

Solicitation for State Proposals to Operate Qualified High Risk Pools

Application for the State of California

Revised and Re-submitted

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Table of Contents

Proposal Certification	4
Background	5
C.4 Technical Approach Content	6
C.4.2 Program Design	7
C.4.2.1 Eligibility Criteria	7
C.4.2.2 Coverage and Benefits	8
C.4.2.3 Pre-existing Conditions	9
C.4.2.4 Premiums and Standard Risk Rate.....	9
C.4.2.5 Cost Sharing Structure	11
C.4.2.6 Provider Network	11
C.4.2.7 Appeals and Reconsideration	12
C.4.3 Enrollment Standards	13
C.4.3 Eligibility Determination Process.....	14
C.4.3.1 Eligibility Determination	15
C.4.3.2 Eligibility Documentation.....	15
C.4.3.3 Citizenship Verification	16
C.4.3.4 Enrollment Process.....	16
C.4.3.5 Disenrollment Process.....	17
C.4.4 Customer Service	17
C.4.5 Provider Technical Support	18
C.4.6 Billing and Collection	19
C.4.7 Utilization and Care Management	19
C.4.8 Claims Payment	20
C.4.9 Outreach and Marketing	21
C.4.10 Insurer Dumping	22
C.4.11 Fraud and Abuse Prevention and Detection	23
C.4.12 Compliance Monitoring	24
C.4.13 Coordination of Benefits	24

C.5 Cost Proposal	25
Budget Narrative	26
Table 1 - Projected Administrative Costs.....	25
Table 2 - Projected Administrative and Claims Costs.....	28
Table 3 - Maintenance of Effort	30
Appendix A: PCIP Benefit Summary	31
Appendix B: Geographic Rating Regions	31
Appendix C: PCIP Subscriber Rates	36
Appendix D: Actuarial Attestation	36

Proposal Certification

I, Richard Figueroa, attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If the State becomes aware of any information in this proposal that is not true, correct, or complete, I agree that the State will notify the Department of Health and Human Services (HHS) immediately and in writing.

I authorize HHS to verify the information contained herein. I agree that the State will notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high-risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with State and Federal requirements. I further agree that the State will immediately notify HHS if, despite these attestations, the State becomes aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

Richard Figueroa

Deputy Cabinet Secretary

Authorized Representative Signature

Date

Background

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, known as the Affordable Care Act, (ACA) into law. ACA contains a provision (Section 1101) requiring the federal government to establish a temporary federal high risk pool no later than 90 days after enactment, to be terminated December 31, 2013. On April 2, 2010, Kathleen Sebelius, Secretary of the Department of Health and Human Services (DHHS) issued a letter to governors and state insurance commissioners asking each State to indicate its interest in administering the temporary high-risk pool.

On April 29, 2010, Governor Arnold Schwarzenegger sent a letter to Secretary Sebelius indicating California's intent to contract with the federal government to operate a temporary health insurance program for currently uninsured individuals with preexisting medical conditions. On May 10, 2010, the federal DHHS agency released the application solicitation to establish the temporary federal high-risk pool program that included an initial submission deadline of June 1, 2010 for contracts to be awarded on July 1, 2010.

Governor Schwarzenegger's letter indicated that California would operate the temporary high-risk pool alongside the State's high-risk pool, the Major Risk Medical Insurance Program (MRMIP). The Managed Risk Medical Insurance Board (MRMIB) has administered MRMIP since its inception in 1991. The Board is comprised of volunteer members appointed by the Governor and the Legislature consistent with strict State conflict of interest standards.

MRMIB is also responsible for administering California's Children's Health Insurance Program (CHIP), known as the Healthy Families Program (HFP) in California, under the federal requirements of Title XXI. MRMIB has successfully administered HFP since its inception in July 1998, and it is the nation's largest CHIP, with enrollment of nearly 900,000 children. Under Title XXI, MRMIB also administers the Access for Infants and Mothers Program (AIM) and the County Children's Health Insurance Program (CCHIP).

MRMIB has a demonstrated record of accomplishment in implementing four new programs with aggressive start-up timelines and successfully opening them on time. The Board contracts with administrative vendors for the day-to-day program operations under the oversight of MRMIB staff and with public and private health plans to provide health care coverage.

On June 29, 2010, the Governor signed legislation (SB 227 (Alquist), Chapter 31 of 2010, and AB 1887 (Villines), Chapter 32 of 2010), requiring MRMIB to establish and administer the new federal high risk pool program, contingent on an agreement with federal DHHS, and receipt of adequate federal funding for the program. The legislation passed on an urgency basis and became law immediately. The legislation prohibits the use of any State funds for the new federal program.

C.4 Technical Approach Content

C.4.1 Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high-risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for subscribers. If the State operates another high-risk pool, describe how the State will segregate funding and expenditures for the two programs and track subscribers separately across all benefits and services.

C.4.1 Response

California will establish and operate at the state-level the federal Pre-existing Condition Insurance Plan (PCIP) through a public-private partnership with contracted vendors supervised and monitored by MRMIB. California expects to begin accepting applications in August 2010 with the goal of coverage that will begin in September 2010.

In record time, MRMIB distributed and completed the solicitation process for selection of vendors to provide administrative vendor (AV) services and to perform third party administrator (TPA) activities. At the August 5, 2010 meeting, the MRMIB initially designated two vendors, a TPA vendor and an AV vendor, for purposes of initiating contract negotiations. As of this writing, MRMIB expects that the vendor negotiation and contracting process will be complete and contracts finalized in a timely manner to facilitate acceptance of applications by August 2010 and coverage effective September 2010.

The contracted AV will have responsibility for eligibility and enrollment services, billing and premium collection and coordination, operation of first-line customer service functions, first-level appeals of eligibility determinations, administration of an independent external review (IER) of adverse coverage decisions made by the TPA, and reporting of program data and information to MRMIB.

The TPA vendor initially designated by MRMIB for contract negotiations includes a primary TPA contractor which proposes to subcontract with a preferred provider organization (PPO) network, a pharmacy benefit manager, and a utilization review and disease management provider. The contracted TPA will be responsible for offering and managing the contracted provider network; processing and paying provider claims; utilization review and utilization management; benefit management; provider relations and provider complaints; first-level appeals of benefit and coverage decisions; responding to subscriber questions and complaints regarding the provision of benefits; and reporting of program data and information to MRMIB. MRMIB will require the TPA

vendor to manage all sub-contracting relationships and to administer the covered benefits and PCIP claims management functions consistent with state and federal requirements.

There is currently a separate AV for the PCIP and the MRMIP. Separate administrators for the two programs enhances MRMIB's ability to account for PCIP program revenues and MRMIP revenues separately in all reporting and accounting processes. MRMIB will ensure that all PCIP premium revenues and interest earned are used exclusively for the costs of the PCIP, both under the current administrative arrangement and in the future should there be one AV for the MRMIP and the PCIP.

C.4.2 Program Design

In response to the questions below, describe how the State will design a high-risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

C.4.2.1 Describe the eligibility criteria that the qualified high-risk pool will use to determine if individuals are eligible to enroll in the proposed high-risk pool program.

C.4.2.1 - Eligibility Criteria

The California PCIP will enroll individuals meeting the following eligibility criteria. To be eligible, an individual must be:

- 1) A resident of the state of California;
- 2) A citizen or national of the United States or lawfully present in the United States (as determined in accordance with federal law);
- 3) Not covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of the ACA) for a continuous period of six months prior to the date on which such individual is applying for coverage through the PCIP; and,
- 4) An individual with a pre-existing condition, demonstrated by one of the following:
 - a. Evidence of denial of individual health coverage; or,
 - b. Evidence of the offer for an individual, not a group, health insurance plan with a premium rate in excess of the subscriber rate for a preferred provider organization (PPO) benefit plan in the Major Risk Medical Insurance Program in the geographic region where the individual is seeking coverage. (MRMIP rates are set in statute at 125-137.5 percent of the standard risk rate.)

