

BILL ANALYSIS

MANAGED RISK MEDICAL INSURANCE BOARD

Author: Dymally	Bill Number: AB 2
Sponsor: Author	Version: Introduced 12-4-06
Subject: Major Risk Medical Insurance Program	
Position: Support	

SUMMARY

AB 2 would make the following significant changes in the Major Risk Medical Insurance Program (MRMIP), California's high risk health insurance pool for medically uninsurable individuals, and in the Guaranteed Issue Pilot Program (GIP) that offers guaranteed issue, private market coverage to individuals terminated from the MRMIP after 36 months:

- (1) Supplement the MRMIP's current, capped funding (\$40 Million annually from the Cigarette and Tobacco Surtax Fund (Proposition 99)) with a monthly "per covered life" fee on health care service plans and health insurers sufficient to permit coverage of all eligible individuals.
- (2) Require health insurers and health care service plans to either (1) participate in MRMIP and subsidize coverage or (2) pay a fee that would contribute to the costs of the MRMIP.
- (3) Modify statutory language on MRMIP benefits to (1) eliminate annual benefit caps; (2) provide for maximum lifetime benefits of \$1 million; (3) make a six-month pre-existing condition exclusion or alternative three-month waiting period mandatory for certain subscribers; (4) permit deductibles over \$500/year contingent on certain board determinations; and (5) explicitly refer to disease management and other cost containment strategies.
- (4) Extend the sunset date for the GIP from January 1, 2008, to July 1, 2008. Prescribe procedures for transitioning GIP subscribers back into MRMIP.
- (5) Prospectively substitute MRMIP coverage for private market, guaranteed issue coverage under the federal Health Insurance Portability and Accountability Act (HIPAA) and state conversion law; provide optional MRMIP eligibility for individuals already receiving private market HIPAA or conversion benefits.
- (6) Require two declinations instead of one for individuals basing their MRMIP eligibility on declination by private market carriers; require the board to establish a list of health conditions conferring automatic MRMIP eligibility.
- (7) Give the MRMIB authority to adjust subscriber premiums to reflect subscribers' ability to pay, to the extent that additional sources of state or federal funding are available; limit these additional subsidies to individuals at or below 200 percent of the federal poverty level (FPL); limit these additional subsidies so that all subscribers pay at least 115 percent of market rates for MRMIP coverage.
- (8) Create a MRMIP advisory panel to address implementation of the carrier fee as well as quality and cost-effectiveness of health care; create a task force to advise the MRMIB and the Legislature on quality and cost-containment strategies for MRMIP.

PURPOSE OF THE BILL

The purpose of the bill is to provide a means of guaranteeing access to affordable, comprehensive health care coverage for persons carriers refuse to insure or "rate up" based on medical conditions.

POSITION AND SUPPORTING ARGUMENTS: SUPPORT

AB 2 offers a long term, stable solution for providing health coverage to all medically uninsurable persons willing to purchase it. A solution now is essential: 1) The GIP – a pilot program in which MRMIP subscribers lose eligibility after 36 consecutive months and instead can purchase guaranteed issue health coverage subsidized jointly by the state and individual market carriers – sunsets September 1, 2007. 2) Continuing the GIP seems infeasible since it results in carrier losses that are not spread equitably across the industry and are borne only by carriers who voluntarily chose to participate in MRMIP. 3) The \$40 million capped appropriation for MRMIP always has been inadequate, resulting in frequent, long waiting lists over the past 15 years. 4) Even with the infusion of carrier funds under the GIP, the MRMIP had to re-impose a waiting list for coverage in May 2006, and further reduced enrollment through attrition. Between May and September, 2006, the waiting list grew to over one thousand individuals. A one-time appropriation of an additional four million dollars in 2006 permitted MRMIB to offer enrollment to everyone on the MRMIP waiting list but this infusion of funds was a temporary measure.

The AB 2 approach is consistent with principles the board adopted at its March 22, 2006 meeting.

- It provides sufficient funding to make comprehensive health coverage available to all medically uninsurable individuals who are willing to purchase it.
- It eliminates annual benefit caps that result in cost-shifting to medically uninsurable individuals and thereby makes benefits in the MRMIP more compatible with the needs of the target population.
- It spreads the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the group and individual market so that the ultimate cost does not fall disproportionately on a small number of health insurance purchasers.
- It gives the MRMIB some authority to address premium affordability in calculating the necessary funding for the MRMIP.
- By eliminating the GIP, which contains disincentives for carriers to participate in the MRMIP, it promotes consumer choice of health plans within MRMIP.

