections," Anthony Wright, executive director of Health Access, said in a news release. "It is imperative these bills are redone in a legislative special session as soon as possible, in order for Californians to get the benefits of reforms scheduled to start in January 2014."

Senate Bill 961 and AB 1461 would have prevented insurers from denying coverage or discriminating against patients with pre-existing conditions.

In his veto message, Brown said the measures fail to adequately link state reforms to federal law.

The Affordable Care Act requires insurers to provide health coverage to all individuals regardless of health status, Brown said. This mandate on insurers is balanced by the mandate on individuals to obtain health coverage, with federal subsidies available to help lower-income people purchase it, he added.

"Without the strong foundation that federal law provides, a state-level mandate on insurers alone could encourage healthy people to wait until they got sick and injured before purchasing coverage," Brown said. "This would lead to skyrocketing premiums, making coverage more unaffordable."

Patrick Johnston, president and chief executive officer at the **California Association of Health Plans**, said health plans remain concerned about a "piecemeal approach" of enacting some, but not all, changes to the state insurance market linked to federal health reform.

Experience in several states has shown that guaranteed issue without an individual mandate is a failure, Johnston said in a prepared statement. Consumers were hit with skyrocketing costs and loss of choice.

"It would be a mistake for California to go at it alone without the protection and full framework of the federal law," he said.

Also vetoed was Senate Bill 970, which would have established a policy of "no wrong door" when individuals seek information about social services and health programs.

The bill is well-intentioned but "overly prescriptive," Brown said in his veto message. It requires the state Health and Human Services Agency to convene a workgroup to study the feasibility, costs and benefits of an integrated application and renewal process — and report to lawmakers by July 2013.

"Codifying another workgroup and requiring another report are not necessary," Brown said.

Despite the vetoes, strides were made toward implementing health reform.

Signed bills establish a minimum set of benefits health plans and insurers must provide, ensure small businesses don't get additional premium spikes based on the health of their workforce and allow the Managed Risk Medical Insurance Program to further subsidize premium contributions paid by individuals receiving coverage through the program in 2013.

Also signed into law are bills to improve independent medical review of decisions to deny coverage, establish information sharing between state regulators and require consumers to be informed of their coverage options during major life changes like divorce.

Daniel Zingale, senior vice president at **The California Endowment**, applauded Brown for signing Assembly Bill 1453 and Senate Bill 951, which set a benchmark for health benefits as envisioned by federal law.

"By establishing a comprehensive baseline of services for health plans, these bills eliminate the 'fear of fine print' and ensure that people will be covered for services they need," Zingale said in a news release.

Health legislation bills signed by Gov. Jerry Brown include:

- **Essential health benefits:** AB 1453 and SB 951 protect consumers from being under insured by requiring health plans and insurers to cover a minimum set of benefits
- **Reforming the small-group market:** AB 1083 phases in new insurance rules for small businesses, including one that ensures small-business owners don't get additional premium spikes based on the health of their workforce
- **High risk pool:** AB 1526, gutted and amended in the final days of the last session, allows the Managed Risk Medical Insurance Program to further subsidize premium contributions paid by individuals receiving coverage through the program in 2013
- **Deceptive marketing:** AB 1761 prohibits any individual or entity from falsely representing themselves as the California Health Benefit Exchange
- **Independent Medical Review:** SB 1410 improves the process by which consumers appeal denial of care decisions and makes it more transparent, with race, ethnicity and language data
- **Coverage options during life changes:** AB 792 requires California consumers to be provided information about their coverage options under the exchange upon filing for a job change, divorce, separation, adoption and other life changes
- **Systems integration:** AB 174 provides funding for the Office of System Integration to establish information sharing between the Franchise Tax Board, the **Employment Development Department**, specified health agencies and county departments and agencies to verify eligibility for state health programs
- **Healthy communities:** AB 1580 requires transportation planning to include health criteria to foster healthier communities

Vetoed:

- **Reforming the individual market:** AB 1461 and SB 961 would have prevented insurers from denying coverage or discriminating against patients with pre-existing conditions and otherwise phases in new rules for individuals who purchase insurance on their own
- **No wrong door:** SB 970 would allow individuals use one portal to apply for both social services and health programs

[Click here for continuing coverage on redefining health care.](#)

Kathy Robertson covers health care, law, lobbying and labor and workplace issues for the Sacramento Business Journal.



