Review of the MRMIP Benefit Plan Design

Issue

Major Risk Medical Insurance Program

During last year's negotiations on AB 1971, a number of issues were raised about the MRMIP benefit plan design. The last version of the bill in print would have required MRMIB to make several changes to the design, and these changes would have taken effect January 1, 2008. These issues are likely to be revisited in legislation introduced this year.

MRMIB has not conducted a review of MRMIP's benefit plan design in some years. In fact, it has not been possible for MRMIB to do a comprehensive review since enactment of AB 1401 which prohibited any benefit changes that would reduce the actuarial value of the benefit package.

MRMIP does not have a deductible. It does not have an overt requirement for plans to provide disease or case management, relying instead on the plans to apply to MRMIP subscribers the practices in their commercial business. There is variation in some benefits and in the co-pays and deductibles for benefits.

SB 1702, enacted after the failure of AB 1971, extends the AB 1401 sunset to December 31, 2007. Most of the benefit design issues raised in the legislation are within MRMIB's administrative authority. Two notable exceptions: 1) raising the benefit cap above its present $ 75,000 level. The Board has the authority to change the benefit cap in regulation, but, absent a substantial expansion of MRMIP's funding, cannot do so with fiscal integrity and 2) establishing a deductible over $500 (discussed below).

Recommendation

CMS has given MRMIB a $150,000 seed grant for a feasibility study addressing a range of issues involved in restructuring MRMIP's financing in order to become a qualified high risk pool eligible for additional federal funding.

Given the availability of federal seed grant funds, staff proposes undertaking a review of the MRMIP benefit plan design. To the extent the review indicates a need for changes in the design, the soonest effective date would be for the benefit year beginning January 1, 2008. Staff proposes to contract with experts for development of issue papers on various topics (detailed below) discussed last year. These papers, including recommendations for benefit changes, will be presented to the Board during public session within the timeframe needed to implement changes for the 08/09 benefit year (which is the calendar year).

Implementation Timeframes

For changes to be completed in time for an effective date of January 2008, the following timeframes must be taken into consideration:

Regulations: MRMIB cannot assume emergency regulation authority and must build in the necessary time for the usual regulatory process. This would require approval of any regulations changes by the ***April 2007*** Board meeting.

Open Enrollment (OE) Materials: OE materials include information on benefits, products available and subscriber premiums. Staff has to know what products MRMIP will be offering by the end of July to get subscriber premiums for the OE packet. The packet itself must be finalized by ***September 30, 2007.***

Plan Contract Changes: To be in cycle with the current process, staff would need a contract amendment package completed for mailing to plans by ***May 16, 2007***

Comments Received

Below, staff describes proposed topics for the benefit plan design issue, indicating whether a change would require regulation changes or plan contract amendments or affect OE materials.

Following the November Board meeting, staff circulated the draft topics to those involved in the negotiations on AB 1971 and posted the draft on the MRMIB web site. Staff received few comments from stakeholders. Below, is a summary of comments received.

Blue Cross: BC thought staff had taken a good approach for review the MRMIP benefit design, but expressed concern about establishing a deductible for MRMIP coverage. This is consistent with the view BC expressed on deductibles in the AB 1971 discussions. Blue Cross argues that deductibles increase the overall costs of the program.

Kaiser:

- Disease, Case and Prescription Management. Kaiser expressed confidence in its existing disease management, case management and prescription management practices which it applies to its entire population. Kaiser doesn't want to change its practices for MRMIP, and doesn't believe it is appropriate to do so. Kaiser noted that its approach, created for its integrated model might not be the right one in a different delivery system.

- Deductibles:
    - High Deductible Plans The premium pricing mechanism for MRMIP will not work with high deductible plans. In the commercial market, these products are chosen by lower risk subscribers. Adding on 25% for MRMIP premium would not be sufficient to pay for the cost of the increased risk. The Kaiser staff person making these remarks indicated the he did not necessarily oppose creating a higher deductible—but was expressing the view that MRMIP pricing would have to change.
    - Multiple plans: The Kaiser staff person discussing this issue was under the impression that it meant multiple plans with different arrays of benefits. He thought this would result in benefit selection based on risk. When informed that staff had meant plans with the same benefits but different levels of deductibles, he commented that the more there are, the more time plans would have to spend trying to figure out the pricing.
    - High out-of-pocket (OOP) costs for a population with chronic diseases results in costs that outweigh premium reduction

Next Steps.

In the following discussion, staff has underlined any changes made to the draft the Board reviewed at the last session. After final Board review at the December meeting, the Executive Director will contract with experts in the given topics to develop issue papers for the Board. Staff will establish the schedule for the papers taking the deadlines above into consideration.

Topics

Disease Management (DM)

- Describe the DM programs available to MRMIP subscribers now. Under what circumstances is DM used? Are services available to MRMIP subscribers in the same way there are available to the commercial population? Are there any data on the extent to which MRMIP subscribers are using the services? What is the cost/benefit information on the particular approach used?
- Is there a consensus on or a standardized definition of DM? What are the distinctions between DM, care coordination and care management? Are all relevant to populations like MRMIP's?
- Are there standardized tools for evaluating the impact of DM?
- Does research support the value of DM in terms of cost reduction and/or improvement in health outcomes for a population like MRMIP? What models have shown success? Do a significant number of MRMIP subscribers have these conditions?
- Does research point to any particular DM approach for a population like MRMIP's?
- Are the approaches used by other risk pools relevant in a purchasing pool environment? Which, if any, have lessons for MRMIP?
- Should MRMIB rely on whatever DM approaches its participating plans use or prescribe one for the program as a whole? If the latter:
    1. Should MRMIB rely on plans to implement it or hire a contractor?
    2. What are the cost implications of doing so?
    3. What are the implications for plan operations?
- What is the most effective way to obtain active subscriber participation in DM programs?