BACKGROUND AND LEGISLATIVE HISTORY

The MRMIP and the GIP

The MRMIP is a high risk health insurance pool which provides access to comprehensive health insurance coverage for Californians who are unable to obtain coverage in the private individual market because they are considered to be medically uninsurable. The MRMIP, established by Chapter 1168, Statutes of 1989, is administered by the MRMIB, and has been accepting subscribers since 1991. MRMIP subscribers pay monthly premiums at rates significantly higher than standard market rates – between 125 percent and 137.5 percent – for coverage from private health plans and insurers under contract with MRMIB. Subscriber premiums cover over half of the total cost of the program. The remainder of the program's cost is subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99).

Because the funding for the program normally has been fixed at \$40 million annually (\$30 million in the MRMIP statute, \$10 million through annual appropriations), the MRMIB has established enrollment caps to ensure that costs do not exceed annual appropriations. This appropriation has proved to be an inadequate source of funding for the pool and has resulted in

long waiting lists to enroll in the MRMIP during much of the MRMIP's existence. Furthermore, in order to avoid even more stringent enrollment caps, the MRMIB has, by regulation, included a \$75,000 annual benefit cap in the MRMIP benefit design. While less than one percent of subscribers reach the benefit cap each year, those who do are high-cost individuals who must bear the costs or liability for treatment themselves or forego needed health care. Even though the MRMIP's target population is uninsurable individuals, nineteen percent make no medical claims at all and 80 percent have annual claims at or under five thousand dollars.

In response to the previous governor's direction to MRMIB to work with the Legislature and insurance industry to find market-based solutions for extending coverage to this high-risk population, the Legislature and the Governor enacted AB 1401 in 2002 (ch. 794, Statutes of 2002). AB 1401 established a pilot program, referred to as the Guaranteed Issue Pilot Program (GIP), in which subscribers are limited to 36 consecutive months of enrollment in the MRMIP; after that, they are eligible for post-MRMIP guaranteed issue coverage in the private market. Every health plan and insurer that sells individual health policies in the private market must offer a statutorily-defined guaranteed issue product to these former MRMIP subscribers. Each GIP product is identical to a MRMIP product, except that the annual GIP benefit cap is \$200,000 rather than \$75,000. MRMIP and GIP products all have maximum lifetime benefits of \$750,000.

Unlike the MRMIP program, in which the state pays for most of the losses associated with care provided to subscribers, in the GIP the carriers and the state equally share the cost of any health care costs above the premiums paid by the subscribers. The state's contributions to the MRMIP and the GIP are both funded by the \$40 million annual appropriation; sharing the cost of the GIP subsidy between the state and the carriers permits coverage of more individuals with the same appropriation. Under the GIP, carriers contributed approximately \$29.3 million through 2005, and were expected to contribute an estimated \$17.1 million in 2006.

Nevertheless, state costs for the MRMIP and the GIP have grown significantly, further reducing the number of individuals who can be enrolled in the MRMIP. Even with the carrier revenue the GIP provided, in May, 2006, MRMIB had to impose a new MRMIP waiting list and a requirement that the total enrollment be further reduced through attrition. Between May and September, 2006, the waiting list grew to over one thousand individuals. In 2006, a one-time appropriation of an additional four million dollars through SB 1702 permitted MRMIB to offer enrollment to everyone on the waiting list. The program has not yet exhausted the appropriation but will be performing another evaluation this year to determine when it will be necessary to reinstitute the waiting list.

In addition, most GIP participants choose the GIP health plan operated by their previous MRMIP carrier. As a result, plans participating in the MRMIP – especially the MRMIP plan with the greatest enrollment – disproportionately shoulder the industry portion of the subsidy for the GIP; plans in the individual market do not share the subsidy equitably. This disparity provides a disincentive for carriers to participate in the MRMIP.