C.4.2.2 Describe the coverage and benefits to be offered by the qualified high-risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

C.4.2.2 - Coverage and Benefits

California's PCIP benefits will cover a broad scope of medically necessary health care services in a Preferred Provider Organization (PPO) model plan. The California benefit design complies with the required benefits for PCIP as outlined in the PCIP interim final rule released by DHHS on July 30, 2010.

The California PCIP benefit plan will require that subscribers satisfy a \$1,500 annual deductible for in-network medical services, with a separate \$500 deductible for brand name drugs. Subscribers will pay a 15 percent coinsurance for in-network services, (except for a \$25 copayment for physician office visits) up to an annual out-of-pocket limit of \$2,500. Pharmacy benefits will have tiered copayments of \$5 for generic drugs, \$15 for formulary brand-name drugs and \$30 for non-formulary brand-name drugs and specialty drugs. In-network preventive care services will be covered with no subscriber cost sharing requirements. Higher cost sharing will apply for services outside of the PPO network, with a \$3,000 deductible for out-of-network services, a separate \$500 deductible for brand-name drugs obtained out-of-network, a 50 percent coinsurance for most services and no maximum annual out-of-pocket limit. There will be no annual or lifetime benefit limit in the California PCIP.

The California PCIP will cover the following services if medically necessary:

- Hospital services;
- Physician office visits;
- Diagnostic X-ray and lab services;
- Prescription drugs;
- Durable medical equipment;
- Ambulance services;
- Emergency health care services;
- Mental health care and substance abuse treatment services;
- Home health care services;
- Skilled nursing services (covered when a medically appropriate more cost-effective alternative plan of treatment); and,
- Physical, occupational and speech therapy.

A detailed program benefit summary is attached as Appendix A.

MRMIB obtained an actuarial certification from Pricewaterhouse Coopers (PwC) that the proposed benefit design will cover at least 65 percent of the costs of benefits provided

to subscribers. The actuarial attestation is included as Appendix D.

C.4.2.3 How will the qualified high-risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

C.4.2.3 - Pre-existing Conditions

The health coverage provided by California's PCIP will include access to covered services, including emergency services, without limitation or exclusion of benefits for a pre-existing health condition. No applicant will be denied coverage because of or related to any pre-existing health condition. The contract for TPA benefits management in the PCIP will prohibit imposition of a pre-existing medical condition exclusion for coverage of any services and will prohibit any waiting period for enrollment or coverage because of a pre-existing medical condition.

C.4.2.4 Describe how the qualified high-risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

C.4.2.4 - Premiums and Standard Risk Rate

The MRMIB adopted the initial premium rates to be paid by PCIP subscribers from program start-up through December 31, 2011. The premium rates are attached as Appendix C. The methodology for the PCIP rates over the life of the program will be as follows:

Market Survey. MRMIB, working with outside consultants, will conduct an annual market survey of the health plans with the largest individual coverage market share in California as close to January 1 of each year as possible. The survey's purpose will be to identify the top-selling individual products and obtain information about the benefit features and average sold premiums for the individual products. MRMIB will incorporate information about average underwriting loads applied by California health plans in the development of the PCIP standard rates. As there is no mechanism to require health plans to cooperate with the market survey efforts, differences in participation from year-to-year may be expected. MRMIB will make every effort to minimize the impact of changes in survey participation on the PCIP rates. As appropriate, the information provided directly by health plans will be augmented with information available from other sources, including premium rates available through insurer web sites.

From the results of the market survey and information gained through alternative sources, MRMIB will select a subset of the top-selling individual products on which to base the PCIP premiums. The designated products will be those that are reasonably similar in design to the PCIP benefit plan with an objective of including at least one product from each surveyed health plan.

California Response
Solicitation to Operate Federal High Risk Pool

Except for the initial premium rate period, which will extend from program start-up in 2010 through December 31, 2011, subscriber premium rates will be adjusted January 1 of each year. Due to differences in the magnitude and timing of rate changes implemented by each health plan, as well as to smooth the rate changes from year-to-year, assumptions about expected premium increases may be applied in the development of the standard premium rates effective each January 1.

Actuarial Adjustments. The following actuarial adjustments will be made as necessary to the standard plan rates obtained through the market survey:

- Benefit adjustments to reflect differences between the surveyed individual products and the PCIP benefit design;
- Gender-specific individual premiums will be converted to unisex rates;
- Adjustments to convert the premium rates based on the health plans' region definitions to premium rates based on the PCIP geographic regions; and
- Adjustments to ensure that the maximum age ratio of 4:1 for participants in PCIP between 19 and 64 year of age is not exceeded.

MRMIB will work with actuarial consultants to develop and apply actuarial benefit adjustments to reflect benefit differences between the designated top-selling individual products and the PCIP benefit plan. Assistance from the health plans in the development of the benefit adjustments will be utilized to the extent possible and appropriate. To the extent there is wide variation in the reported premium rates for the market products, and enrollment data for those products are available, the benefit-adjusted rates will be averaged using relative enrollment as the weights. If such data are not available, a simple average will be used.

For 2010-11, PwC developed the PCIP premiums by analyzing premiums for several of the predominant California health plans' top selling individual benefit plans in 2009 and early 2010, and applying actuarial benefit adjustments to convert the rates to the PCIP benefit plan. PwC applied adjustments for the average risk load applied by each of the health plans to their published rates to reflect the average underwriting rate-up applied in their sold rates; the underwriting adjustments ranged from 1.4% to 5.8%. PCIP premiums vary by age band, and are limited to a range of 4:1 (i.e., the most expensive premium is not greater than four times the cost of the least expensive premium within a geographic region), for age bands covering subscribers between the ages of 19 and 64.

PCIP premiums will vary among the six geographic regions used for California's existing high-risk pool (included as Appendix B).

C.4.2.5 Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high-risk pool that complies with the requirements outlined in A.4.2.7.

C.4.2.5 - Cost Sharing Structure

The California PCIP benefit plan will require that subscribers satisfy a \$1,500 annual deductible for in-network medical services, with a separate \$500 annual deductible for brand name drugs, impose a 15 percent coinsurance for most in-network services, (there will be a \$25 flat rate copayment for in-network physician office visits), and cap annual out-of-pocket subscriber costs for in-network services at \$2,500. Pharmacy benefits will be subject to tiered copayments of \$5 for generic drugs, \$15 for formulary brand-name drugs and \$30 for non-formulary brand-name drugs and specialty drugs. Higher cost sharing will apply for services outside of the PPO network, with a 50 percent coinsurance for most services, a separate \$3,000 annual deductible and separate \$500 deductible for brand-name drugs, and no maximum annual out-of-pocket limit. In-network preventive care services will be covered with no subscriber cost sharing requirements. The plan year for accumulation of subscriber deductibles and out-of-pocket limits will be the calendar year.

The proposed out-of-pocket limit does not exceed the 2010 limit of \$5,950 imposed for Health Service Account plans pursuant to Section 223(c)(2) of the Internal Revenue Code.

PwC certifies that the California PCIP benefit plan and cost-sharing structure complies with the federal requirement that the PCIP cover at least 65 percent of the costs of covered health services (see Appendix D).

C.4.2.6 If applicable, describe the provider network(s) proposed to be used by qualified high-risk pool subscribers and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

C.4.2.6 - Provider Network

The PCIP will offer a PPO benefit plan design. MRMIB staff is in the process of negotiating contract terms with the TPA vendor initially designated by MRMIB. MRMIB will require by contract that the TPA/PPO maintain an accessible and available provider network at all times and conduct appropriate provider credentialing and provider quality monitoring.