END OF POPULAR STATE HEALTH PROGRAM RAISES CONCERNS

Money-saving move prompts questions about access to care

By Michael Gardner

Originally published September 30, 2012 at 12:01 a.m., updated September 29, 2012 at 9:56 p.m.

SACRAMENTO

The state is moving to dismantle the popular Healthy Families program and shift nearly 900,000 children into Medi-Cal, the health care system for low-income families.

It's a cost-cutting move by Gov. Jerry Brown and lawmakers who are faced with ongoing, huge budget deficits. Yet backers of the change say the children should experience little change in coverage.

Not everybody is convinced. Some skeptics question whether these children will have the same access to health care, especially in rural areas where doctors may be few and far between and many don't accept Medi-Cal patients.

Some people facing the changeover, which will occur in three phases starting Jan. 1, say they are confused by it.

Adriana Ramirez works as a medical assistant at an Imperial Beach clinic, yet even she is bewildered by the looming transition that will move two of her children out of Healthy Families program and enroll them in Medi-Cal.

"Are my kids going to get the same benefits? Is it going to affect them in any way? Are we going to still qualify?" she wonders.

René Mollow, who is overseeing the transition for the state Department of Health Care Services, said patients should see "virtually no difference" once they enroll in Medi-Cal. "Children transferring to Medi-Cal will receive the same quality of care," she said.

Some coverage will actually improve, Mollow said, citing more comprehensive mental health care, better access to immunizations and a retroactive provision allowing new applicants to be covered for health care three months before registering.

She estimates state savings of \$13 million in the first half of 2013 and \$58 million in 2013-14. After that, the state will spend \$71 million annually less than it does now, she said.

That's out of a more than \$1 billion annual budget for Healthy Families, of which \$288.6 million is general state taxpayer dollars and \$769 million is generated from federal funds.

Dr. Stuart Cohen, a San Diego pediatric specialist, says the transition will pose a number of challenges for patients and physicians. Cohen is particularly concerned about how the program transfer will affect the ability of patients to find doctors.

"In rural areas, there are doctor shortages. Many physicians there do not take Medi-Cal because of low payments," he said.

Even in urban areas, there could be headaches as patients scramble to sign up with health plans that accept Medi-Cal patients, Cohen continued. And finding specialists will be a daunting chore as well, given the reluctance of some experts to deal with Medi-Cal.

"One in five kids have special health care needs. Any discontinuation of care could be harmful," said Cohen, chairman-elect of the California district of the American Academy of Pediatrics.

Mollow said 90 percent of the current Healthy Family coverage plans also have contracts with Medi-Cal, assuring a smooth transition.

“The goal is to ensure children are able to stay in the same plan and see the same provider,” she said.

There are some out-of-pocket considerations.

Under Healthy Families, premiums are assessed depending on family size and coverage selected. The monthly bill is between \$4 and \$24 per child, up to a maximum of \$72 for all. Co-payments can range from \$5 to \$15, up to a maximum of \$250 annually per family.

Families moving to Medi-Cal will pay monthly premiums of \$13 per child up to a maximum of \$39 per family. Children in Medi-Cal will be exempt from the routine co-payments charged to adults. The state also has asked the federal government for permission to require a \$15 co-payment for emergency room visits that are not emergencies, and \$1 to \$3 co-payments for certain medicines.

Doctors may see lower reimbursements through Medi-Cal, but those should be offset by reimbursement rate increases the federal government has promised under provisions of the new national health care law in calendar years 2013 and 2014, Mollow said.

Eligibility is determined by federal poverty guidelines. For Medi-Cal, the average family of four can earn up to \$1,921 a month and still qualify.

Antonio Martinez, outreach coordinator for the Imperial Beach Community Clinic, has taken a more wait-and-see attitude as Jan. 1 looms. “The biggest thing right now is informing people that the change is coming so when it happens it’s not going to be a surprise,” he said.