Premiums within the MRMIP and the GIP appear to be unaffordable for many eligible individuals. Depending on subscribers' incomes, MRMIP premiums range from six to 36 percent of annual income. Annual disenrollment surveys of former MRMIP subscribers show that significant numbers disenroll because they cannot afford the monthly premium (51.1 percent, 45.6 percent, and 22.9 percent of those disenrolled in 2003, 2004 and 2005, respectively).

GIP premiums are more expensive than MRMIP premiums; they are statutorily fixed at 110 percent of premiums for the comparable MRMIP products. This pricing appears to have

affected enrollment in GIP plans. Of the first and largest group of individuals disenrolled from the MRMIP – 9,140 on September 1, 2003 – only about 75 percent initially enrolled in GIP coverage. By June, 2005, only 58 percent of all GIP-eligible individuals were enrolled in a GIP plan. While 41 percent of “GIP decliners” in a recent survey said they had obtained other coverage through a job or a spouse, 53 percent said they could not afford the monthly premiums. Participants in the survey were not limited to one reason. It is not known whether the coverage purchased by “GIP decliners” was satisfactory or adequate.

The legislation creating the GIP sunsets January 1, 2008.

Recent Legislative History

In 2006, the California Legislature considered AB 1971 (Chan), which would have supplemented MRMIP’s capped appropriation with a monthly “per covered life” fee on health insurers’ and health care service plans’ insured, “administrative services only” and “leased network” lives. MRMIB supported AB 1971, as did consumer groups (Health Access, AARP, Older Women’s League), the California Medical Association, and several carriers: Blue Cross of California, Blue Shield of California, Kaiser and Health Net. The carriers that supported AB 1971 have significant individual market business; three (Blue Cross, Blue Shield and Kaiser) are participating carriers within MRMIP. Opposition to AB 1971 included carriers not participating heavily in the individual market, such as Aetna, Cigna, and Pacificare.

AB 1971 failed passage. However, the Legislature passed, and the Governor signed, SB 1702 (ch. 683, Statutes of 2006). SB 1702 (1) appropriated an additional four million dollars to MRMIP in 2006 and (2) extended the GIP sunset date to January 1, 2008. With a January 1, 2008 sunset date for the GIP, MRMIB will do its last 36-month MRMIP disenrollments on September 30, 2006.

Other States’ Information

According to *“Comprehensive Health Insurance for High-Risk Individuals/A State-by-State Analysis,”* published by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), 34 states, including California, administer high risk pools for medically uninsurable individuals. California’s MRMIP is one of three state high risk pools that are funded only with state dollars and consequently have enrollment caps. Most states use some form of carrier assessment. Some states that do not directly fund their high risk pools with state dollars offset a portion of the carrier assessments through state tax credits. Despite California’s population, the MRMIP is only the third largest state high risk pool. In 2004, with enrollment of 12,221 MRMIP subscribers and 7,569 GIP subscribers, MRMIP enrollment fell behind Minnesota’s (32,959) and Texas’s (27,573).

Federal Funding

The federal Trade Act of 2002 provided state high risk pools with funding for two federal fiscal years (FFYs), 2003 and 2004, based on the state’s number of uninsured individuals. While California theoretically could have received approximately ten million dollars for each of the two FFYs funded under the Act, California was unable to receive any funding because the MRMIP did not meet the statutory criteria for a “qualified high risk pool.” The primary reason California could not meet the federal standards was the state’s inability, because of its enrollment cap, to guarantee pool participation to any and all individuals eligible for guaranteed issue private market coverage under federal law (HIPAA) as required by the Trade Act. Secondly, the federal Centers for Medicare and Medicaid Services (CMS) suggested that California also might

fail to qualify as a result of the MRMIP's \$75,000 annual benefit cap; at the time, CMS did not reach a final conclusion on the benefit cap issue.

Congress did not appropriate additional funds for FFY 2005. In February, 2006, Congress passed, and the President signed, the State High Risk Pool Funding Extension Act of 2006. Simultaneously, the Deficit Reduction Act of 2005 appropriated additional funding for FFY 2006. No funds have been appropriated yet for additional FFYs.

As a result of amendments enacted in the State High Risk Pool Funding Extension Act of 2006, California meets a newly modified federal requirement to accommodate all HIPAA-eligible individuals through a combination of the state's high risk pool and the private market. In 2006, CMS indicated definitively that California still does not qualify for funding because of the \$75,000 annual benefit cap. However, without a greater level of funding for MRMIP, lifting the benefit cap significantly would result in even more stringent enrollment caps.