The initially designated TPA vendor offers, through a subcontracted statewide PPO network and subcontracted PBM, coverage in all 58 California counties sufficient to ensure that covered services are reasonably available and accessible to subscribers on an in-network basis. The proposed provider network includes 65,000 contracted

providers and 350 contracted facilities in California. The proposed pharmacy network includes 7,000 locations in California, including all major retail chains, independent retail locations and a mail-service pharmacy option. In addition, the proposed PPO network includes Centers of Excellence for transplants, cardiac care, bariatric surgery, knee and hip replacement and spine surgery.

C.4.2.7 Describe the appeals and reconsiderations process that the qualified high-risk pool proposes to make available to subscribers in the high-risk pool program as per the description of section A.4.2.10.

C.4.2.7 - Appeals and Reconsideration

Appeal procedures will ensure applicants and subscribers have the right to file an appeal with at least two levels of review, one internal to the program and a state-level administrative review independent of the PCIP through the State Office of Administrative Hearings (OAH).

The first level of appeal will be internal to the program through the contracted AV for eligibility and enrollment related appeals and through the contracted TPA for appeals related to benefit and coverage decisions. Eligibility and enrollment appeal decisions include denial of eligibility and termination of enrollment, including disenrollment for failure to monthly premiums. Coverage and benefit decisions include denial of benefits or payments, coverage for specific treatments or procedures because of medical necessity criteria and services covered at a lower percentage because they are obtained out-of-network.

The final level of appeal for all appeals will be an administrative review through the OAH. OAH will make recommendations to the MRMIB who will make the final determination. As provided in the California Administrative Procedures Act, OAH will issue proposed decisions to the MRMIB which will make the final determination.

Prior to the OAH hearing, the PCIP appeals process for coverage decisions will also include an independent external review (IER) of adverse medical necessity coverage decisions made by the contracted TPA. To ensure that the IER is independent, MRMIB will contract with the AV to administer the IER. There may also be a second level of administrative review before the OAH hearing for appeals of other determinations.

MRMIB will impose contract performance standards requiring that, at a minimum, 95 percent of all first-level eligibility redeterminations are processed by the AV contractor within 20 business days, and, at a minimum, 95 percent of all first-level coverage appeals are processed by the TPA within 30 calendar days. The PCIP appeals process will also provide for an expedited review within three days for coverage and medical necessity determinations where the timeframe for completion of a standard appeal would seriously jeopardize the life or health of the covered person or would jeopardize

the covered person's ability to regain maximum function.

The process for all appeals will be outlined in the program handbook and in notification letters to applicants and subscribers. All decisions will be in writing and all decisions that have an impact on an applicant or subscriber will include instructions on how to file an appeal when an applicant or subscriber believes the decision was incorrect. Any notification of a first-level appeal determination will include full notification of the second level appeal opportunity and the timelines and process for accessing the second level review.

C.4.2.8 Premium Grace Period

Please describe the premium grace period and nonpay termination appeal process.

The AV will send billing notices out on the 1st of each month (with payment due on the 15th) for coverage that will begin the following month. Subscribers will have a grace period from the 15th to the end of the month. If payment is not received by the 15th of the month, non-payment disenrollment notices will be sent notifying subscribers of the right to appeal the pending disenrollment by the 25th of the month. Any payments received before midnight on the last day of the month will result in no break in coverage. If payment is not received by the end of the month, the nonpayment disenrollment will proceed effective the first of the following month.

C.4.2.9 Premium Rates

Provide the actual initial premium rates, by age.

The initial premium rates for the California PCIP for the period September 2010 to December 31, 2011 are attached as Appendix C.

C.4.2.10 Premium adjustments

Describe how often the state proposes to adjust premiums for changes in market rates.

Except for the initial premium rate period, which will extend from program start-up in 2010 through December 31, 2011, subscriber premium rates will be adjusted January 1 of each year.

C.4.2.11 Third Party Payments

Is the state proposing to accept premium payments from third party payers? If so, please describe from which major entities, organizations and agencies such payments will be received.

MRMIB will not establish any formal structure for accepting third party payments but will accept payments from any person or entity on behalf of a subscriber. There will be no

separate tracking of who pays the premiums for a subscriber.

C.4.2.12 Proposed Plan Year

Is the state's proposed plan year on a calendar year basis for accumulation of member deductibles and out-of-pocket limits, or some other time period.

The plan year for accumulation of subscriber deductibles and out-of-pocket limits will be the calendar year.

C.4.3 Enrollment Standards

Describe the qualified high-risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

C.4.3 - Eligibility Determination Process

The AV will manage and administer the eligibility and enrollment process and will be responsible for eligibility determinations, premium collection, transmission of enrollment information to the TPA, and printing and mailing of application materials. MRMIB will initially require by contract that a mail-in application be processed within twenty days for complete applications; 10 days for application processing by the AV and 10 days for the TPA to provide subscribers with a health plan card, subscriber materials and the certificate of coverage booklet.

Initially, the application and enrollment materials will be published in English and Spanish, and subsequently will be provided in any language that reaches a 5 percent threshold level of subscribers based on data collected at the time of application. For this purpose, the application will include a question to identify the primary spoken and written language of the applicant. MRMIB will require the AV contractor to have trained bilingual staff and to operate a toll-free telephone line that can provide language interpretation services in any language requested by applicants and subscribers.

Completed applications submitted by the 10th of the month will be processed for an effective coverage date on the 1st day of the following month.

Similar to its administrative vendor contract for the Children's Health Insurance Program, HFP, MRMIB will establish performance requirements for process and accuracy. The AV contract will have a liquidated damages provision that allows MRMIB to impose liquidated damages on vendors if the required standards are not achieved. The federal Payment Error Rate Measurement (PERM) audit for HFP found a very high rate of eligibility determination accuracy.

C.4.3.1 How will the qualified high risk pool develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?

C.4.3.1 Eligibility Determination

As outlined in C.4.3 above, California will establish in the enrollment application and by contract with the AV contractor specific eligibility processing and documentation requirements for each of the PCIP eligibility criteria. The PCIP program application will be designed to verify:

- State residency, as determined by the applicant having a California address or other appropriate documentation as determined by MRMIB;
- U.S. citizenship and immigration status of applicants, obtained through questions and required supporting documentation (see C.4.3.3 below);
- The applicant has been without creditable coverage for at least 6 months, as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of the ACA; and,
- The applicant has a pre-existing condition, to be confirmed by either a notice of rejection for individual coverage from a health plan or insurer, or proof of an offer of individual insurance at rates higher than PPO coverage in California's state high-risk pool program, MRMIP (premiums are set in MRMIP at 125%-137.5% of market rates).

MRMIB will implement the requirement concerning creditable coverage relying on federal guidance; for purposes of this program, MRMIB will consider only Medicaid with no share of cost, and not other forms of Medicaid, to be creditable coverage.

C.4.3.2 How will the qualified high-risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high-risk pool program?

C.4.3.2 Eligibility Documentation

MRMIB will implement through the AV contractor a PCIP program application to collect the information required including name, address, date of birth, Social Security number, contact information and appropriate information and documentation to verify eligibility as described above. MRMIB will ensure the application collects the information and documentation necessary to verify eligibility and prioritizes timely enrollment of eligible persons.

C.4.3.3 Describe the process that the qualified high-risk pool will use to confirm that a subscriber is a citizen or national of the United States or an alien lawfully present in the United States.

C.4.3.3 Citizenship Verification

MRMIB will establish the acceptable documentation to confirm that an applicant is a citizen, national or alien lawfully present in the United States, consistent with federal requirements. Applicants will be required to provide hard copy documentation, (including the applicant's Social Security number), which will include, but may not be limited to: certified copies of birth certificates; U.S. passports; Native American tribal documents; or legal certificates of U.S. citizenship or naturalization issued by the federal government.