It will be confusing, most agree. The state plans to phase in the switch between Jan. 1 and Sept. 1. When a family must enroll will depend on what type of health coverage they have now.

The state early this fall plans to start sending out information packets in English and Spanish to families with the goal of notifying them 90 days before the effective date of their changeover. More notices will follow 60 days and 30 days ahead of time.

Martinez said he sees some potential pitfalls as families scramble for coverage.

“Access will be difficult. That’s an unintended consequence,” he said. “I can guarantee you there’s going to be a lot of families who will have to change doctors.”

Californians for Patient Care, a statewide advocacy group, warns parents not to wait to enroll at the last minute or their options could grow more limited.

Carmella Gutierrez, the group’s president, advised families to immediately contact their primary care doctors and start asking questions about their children’s future coverage and what happens to prescriptions and medical records if they switch providers.

Gutierrez described Healthy Families as a “program that was working well. There were no complaints.” Now she’s concerned about its replacement.

Meanwhile, the state continues to take applications for families to enroll in Health Families because the transition has yet to launch.

September 20, 2012 - Capitol Desk

MRMIB Balks at Oct. 1 Deadline to Start HF Notices

by David Gorn

Managed Risk Medical Insurance Board officials yesterday expressed reluctance and worry over the state's plan to move 415,000 children out of the Healthy Families program and into Medi-Cal managed care plans on a single day -- Jan. 1, 2013.

Because notices of the change would need to be sent 90 days prior to the big shift, letters would need to be mailed to beneficiaries in a little more than a week, by Oct. 1.

That plan moves too many children too quickly, said board member Richard Figueroa.

"As I understand it, the Jan. 1 date is just a beginning date," Figueroa said. "We don't want to lose thousands of children in the process."

The MRMIB staff yesterday proposed a more phased-in version of the move, with about 144,000 children switching to Medi-Cal managed care plans on Jan. 1. Figueroa and several other board members liked that idea.

"This is exactly what we need to be moving toward," board member Samuel Garrison said. "The folks I've talked to, the consensus is, doing this all at once is a terrible idea."

Figueroa added that CMS officials need to sign off on the whole transfer, and said the board should stay put until that federal approval comes through.

But board member Katie Johnson, who works with the Brown administration as assistant secretary in the Office of Program And Fiscal Affairs in Health and Human Services, had a different point of view.

"It's pretty clear that the transfer takes place on Jan. 1," she said.

Figueroa answered that the logistics of the transition might preclude that. "I just don't know if that's possible," he said. "The feds do need to sign off on this."

Johnson insisted: "The [Brown] administration is still working with the Jan. 1 date," Johnson said.

She added that public comments on the transition are due today.

"We've been working collaboratively with everyone," she said.

Johnson's voice was the only one in favor of the full transition at yesterday's MRMIB monthly meeting.

"Families are scared out there," said Hellan Roth Dowden, head of HR Dowden and Associates. "When I hear Ms. Johnson say we're going to do this Jan. 1, I am very, very concerned."

Diane Van Maren, health consultant for the office of Senate President pro Tem Darrell Steinberg (D-Sacramento) said when the legislation was first passed some flexibility was built into the law.

"This legislation was drafted at the 11th hour, it was budget legislation. It was drafted as a process," Van Maren said. "We have a start date for this, but we intentionally did not have an end date for this. We realize we have a significant transition ahead of us, but we don't want to put children at risk."

Van Maren said network adequacy and appropriate planning are paramount to the transfer.

"Whenever we make any kind of change, and this is substantive change, we learn as we go," she said. "We want to make sure this is done well, and if we need more time, then we should take that time, and be able to make course corrections as we go."

Dowden put it a little more forcefully: "As I read the regulations, they say they just have to tell the Legislature if the networks are going to be adequate, and they're not adequate," Dowden said.

She said the Legislature doesn't convene until December at the earliest, and by then it would be too late, if the implementation went the way the state wants it to go.

"I don't know how the Legislature could act on this when the notices are already out," Dowden said. "Once the notices go out, that's when all hell will break loose."