Because of the \$75,000 cap, California did not qualify for the four to eight million dollars that could otherwise have been available in 2006. However, California successfully applied for a federal "seed grant" to help California become a "qualified high risk pool. CMS granted California \$150,000 to perform a "feasibility study." The study will address issues involved in enacting legislation to fund MRMIP fully, including additional information about the impact of a fee on the existing health insurance market; improved fiscal forecasts to ensure adequate funding for all qualified individuals; and further exploration of the disease management and other benefit design issues.

ANALYSIS

At its March 22, 2006 meeting the MRMIB board adopted the following principles for evaluating legislation affecting the future of the MRMIP:

- Enrollment in coverage for high risk persons should be available to all willing to purchase it.
- The structure of coverage for medically uninsured persons should not provide health plans with a disincentive to participate in the purchasing pool.
- The structure of benefits should be compatible with the medical needs of the population. It should not provide a disincentive for utilizing needed health care.
- The program should be structured and administered in a way to encourage and promote consumer choice of health plans.
- Coverage should be affordable.
- There should be some mechanism to ensure that the diverse population of California is aware of the availability of coverage for medically uninsured persons.

The key provisions of AB 2, described below, are consistent with these principles.

Comprehensive Funding for the MRMIP through Carrier Fees and Subsidies

"Play or Pay"

In order to provide funding for all eligible individuals, the bill would codify MRMIP's annual \$40 million "Proposition 99" appropriation and would give health insurers and health care service plans a choice between: (1) becoming participating carriers in MRMIP and subsidizing subscribers' coverage; or (2) paying a fee that would support MRMIP. In both cases, carriers'

fees or subsidies would depend on their share of the private health coverage market (“covered lives”), including insured lives (lives for whom the carrier provides or indemnifies health care services), “administrative services only” (ASO) lives, and “leased network” lives. “Covered lives” would not include individuals covered by Medi-Cal, Medicare, the Healthy Families Program, Access for Infants and Mothers, MRMIP, California Children’s Services (CCS), county-based “Healthy Kids” programs, and various specialized or supplemental products. Carriers opting to pay the fee would pay the fee to their regulators: the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI). The two departments already have the infrastructure in place to collect other fees on carriers.

MRMIB would calculate the level of the fee by determining the total amount needed for program costs, including funding needed for individuals previously enrolled in the GIP, net of the state appropriation and subscriber premiums. The fee for each covered life would depend on total program costs and the total number of covered lives for all carriers. The bill would cap the fee at \$1.35 per covered life.

For each carrier opting to participate in MRMIP, MRMIB would calculate an enrollment target based on the carrier’s share of covered lives in the market. Carriers enrolling fewer than their assigned number of subscribers would pay their regulators the “per covered life” fee for the difference; carriers enrolling more would be reimbursed for excess costs.

Adequate funding spread over the market

Writ large, this arrangement satisfies a key principle articulated by the MRMIB board. Specifically, the assessment mechanism would be based on the full cost of running the program. This approach would eliminate the current capped funding that has resulted in waiting lists and that also has necessitated an annual benefit limit (\$75,000), which is incompatible with mainstream, private coverage. Absent the existing special waiver from DMHC for purposes of MRMIP, the current annual benefits caps would not meet Knox-Keene regulatory standards.

The author’s decision to assess group as well as individual carriers is sound; it would spread the fee over the market at large rather than confining it to the individual market. When carriers are assessed, the costs are passed on to purchasers of health coverage. The narrower the base over which the fee is spread, the greater the impact on the cost of health coverage. It seems particularly inappropriate to require purchasers in the individual market, which already is significantly more costly than the group market, to bear the full additional cost that would result from the fee.

Furthermore, group carriers’ underwriting behavior has a direct impact on the individual market. Under current law, health care service plans and insurers generally are not prohibited from denying health coverage to individual applicants, with specified exceptions under state and federal law; or from denying coverage to group purchasers with more than 50 group members, based on the demographic characteristics, industry, preexisting health conditions, health history, health status, health service utilization or anticipated risk of health service utilization. In addition, carriers are permitted to charge higher premium rates to individuals and groups based on these factors. Therefore, group carriers’ underwriting and rating practices leave groups without health coverage and this, in turn, forces many employed individuals to seek coverage in the individual market.