After the initial implementation of the PCIP, California will assess the feasibility of establishing interfaces with the Social Security Administration (SSA) and the Department of Homeland Security (DHS) to conduct electronic administrative verifications of citizenship and immigration status. MRMIB would look to work collaboratively with DHHS to establish the connectivity with SSA for citizenship originally developed through CHIPRA in January 2010 and DHS for immigration status on a yet to be developed interface.

C.4.3.4 Describe the enrollment process that the qualified high-risk pool proposes to use.

C.4.3.4 Enrollment Process

The AV will process and screen all applications for completeness and potential eligibility for either the PCIP and/or the MRMIP state high-risk program. MRMIB may require the AV to forward appropriate applications for the state high-risk pool, MRMIP, to the MRMIP enrollment vendor for processing. The PCIP AV contract will provide for applications to be processed within twenty days for complete applications; 10 days for application processing and 10 days to provide subscribers with enrollment materials. At a minimum, the TPA will be required to process and provide identification cards and member materials within 10 calendar days of receipt of enrollment information from the AV vendor.

The AV will forward enrollment data to the TPA of PCIP eligible persons on an ongoing basis. Vendor contracts will outline the process for enrolled persons to receive the subscriber welcome packet, coverage identification card, provider directory, certificate of coverage and benefits and other appropriate subscriber materials as determined by MRMIB. MRMIB will develop procedures and contract requirements so that subscribers enrolled in the PCIP receive program materials in a timely manner, that enrollment processing between the AV and the TPA is coordinated, and that subscribers have the necessary information they need to access services by their coverage effective dates.

Completed applications submitted by the 10th of the month will be processed for an effective coverage date on the 1st day of the following month.

Periodic enrollment caps may be necessary as a tool to manage the funds available for the program. The AV will be tasked with administering enrollment caps if instituted and any waiting lists that might be necessary for fiscal reasons. MRMIB will actively monitor enrollment and claims expenses to manage program costs and revenues on an ongoing basis. MRMIB has successfully managed the existing state high-risk pool within budgeted resources through the strategic use of enrollment caps and subscriber waiting lists.

C.4.3.5 Describe the disenrollment process that the high-risk pool plan proposes to use.

C.4.3.5 Disenrollment Process

MRMIB will implement procedures for disenrollment from PCIP, which, at a minimum, will require disenrollment for the following:

- At the request of the subscriber;
- Failure of the subscriber to make timely payment of premiums (see C.4.6);
- The subscriber obtains other creditable coverage;
- Death of the subscriber;
- At any time that a subscriber fails to meet any eligibility requirements of the program; and,
- When subscribers are enrolled in a health insurance exchange or the federal act terminates, whichever is later.

The contracted AV will process subscriber disenrollments, and notify the TPA of subscribers disenrolled, consistent with contract requirements and standards prescribed by MRMIB. The subscriber will be notified of the right to appeal disenrollment decisions along with the timelines and process for appeals.

C.4.4 Describe the customer service functions and standards that will be employed by the qualified high-risk pool program. The description should include the qualified high-risk pool's proposal for the staffing, hours of operation and service levels that the qualified high-risk pool will provide to subscribers in the qualified high-risk pool.

C.4.4 Customer Service

MRMIB will contract with the AV and the TPA to operate customer service call centers appropriately staffed to be responsive to the number of plan subscribers and to provide prompt and accurate information and services to high-risk pool program subscribers. At

California Response
Solicitation to Operate Federal High Risk Pool

a minimum, the customer service call centers will be available Monday-Friday from 8 a.m. to 5 p.m.

MRMIB will require the AV and TPA, by contract, to have the capability to provide customer service and plan enrollment information in languages other than English, as necessary to meet the needs of the population anticipated to be served by the PCIP, and to make customer service and plan enrollment information available in formats that are accessible for subscribers with disabilities. The AV and TPA vendors will, at a minimum, provide interpreter services through a contracted language line service.

MRMIB will require the AV and the TPA to coordinate customer service functions so that subscribers are able to have all of their questions answered and service needs met whether they make initial contact through the AV or the TPA call center.

MRMIB will require by contract the AV and the TPA contractors to monitor the quality and accessibility of the call center services on an ongoing basis and to meet the following specified contract quality standards, at a minimum:

- a) Respond to all subscriber correspondence within 20 calendar days;
- b) Telephone abandonment rate of no more than 5 percent;
- c) Telephone line busy rate of no more than 5 percent;
- d) 80 percent of calls reach a live voice within 30 seconds; and,
- e) 90 percent of voice mail calls answered within two business days.

The TPA will offer a 24/7 website with subscriber access to PPO provider information and claims status.

C.4.5 Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high-risk pool. The description should include the qualified high-risk pool's proposal for the staffing, hours of operation and service levels that the qualified high-risk pool will provide.

C.4.5 Provider Technical Support

The TPA contractor will operate the technical support center for health and pharmacy providers to meet state and federal requirements. MRMIB will require the TPA, by contract, to ensure that the technical support center is appropriately staffed to be responsive to the number of providers and the anticipated volume of calls based on the number of subscribers enrolled in the PCIP.

At a minimum, the technical support center will be available Monday-Friday from 8 a.m. to 5 p.m. MRMIB will require the TPA contractor to monitor the quality and accessibility of the call center services on an ongoing basis and to meet specified contract quality

standards for customer service similar to those imposed for the subscriber customer call centers.

C.4.6 Describe the qualified high-risk pool's system for billing, collecting, and accounting for premiums.

C.4.6 Billing and Collection

MRMIB will establish the procedures for billing, collecting and accounting for premiums by contract with the AV as it does now for the CHIP program. The current AV for the MRMIP is separate from the AV for the PCIP. Separate vendors for the two programs will enhance MRMIB's ability to account for PCIP program revenues and MRMIP revenues separately in all reporting and accounting processes. MRMIB will ensure that all premium revenues and interest earned are used for the costs of the PCIP both under the current arrangement and in the future should there be one AV for the PCIP and MRMIP.

The AV will send billing notices out on the 1st of each month (with payment due on the 15th) for coverage that will begin the following month. Subscribers will have a grace period from the 15th to the end of the month. If payment is not received by the 15th of the month, non-payment disenrollment notices will be sent notifying subscribers of the right to appeal the pending disenrollment by the 25th of the month. Any payments received by midnight on the last day of the month will result in no break in coverage. If payment is not received by the last day of the month, the nonpayment disenrollment will proceed effective the first of the following month. At initial implementation, MRMIB may credit the premium paid for the first full month of operation for any portion of partial month of coverage.

C.4.7 If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.7 Utilization and Care Management

MRMIB will contract with the TPA vendor for utilization management, care management and disease management, as appropriate for the subscribers who enroll in PCIP. Contract negotiations with the initially designated vendor are still underway. In refining the contract requirements, MRMIB will focus on best value services, including prior authorization and concurrent review of inpatient medical services and management of specialty referrals. As included in the benefit sections, MRMIB will work with the subcontracted PBM to implement a tiered pharmacy benefit design that includes mandatory prior authorization for all specialty medications.

MRMIB will task the TPA Contractor with discharge planning, care coordination services for subscribers leaving the inpatient setting, care management services for designated subscribers with chronic illnesses or co-occurring behavioral health diagnoses, which typically include the coordination of medically necessary home, and community-based services. MRMIB will require the TPA Contractor to track and monitor the quality performance of the provider network including the number and type of specialty referrals made, the timeliness of the specialty referrals, and whether appropriate follow-up occurs for each specialty referral. In addition, MRMIB will require the TPA Contractor to have mechanisms to detect both under- and over-utilization of health care services, focusing in particular on emergency room over-utilization and inappropriate inpatient admissions and lengths of stay.