Program changes required:

- Encouraging active subscriber participation would likely require regulations and affects the content of the OE package.
- Adding DM as a required benefit would require regulations.
- Requiring plans to provide DM services, whether prescribed or general, could require plan contract changes.
- Information regarding any disease management benefit would be included in the OE packet.

Case Management (CM)

- Describe the CM programs available to MRMIP subscribers now. . Under what circumstances is CM used? Are services available to MRMIP subscribers in the same way there are available to the commercial population? Are there any data on the extent to which MRMIP subscribers are using the services? What is the cost/benefit information on the particular approach used?
- What is known (or what can become known) about the extent of co-morbidities in the MRMIP population?
- Given the above, does research indicate that CM would reduce program costs or improve health outcomes for a population like MRMIP's?
- Are the approaches used by other risk pools relevant in a purchasing pool environment? Which, if any, have lessons for MRMIP?

- Should MRMIB rely on whatever CM approaches its participating plans use or prescribe or create one for the program as a whole? If the latter:
    1. Should MRMIB rely on plans to implement it or hire a contractor?
    2. What are the cost implications of doing so?
    3. What are the implications for plan operations?

Program changes required:

- Adding CM as a required benefit would require regulations and affects the content of the OE package.
- Requiring plans to provide CM services, whether prescribed or general, could require plan contract changes.
- Information regarding any case management benefit must be included in the OE packet.

Benefits Management

- How are plans managing utilization and costs of MRMIP benefits now?
- Are there additional steps they could take, consistent with their existing business practices that would improve care and/or decrease costs?
- Are the approaches used by other risk pools relevant in a purchasing pool environment? Which, if any, have lessons for MRMIP?
- Are there best practices used by other plans that would have these results?

Prescription Drugs

- What do plans do now regarding use of formularies, co-pays, incentives for use of lower cost drugs?
- Within the structure of the existing plans, are there ways to improve cost-effectiveness and/or improve outcomes?
- Are the approaches used by other risk pools relevant in a purchasing pool environment? Which, if any, have lessons for MRMIP?
- Should MRMIB continue to rely on the structure of benefits offered by the plans or prescribe its own, standardized prescription drug benefit? If the latter:
    - Should MRMIB rely on plans to implement it or hire a contractor?
    - What are the cost implications of doing so?
    - What are the implications for plan operations?

Program changes required:

- Depending on the proposal, implementation could require regulations and/or contract amendments.
- Clarity on the benefit must be final for plans to estimate subscriber premiums. A description of benefits must be included in the final OE packet.

Deductibles

- Multiple Products
    - What array of products is available in other high risk pools? Do they occur in a purchasing pool environment? Which of these, if any, have lessons for MRMIP?
    - One argument for including several products with varying deductibles is that coverage in the pool should reflect that available in the individual market. Given that, by definition, MRMIP subscribers have been denied coverage in the individual market, is the array of products available in the market relevant to their needs?
    - Is there risk selection with lower risk selecting higher deductibles?
    - Is there selection by income with lower income selecting higher deductibles?

- Noting that AB 1971 would have required the pool to also be the locus for HIPAA guaranteed issue individual market coverage, are there any HIPAA or federal funding requirements regarding product choice?
- To what extent would offering multiple products deter plan participation? To what extent would it increase plan and/or administrative costs?
- What impact is there on program costs overall?

- High Deductible Products:
  - To what extent do other high risk pools provide high deductible products? To what extent are they selected by subscribers? To what extent, and how, do they provide subscribers with information on the risk and benefits of such coverage?
  - Is there data on the out-of-pocket costs of subscribers in high deductible products in other pools?
  - Given varying degrees of deductibles, what premium savings would a subscriber experience? What savings in *total* costs (including out-of-pocket costs)?
  - What are the approaches used by other risk pools? Do they occur in a purchasing pool environment? Which of these, if any, have lessons for MRMIP?
  - What is the experience of other pools offering an HSA compatible, high deductible product that allow subscribers a federal tax credit for costs below the deductible? Are subscribers purchasing such coverage?
  - What types of services should be outside any deductible (i.e. preventive services, maintenance medications)?
  - Do subscribers in high deductible plans obtain needed care not paid for via coverage? If they defer care, does this end up increasing costs to the program overall?
  - Does care provided to subscribers in high deductible plans become uncompensated care? If so, how are these costs borne and distributed?
  - How would the MRMIP population be distributed between those who would have savings from high deductible plans and those who would not (total costs)?
  - What would the effect of risk selection by deductible product have on the pool's overall costs?
  - If MRMIB chose to establish a high deductible plan, would it be advisable to establish a new mechanism to set premium prices?
  - How would high-deductible plans interact with California's (and MRMIP's) managed care environment?

  Program changes required.
  - Establishing a deductible of over $500 would require a change in statute ***and*** regulations.
  - Changing the way premiums are established for MRMIP subscribers would require a change in statute and regulations.
  - To be timely for the OE process for the 2008/09 benefit year, statute would have to be enacted by **July 2008** (when MRMIB has to finalize subscriber premiums for MRMIP products) and provide MRMIB with emergency regulation authority.
  - Establishing one or more deductibles would also require changes in plan payments delineated in the contract. Given the May 16th deadline for contract amendment packages under the current process, staff would likely have to conduct a second contract amendment process to reflect any legislative changes.