In conjunction with discussions about AB 1971, MRMIB asked PricewaterhouseCoopers (PwC) to analyze the “per covered life” cost of funding MRMIP fully. PwC provided a multi-year analysis based on various scenarios, including narrower and broader definitions of “covered life”

as well as inclusion and exclusion of new HIPAA- and conversion-eligible individuals. Under a covered life definition similar to that in AB 2, the monthly “per covered life” fee for covering MRMIP and former GIP subscribers started at twenty-seven cents in the first year and grew to sixty-one cents in the fifth year. The monthly “per covered life” fee for covering new HIPAA and conversion enrollees and a portion of current HIPAA enrollees started at nineteen cents per month and grew to eighty-eight cents in the fifth year. The combined “per covered life” fee started at forty-six cents and grew to one dollar forty-nine cents in the fifth year.

The significance of separating the cost of MRMIP and former GIP subscribers from the cost of HIPAA and conversion subscribers is that, under current law, individual market carriers already subsidize HIPAA coverage and group carriers already subsidize conversion coverage. Therefore, the fee to cover these individuals would represent a change in form but not a new cost. The primary new cost to carriers would be the portion of the fee attributable to MRMIP and former GIP subscribers. This is important since, as discussed further in this analysis, AB 2 proposes to terminate new private-market guaranteed-issue coverage for HIPAA- and conversion-eligible individuals, substituting MRMIP coverage.

MRMIB staff will continue to work with PwC to refine PwC’s assumptions and to analyze the adequacy of the fee as the bill evolves.

Fees Under California Law

Under the California Constitution, (Article XIII A, sec. 3), taxes must be enacted by a two-thirds vote, whereas a variety of fees may be enacted by a simple majority vote. The Legislative Counsel digest indicates that passage of the bill will require a majority vote. Pairing carriers’ obligation to participate in MRMIP with the alternative of electing to pay a fee is consistent with a characterization of the carrier assessment as a fee and not a tax.

MRMIB Authority to Adjust Subscriber Premiums for Affordability

The bill would allow the MRMIB to adjust subscriber premiums to reflect subscribers’ ability to pay. This change in the methodology for calculating subscriber premiums would be contingent on the availability of additional state or federal funds. The board could reduce premium to not less than 115 percent of market rates for subscribers with annual income at or below 200 percent FPL.

The authority to adjust premiums in this way addresses, but does not necessarily satisfy, the board’s principle that coverage should be affordable. According to a 2005 survey of MRMIP subscribers, 27 percent had incomes below 200 percent FPL. Individuals with income below \$20,000 paid 36 percent of income for MRMIP coverage; individuals with income between \$20,000 and \$40,000 paid 19 percent of income. Under 2006 federal poverty guidelines, a family of four with income of \$20,000 is at poverty level; a family of four with income of \$40,000 is at 200 percent of FPL. It is questionable whether the subsidies permitted under AB 2 would render MRMIP premiums truly affordable for these lower income individuals. Reducing their premiums from 125 percent of market rates to 115 percent of market rates would continue to require that they pay a substantial percentage of their incomes for health coverage. This is an important issue in light of the evidence that many subscribers disenroll – and many GIP-eligible individuals did not purchase coverage – because of cost.

Eligibility Changes

The bill would make important changes in MRMIP eligibility:

Two Declinations/Qualifying Medical Conditions

The bill would require subscribers qualifying for MRMIP on the basis of rejection by a carrier to sustain two declinations; currently the law requires only one declination from subscribers qualifying on this basis. The bill also would require MRMIB to develop a list of medical conditions conferring automatic eligibility; MRMIB would base the list on common underwriting and rating practices to the extent that they are known and available to the board.

The requirement for two declinations was included in later versions of last year's AB 1971 at the urging of some carriers, who argued that this change would ensure MRMIP did not serve individuals who were insurable in the private market. Others argued against this proposed change on the basis that (1) it would delay coverage of eligible individuals and (2) it was unnecessary because agents and brokers draw on their experience and currently do not refer apparently-insurable individuals to MRMIP after only one declination. In addition, some questioned the importance of ensuring, at all costs, that the pool not include any insurable individuals; if these individuals are enrolled in MRMIP currently, it is likely that they subsidize the pool rather than adding to the pool's costs. To the best of MRMIB's knowledge, only four state high risk pools – Kansas, Montana, Oklahoma and Wisconsin – require two declinations.