MRMIB will require the TPA Contractor to conduct and report periodic reviews of emergency room usage and implement measures to reduce inappropriate emergency room use if detected. The TPA Contractor will also be required to implement mechanisms to notify primary care providers when utilization of services falls outside of established practice guidelines, so that primary care providers can work with subscribers to ensure appropriate service utilization.

In addition, MRMIB will require the TPA contractor to make available to the PCIP a data warehouse with specified data reports and data analysis including the ability to develop ad hoc analyses and reports. The TPA contractor will make the data warehouse directly available to MRMIB staff which will allow MRMIB to work closely with the TPA and its subcontractors to actively monitor claims costs and service utilization to ensure quality of care and to proactively manage the program budget on an ongoing basis.

C.4.8 Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high-risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.8 Claims Payment

The contracted TPA vendor will be responsible for implementing a system for timely and accurate payment of claims. The pharmacy management program will include the capability for point-of-sale claims for prescription drug services. MRMIB will impose specific performance standards for the timely and accurate payment of claims, including, at a minimum, the following:

- a) 95 percent of clean claims paid within 30 calendar days of receipt; and
- b) 95 percent of clean claims paid accurately.

The PCIP claims processing system will encompass claims receipt through final payment, or denial, through a fully automated claim adjudication system that is

California Response
Solicitation to Operate Federal High Risk Pool

consistent with industry standards for comparable commercial health insurance carriers or health plan administrators. The adjudication system should allow the TPA Contractor to ensure and monitor that claims are adjudicated in a timely and accurate manner.

California will require by contract the TPA Contractor to ensure that at all times claims handling and claims payment processes and policies comply with all State and federal laws and contract requirements. In addition, the TPA contractor will make available to the PCIP a data warehouse with specified data reports and data analysis including the ability to develop ad hoc analyses and reports. The TPA contractor will make the data warehouse directly available to PCIP staff at MRMIB to allow MRMIB to carefully review and evaluate PCIP claims. At a minimum, the claims adjudication system will have the following capabilities:

- Automated eligibility verification that coverage has not terminated on the date of service;
- Benefit plan information stored on the system;
- Automatic calculation and tracking of subscribers' deductibles, coinsurance, copayments, and out-of-pocket limits and any other benefit such as limits on days, sessions, or visits, consistent with industry standards;
- Individual claim history stored on the system and automatically updated;
- Ability to distinguish claims by diagnosis code;
- Automated calculation of cost containment provisions;
- Identification and collection of claim overpayments;
- Procedures for review of "medically necessary" determinations; and,
- Automated production of an Explanation of Benefits.

The TPA Contractor will establish and manage provider payment rates in the PCIP. Given the inclusion of an existing PPO network as a subcontractor to the TPA, MRMIB anticipates that the rate methodology used is consistent with the one used by the PPO for large employers. The TPA vendor solicitation required prospective vendors to provide information on proposed provider rates and the provider rate setting process. MRMIB contracted with Mercer to review and provide feedback to MRMIB on the proposed rates.

C.4.9 Describe the qualified high-risk pool's proposed efforts to conduct outreach and marketing for the high-risk pool program.

C.4.9 Outreach and Marketing

California has already begun to respond to consumer inquiries regarding the California PCIP and is collecting the names of interested persons. As of August 10, 2010, there were approximately 4,400 individuals on the interested persons list.

MRMIB has established successful marketing and outreach programs for other programs it administers including the children's coverage program, HFP. For this new

California Response
Solicitation to Operate Federal High Risk Pool

program, MRMIB will task the AV with the lead responsibility to develop, conduct and support marketing and outreach activities as determined by MRMIB to be appropriate for the program and the population. MRMIB will work with the AV vendor and other state programs and agencies to notify potentially eligible individuals, and the organizations and providers who interact with them, about the availability of the California PCIP. The AV will also develop an Internet website for the program. The web site will serve as a platform for providing access to applications and communicating program rules.

MRMIB will require the AV by contract to implement, at a minimum, the following marketing and outreach activities:

- a) Application assistance fees to health insurance agents and brokers for facilitating a successful enrollment into the program;
- b) Blast e-mails to application assisters through California's online electronic application system for Medi-Cal and the Healthy Families Program;
- c) Targeted mailings to potentially eligible individuals, disease-related organizations and associations and providers and institutions most likely to provide services to potential PCIP-eligible individuals;
- d) Announcements and communications through social media (Facebook, Twitter and program blogs);
- e) Outbound telephone calling campaigns;
- f) Distribution of marketing materials developed by the Center for Health Literacy;
- g) Traditional media marketing (print and radio public service announcements); and
- h) Coordination with any federally-funded Consumer Assistance Program that may be available in the state.

In addition, one of the enabling bills for California's PCIP, SB 227 (Alquist), requires California health plans and health insurers who deny someone individual coverage to include information about the potential for eligibility in MRMIP and the federal PCIP in the written notice of denial mandated under California law.

C.4.10 Describe the process the qualified high risk pool proposes to use to identify and report to DHHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.

C.4.10 Insurer Dumping

MRMIB will establish procedures working with the contracted TPA and AV to report to DHHS for investigation and follow-up information obtained by the vendors that point toward health insurance issuers or group health plans discouraging individuals from remaining in existing coverage.

The California PCIP program application will incorporate questions from the federal PCIP application regarding insurance coverage in the previous twelve months to identify applicants (or their family members) that are employed, may have, or have had, access to other coverage. The California application also requires applicants to notify the PCIP if they obtain health insurance in the future.

C.4.11 Describe the procedures that qualified high-risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.11 Fraud and Abuse Prevention and Detection

Consistent with the successful track record of management of other coverage programs, MRMIB will conduct independent and objective audits, evaluations, and investigations to ensure program integrity. The CHIP program administered by MRMIB performed extremely well in the federal PERM audits. MRMIB will investigate written complaints regarding fraud or abuse of the program. MRMIB will review statutes and regulations for guidance to ensure compliance with all state and Federal laws applicable to the PCIP.

MRMIB will require by contract both the AV and the TPA contractors to implement fraud detection and prevention programs and to regularly report to MRMIB the experience and the results of those fraud detection efforts. MRMIB, and its contracted vendors, will cooperate with federal law enforcement authorities in any potential cases of fraud, waste and abuse.

The AV contractor will be required to implement industry standard fraud prevention strategies to prevent and discourage applicant activity that is inappropriate or fraudulent. At a minimum, fraud prevention performance standards for the AV will include:

- a) Call center reports including algorithms or tools to identify unusual behavior and analyze its impact on program integrity;
- b) Qualitative feedback from call center and eligibility personnel;
- c) Application data reports that identify trends among denied applications and re-applications;
- d) Employee fraud prevention training;
- e) Periodic internal audits; and,
- f) Quality management policies and procedures.

The TPA vendor contract will impose specific responsibilities on the TPA, and its subcontractors (the PPO network and the PBM), for identification of health services fraud, waste, and abuse through predictive models. The contract will require the TPA to implement industry standard fraud prevention and detection strategies, including but not limited to, mandatory anti-fraud and abuse training for TPA staff, claims processing edits to identify cases and health service claims costs, including pharmacy claims costs,

with a high potential to be fraud, waste, or abuse. The TPA and its subcontractors will monitor claims for under- and overutilization and indications of potential fraud.

The TPA and its subcontracted PPO will use the provider credentialing process to flag providers who need further monitoring based on identified patterns of health service claims and utilization that may be indications of potential fraud, waste and abuse. The TPA, through its subcontractors, will rely on an existing and experienced team of full-time investigators to deter and prevent fraud and abuse, and a special investigations department working with MRMIB and federal regulatory agencies to detect and report instances of potential fraud or abuse.

C.4.12 Describe the system for routine monitoring and identification of compliance risks.

C.4.12 Compliance Monitoring

MRMIB has an active internal federal compliance team that ensures on an ongoing basis that all MRMIB programs comply with applicable state and federal laws. This successful approach and dedicated staff focus will be replicated for PCIP to ensure compliance with federal requirements.

The vendor contracts for the AV and the TPA will require compliance with state and federal laws and the terms of California's contract with DHHS for the PCIP. Vendor contracts will include specific performance standards as well as mandatory internal contract and quality monitoring audits by each contracted vendor to allow MRMIB to proactively monitor the extent to which vendors are complying with all contract requirements and federal standards. MRMIB will require regular reporting of vendor performance and quality monitoring results to the Board. In addition, MRMIB will include in vendor contracts provisions that allow MRMIB to impose liquidated damages related to specific performance standards and reporting requirements in the event that the requirements are not met.

At program start-up, MRMIB will establish new staffing positions related to the implementation and monitoring of the PCIP and compliance with the federal contract and program rules. The addition of staff dedicated to the PCIP will enhance the ability of MRMIB to conduct effective monitoring and identification of compliance risks. The MRMIB internal compliance team works on an ongoing basis to address compliance in all MRMIB programs, working collaboratively with the MRMIB legal counsel and management team.

C.4.13 Describe the system the qualified high-risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.4.13 Coordination of Benefits

California Response
Solicitation to Operate Federal High Risk Pool

MRMIB will task the contracted TPA with coordinating benefits for PCIP subscribers. The initially designated TPA vendor demonstrated in the vendor solicitation response experience and a successful record of accomplishment with subrogation in securing payments from other sources of coverage, such as workers' compensation and automobile medical coverage.

C.5 Cost Proposal

Budget Narrative

I. Projected Administrative Costs (Table 1)

Table 1 shows projected administrative costs, assuming that California will spend 10 percent of total program revenues (federal allotment plus projected premium revenues) over the life of the PCIP, for a total of \$118.9 million projected administrative costs. Actual administrative costs in each cost category and the total amount will be subject to vendor contract negotiations and experience with administration of the program. A narrative description of costs in each category follows Table 1.

PwC Enrollment Projection

	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
(Stated as annual member months)	69,300	277,200	277,200	277,200

Table 1 California PCIP Projected Administrative Costs						
Cost Category	Annual Administrative Costs					Totals
	2010	2011	2012	2013	2014	
<u>Contracted Administration</u>						
Administrative Vendor	\$4,377,863	\$8,752,387	\$8,752,387	\$8,752,387	\$4,367,843	\$35,002,866
TPA Vendor	8,074,143	16,142,126	16,142,126	16,142,126	8,055,663	64,556,184
Other Contracted Services	655,369	1,310,238	1,310,238	1,310,238	653,869	5,239,950
Total contracted services	\$13,107,375	\$26,204,750	\$26,204,750	\$26,204,750	\$13,077,375	\$104,799,000
<u>State Department Administration</u>						
Personnel and related expenses	1,738,000	3,476,000	3,476,000	3,476,000	1,738,000	13,904,000
Other Administrative Costs	20,000	50,000	50,000	50,000	50,000	220,000
TOTALS	\$14,865,375	\$29,730,750	\$29,730,750	\$29,730,750	\$14,865,375	\$118,923,000

California Response
Solicitation to Operate Federal High Risk Pool

There are two administrative cost components, contracted services and state department costs.

Contracted Services

There are three components to estimated contracted administrative services:

- a) Administrative Vendor Services -- The Contracted AV will be responsible for eligibility/enrollment, marketing and outreach, member materials, customer service, information technology, premium administration, appeals and reconsiderations, accounting services and related activities.
- b) Third Party Administrator Services -- The Contracted TPA will be responsible for provider network development and maintenance, provider relations, benefits administration, claims processing, pharmacy benefit management, utilization review, care management, accounting services, claims reconciliation and other related activities.
- c) Other Contracted Services -- Includes legal, actuarial and evaluation consulting services.

State Department Costs

There are two components to state agency administrative costs:

- a) Personnel and related expenses -- Includes the projected costs for MRMIB staff and related equipment and support for program administration and contract oversight.
- b) Other Administrative Costs -- Includes the costs of interagency services to conduct administrative hearings for subscriber appeals and to investigate fraud complaints.

II. Projected Administrative and Claims Costs (Table 2)

California’s federal allotment for the PCIP is \$761 million over the life of the program. PwC estimates that premium revenues for the California PCIP will be approximately \$428 million total over three years. The total projected available revenues for the program will be \$1.2 billion.

Table 2 - Projected Administrative and Claims Costs (One Benefit Plan Option)					
Year	Average Monthly Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010	23,100	\$28,759,500	\$42,829,000	\$14,865,375	\$28,934,875
2011	23,100	115,038,000	291,361,000	29,730,750	206,053,750
2012	23,100	132,293,700	331,928,000	29,730,750	229,365,050
2013	23,100	152,137,755	365,121,000	29,730,750	242,713,995
2014			39,066,955	14,865,375	53,932,330
<u>TOTAL</u>		<u>\$428,228,995</u>	<u>\$1,070,305,955</u>	<u>\$118,923,000</u>	<u>\$761,000,000</u>

Premium Revenue Methodology. MRMIB contracted with PwC to provide actuarial and consulting support in developing estimated premium revenues and projected enrollment. PwC developed projections using the most accurate data available; but the estimates are subject to change as more information becomes available. The PwC certification is attached (Appendix D).

California will offer a single benefit design option with an actuarial value above the required 65 percent minimum. The California PCIP benefit plan will require that subscribers satisfy a \$1,500 annual deductible for in-network medical services, with a separate \$500 annual deductible for brand name drugs, impose a 15 percent coinsurance for most in-network services (there will be a \$25 flat rate copayment for in-network physician office visits) and cap annual out-of-pocket subscriber costs for in-network services at \$2,500. Pharmacy benefits will be subject to tiered copayments of \$5 for generic drugs, \$15 for formulary brand-name drugs and \$30 for non-formulary brand-name drugs and specialty drugs. Higher cost sharing will apply for services outside of the PPO network, with a 50 percent coinsurance for most services, a

separate \$3,000 annual deductible and separate \$500 deductible for brand-name drugs, and no maximum annual out-of-pocket limit. In-network preventive care services will be covered with no subscriber cost sharing requirements. The plan year for accumulation of subscriber deductibles and out-of-pocket limits will be the calendar year.

The claim cost and age distribution assumptions underlying the projections are primarily based on recent experience of the MRMIP, California's state high risk pool and the Guaranteed Issue Pilot Program (GIP, consisting of former MRMIP participants). The actuarial projections reflect assumed incurred claim costs of \$1,000 per month in 2010 and annualized claim cost trends of 10 percent per year. The projected total administrative costs over the life of the plan are assumed to be 10 percent of the total costs of the program.

PwC developed the PCIP premiums by analyzing premiums for several of the predominant California health plans' top selling benefit plans in 2009 and early 2010, and applying actuarial benefit adjustments to convert the rates to the PCIP benefit plan. PwC applied adjustments for the average risk load applied by each of the health plans to their published rates to reflect the average underwriting rate-up applied in their sold rates; the underwriting adjustments ranged from 1.4% to 5.8%. PCIP premiums vary by age band, and the PwC projections assume that the age distribution of PCIP enrollees will be similar to that in MRMIP, resulting in an average estimated premium of approximately \$415 per member per month in 2010 and 2011. The cost proposal assumes premiums will be reset each January 1 starting in 2012 and that the average premium increase would be 15 percent per year.

Based on the assumptions described above, PwC estimates that California's federal allotment of \$761 million and subscriber premiums will support an average of 23,100 PCIP enrollees per month. The PwC estimate assumes that all available slots will be filled by October 1, 2010 and further assumes that new subscribers will immediately replace subscribers who are disenrolled.

III. Maintenance of Effort Description (Table 3)

The budget narrative should contain a separate section that describes how the State proposes to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. A State should provide a narrative description of its maintenance of effort strategy and also provide a table identifying State allocated funds and other current State high risk pool program revenues that supplemented premiums paid by current state high risk pool program enrollees in 2009. The narrative and accompanying table should demonstrate that the State will maintain that level of support of its state high-risk pool programs.

California Response
Solicitation to Operate Federal High Risk Pool

California state law (Chapter 1168, Statutes of 1989) created the MRMIP to provide health insurance through a high-risk pool to medically uninsurable Californians. The MRMIP is funded by a combination of subscriber premiums and Proposition 99 (tobacco tax) funds. MRMIP subscribers pay monthly premiums at rates set in statute between 125 percent and 137.5 percent of standard rates for comparable coverage in the private insurance market. The State reimburses carriers participating in the MRMIP for nearly all costs that exceed the amount of premiums paid to the carriers by subscribers. The Governor's 2009-10 May Revise Budget Proposal, approved by the Legislature provided the MRMIP \$31.8 million for the 2009-10 fiscal year.

SB 1379 (Ducheny), Chapter 607, Statutes of 2008, also requires that any amount over the first \$1 million in fines and penalties collected by the Department of Managed Health Care (DMHC) be transferred to the Major Risk Medical Insurance Fund and used to fund the MRMIP. The amount of fines and penalties imposed on health plans regulated by DMHC varies year-to-year and are not accounted for as state revenues. California does not consider such funds to be subject to the PCIP maintenance of effort requirement. In 2009, the amount of health plan fine revenues was approximately \$1 million.

By authorizing the submission of this proposal through the Governor's Office, the State of California communicates that it fully intends to comply with the federal maintenance of effort requirement and maintain funding for MRMIP at **\$31.8 million** on an annual basis through the time period of the PCIP, September 2010 through January 2014. MRMIB does not have the authority to determine the level of funding appropriated to the MRMIP but agrees to communicate with DHHS should there be any shortfalls in the future.

Table 3 Maintenance of Effort 2009-10 MRMIP Revenues (\$ in thousands)		
Source of Revenue	Amount	Percent
Premium revenues ¹	\$52,512	62%
State Funds: (Proposition 99)	\$31,834	37%
Administrative Fines and Penalties (Department of Managed Health Care)	\$1,041	1%
Total	\$85,387	100%

¹ Premiums are paid directly to participating health plans.

California Response
Solicitation to Operate Federal High Risk Pool

Appendix A
California Pre-Existing Condition Insurance Plan Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What Subscribers Pay Participating Provider</i>	<i>What Subscribers Pay Non-Participating Provider</i>
Annual Deductible	The amount that a subscriber must pay for covered services except for preventive care services before the program will cover those services at the copayment or coinsurance amount in one calendar year	\$1,500 per subscriber	\$3,000 per subscriber; does not count toward in-network deductible
Annual Deductible – Brand Name Prescription Drugs	The amount that a subscriber must pay for brand-name drugs before the program will cover those drugs at the copayment or coinsurance amount in one calendar year.	\$500 per subscriber	\$500 per subscriber; does not count toward in-network deductible
Copayment/Coinsurance	Subscriber's amount due and payable to the provider of care	See Below	
Annual Maximum Copayment/	Subscriber's annual maximum copayment/coinsurance limit when using participating providers in one calendar year	\$2,500 per subscriber	No annual maximum copayment/coinsurance limit for non-participating providers. Subscribers pay unlimited coinsurance
Coinsurance Limit	<ul style="list-style-type: none"> The annual maximum copayment/coinsurance includes the \$1,500 annual deductible and the \$500 annual deductible for brand-name drugs If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the subscriber's responsibility and do not apply to the annual maximum copayment/coinsurance limit 		
Annual Benefit Maximum	There is no annual benefit maximum in this program	None	None
Lifetime Benefit Maximum	There is no lifetime benefit maximum in this program	None	None
Preventive Care Services**	Preventive Services Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Human Papillomavirus (HPV) screening test, Ovarian and Cervical Cancer Screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Infections (STI) tests, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain Immunizations for children and adults, and Disease Management Programs	No Charge	50% of customary and reasonable charges and any in excess
Hospital Services	Inpatient medical services (semi-private room)	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	Outpatient services; ambulatory surgical centers	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Physician Office Visits	Services of a physician for medically necessary services	\$25 copayment per visit	50% of customary and reasonable charges and any in excess
Diagnostic X-ray and Lab Services**	Outpatient diagnostic X-ray and laboratory services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

California Response
Solicitation to Operate Federal High Risk Pool

Appendix A
California Pre-Existing Condition Insurance Plan Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What Subscribers Pay Participating Provider</i>	<i>What Subscribers Pay Non-Participating Provider</i>
Prescription Drugs	<ul style="list-style-type: none"> Maximum 30-day supply per prescription when filled at a participating pharmacy 90-day supply for mail order 	<p>\$5 for generic drugs</p> <p>After the annual \$500 brand-name deductible is met:</p> <ul style="list-style-type: none"> \$15 for formulary brand-name \$30 for non-formulary brand-name drugs and specialty drugs (need pre-authorization for specialty) <p>Same copayments for mail order</p>	Full cost of drugs at non-participating pharmacy; program reimburses subscriber 50% of generic and brand name prescription drug fee schedule
Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy** and Maternity Care	<ul style="list-style-type: none"> Inpatient normal delivery and complications of pregnancy Prenatal ** Postnatal 	<p>15% of negotiated fee rate</p> <p>No charge</p> <p>15% of negotiated fee rate</p>	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess
Ambulance Services	Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Emergency Health Care Services*	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional, and supplies	15% of negotiated fee rate	50% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours
Mental Health Care Services*	<ul style="list-style-type: none"> Inpatient basic mental health care services 10 days each calendar year Outpatient basic mental health care services 15 visits each calendar year <p>* Unlimited inpatient days and outpatient visits for Severe Mental Illnesses</p>	<p>15% of negotiated fee rate and all costs for stays over 10 days</p> <p>15% of negotiated fee rate for 15 visits per year and all costs for over 15 visits</p>	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess and all costs for stays over 10 days 50% of customary and reasonable charges and any in excess and all costs over 15 visits
Alcohol and Substance Abuse Treatment*	<ul style="list-style-type: none"> Inpatient: As medically appropriate to remove toxic substances from the system Outpatient: 20 visits per benefit year (the number of visits may be increased in a benefit year if outpatient services are determined medically necessary) 	<p>15% of negotiated fee rate</p> <p>15% of negotiated fee rate for 20 visits per year and all costs for over 20 visits unless additional visits are determined medically necessary</p>	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess and all costs over 20 visits
Home Health Care	Home health services through a home health agency or visiting nurse association	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for subscribers who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	<p>Skilled nursing care</p> <p>Covered when determined to be a medically appropriate more cost-effective alternative plan of treatment</p>	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Infusion Therapy*	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess for all infusion therapy related administrative, professional, and drugs

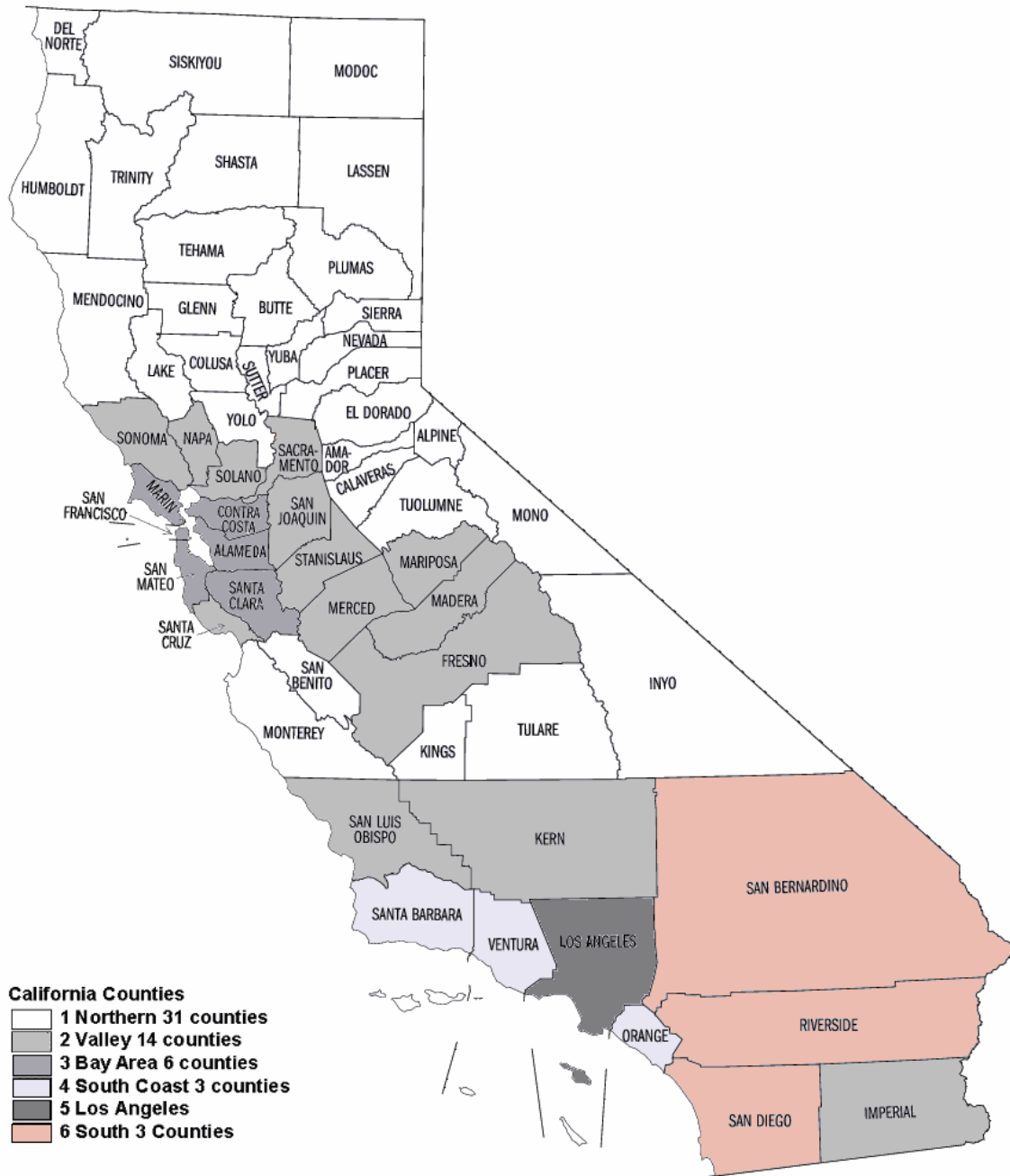
California Response
 Solicitation to Operate Federal High Risk Pool

Appendix A
California Pre-Existing Condition Insurance Plan Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What Subscribers Pay Participating Provider</i>	<i>What Subscribers Pay Non-Participating Provider</i>
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

* Exact terms and conditions of coverage will be provided to subscribers in the Certificate of Coverage booklet.
 ** Preventive care services are covered with no charge even if subscribers have not met the annual deductible.

Appendix B California PCIP Geographic Rating Regions



Appendix B PCIP Geographic Regions Counties in Each Region					
Region 1 Northern	Region 2 Valley	Region 3 Bay Area	Region 4 South Coast	Region 5 Los Angeles	Region 6 South
Alpine Amador Butte Calaveras Colusa Del Norte El Dorado Glenn Humboldt Inyo Kings Lake Lassen Mendocino Modoc Mono Monterey Nevada Placer Plumas San Benito Shasta Sierra Siskiyou Sutter Tehama Trinity Tulare Tuolumne Yolo Yuba	Fresno Imperial Kern Madera Mariposa Merced Napa Sacramento San Joaquin San Luis Obispo Santa Cruz Solano Sonoma Stanislaus	Alameda Contra Costa Marin San Francisco San Mateo Santa Clara	Orange Santa Barbara Ventura	Los Angeles	Riverside San Bernardino San Diego

Appendix C

California PCIP Subscriber Premiums Effective Through December 31, 2011

Age Band	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
<15	\$145	\$138	\$140	\$127	\$142	\$127
15-29	\$199	\$195	\$201	\$180	\$200	\$181
30-34	\$286	\$282	\$292	\$258	\$288	\$260
35-39	\$319	\$314	\$325	\$288	\$321	\$289
40-44	\$337	\$332	\$344	\$304	\$339	\$306
45-49	\$369	\$364	\$377	\$334	\$371	\$335
50-54	\$494	\$481	\$499	\$445	\$495	\$448
55-59	\$627	\$608	\$624	\$564	\$625	\$567
60-64	\$796	\$780	\$802	\$720	\$799	\$723
65-69	\$891	\$873	\$899	\$806	\$895	\$810
70-74	\$939	\$920	\$947	\$849	\$943	\$853
>74	\$995	\$975	\$1,003	\$899	\$999	\$904

Appendix D
Actuarial Certification of the Cost Proposal for the
California Pre-Existing Condition Insurance Program

I, Peter B. Davidson, am associated with the firm PricewaterhouseCoopers. I am a Member of the American Academy of Actuaries and meet its qualification standards to attest to the actuarial soundness of the projections in the cost proposal submitted by the State of California to the United States Department of Health and Human Services (DHHS) for the establishment of a Pre-Existing Condition Insurance Plan (PCIP). I have been retained by the State of California Managed Risk Medical Insurance Board (MRMIB) to assist in the development of actuarial projections and to prepare an actuarial attestation of the Cost Proposal for the California PCIP for filing with DHHS. The cost proposal covers program enrollment from September 2010 through December 31, 2013, with consideration of claims runout and other continuing costs through 2014.

In the development of California's cost proposal, it is my opinion that reasonable and appropriate methods and assumptions were applied to estimate future enrollment levels, premium revenue, and claims costs. Detailed descriptions of the methodology and assumptions used in the development of the projections are contained in reports and other communications provided to the MRMIB and are available for DHHS review upon request. I believe that the cost proposal is actuarially sound; that is, it has been developed in accordance with generally accepted actuarial principles and practices, complies with the requirements of Section 1101 of the Patient Protection and Affordable Care Act and subsequent direction provided by DHHS, and is appropriate for the estimated population to be covered, the services to be furnished, and the premiums to be charged under this program. The benefit plan offered under California's PCIP is consistent with the federal statutory requirement that the issuer's share of costs is not less than 65 percent of the total costs of the benefits provided.

In the development of the values contained in the cost proposal, I relied upon the accuracy of historical state high-risk pool enrollment and claims, other data, and assumptions provided by MRMIB and other entities. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data. Actuarial methods, considerations, and analyses used in developing the cost estimates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial Standards Board. The California cost proposal to which this certification is attached is based on a projection of future events. Since limited data exist on which to base predicted enrollment levels, risk mix, and claims costs in the PCIP, it is certain that actual experience will vary from the

California Response
Solicitation to Operate Federal High Risk Pool

values contained in the cost proposal. Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. Because of the uncertainty associated with the assumptions underlying the cost proposal, I recommend on-going monitoring, and as appropriate, adjustments to the program benefits, subscriber premiums, and/or enrollment to ensure that expenditures under the program do not exceed limits set by DHHS.



Peter B. Davidson, FSA

Member, American Academy of Actuaries