While MRMIP supports AB 2, the requirement for two declinations does not appear to add value and could potentially delay enrollment of eligible individuals needing health care. The requirement for a standardized list of medical conditions ameliorates this difficulty somewhat. However, the bill directs MRMIB to base such a list on carriers' underwriting and rating practices to the extent that these are known and available; in fact, carriers closely guard their underwriting and rating practices and this information is not known and available. Furthermore, the process of identifying and verifying applicants' medical conditions during eligibility determinations may itself delay coverage. If requiring a second declination does not "fix" a real problem, then including this new requirement – along with the requirement that MRMIP develop a list of qualifying medical conditions – simply adds barriers to enrollment along with associated administrative costs.

Applicants who are "rated up"

The bill would modify current language permitting applicants to qualify because they are quoted excessive rates. The current statutory requirement is simply that the quoted rates "afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates." By regulation, the MRMIB requires that the applicant be quoted an individual market rate in excess of the rate for the applicant's first choice MRMIP plan. The proposed amendment would compare the quoted rate to the rates for the product type (HMO or PPO) the applicant seeks in MRMIP. If this requirement is maintained in the bill, MRMIB suggests that it be further refined so that the board may consider the benefit design offered by the applicable PPO or HMO product.

HIPAA- and Conversion-Eligible Individuals

The federal HIPAA law requires carriers to sell their most popular individual market products on a guaranteed issue basis to individuals who lose their group coverage and who have 18 or more months of prior "creditable" health coverage. State law requires a group carrier to sell

“conversion” products to individuals losing group coverage with that carrier. As a result of AB 1401, conversion products in California are essentially the same as HIPAA products. Both may be sold at above-market rates, but California law limits these rates.

The bill would terminate private market, guaranteed-issue coverage for new HIPAA-eligible and conversion-eligible individuals and instead would provide eligibility for these individuals in MRMIP. In addition, the bill would permit individuals already enrolled in HIPAA or conversion coverage to remain in their HIPAA or conversion plans or opt into MRMIP. Last year, carriers advocating for inclusion of the HIPAA and conversion populations in MRMIP argued that all three populations (MRMIP, HIPAA and conversion) were similar and should be treated similarly. In addition, carriers already bearing losses for HIPAA and conversion coverage did not wish to bear losses for uninsurable individuals in two different forms, i.e., HIPAA/conversion losses and the new fee supporting MRMIP.

Providing HIPAA and conversion coverage through MRMIP appears to simplify the market for high risk individuals and makes the financing of guaranteed issue coverage for similarly situated individuals more transparent. In some cases, individuals may prefer the coverage available through HIPAA or conversion to the coverage available through MRMIP. By permitting individuals already receiving HIPAA or conversion coverage to choose between their current coverage and MRMIP, the bill addresses this concern. If the bill continues to include HIPAA and conversion coverage in MRMIP, it is important to understand that, as discussed above, a significant portion of the carrier fee is not a “new” cost but rather a substitute for the losses carriers currently bear as a result of HIPAA and conversion coverage.

Modification of MRMIP Benefits

The bill would eliminate any annual cap on benefits. The bill also would require a lifetime cap on benefits of one million dollars or less and would make a six-month pre-existing condition exclusion, or alternative three-month waiting period, mandatory for subscribers other than HIPAA- and conversion-eligible individuals. In place of the current statutory maximum deductible of \$500 annually, the bill would exclude preventive services from any deductible but would permit MRMIB to include deductibles over \$500/year contingent on board determinations that such deductibles would sufficiently reduce subscribers’ annual costs and that such deductibles would be consistent with providing quality, comprehensive coverage for high-risk individuals. Currently, although the law permits up to a \$500 deductible, MRMIP products do not include any deductible.

In addition to bringing the MRMIP into compliance with federal funding standards, elimination of the annual cap complies with the board’s principle that coverage in the high risk pool should be compatible with the medical needs of uninsurable individuals. While the MRMIP’s \$75,000 annual benefit cap, imposed by regulation, is a means of living within a capped appropriation while avoiding further enrollment limits, it is, in essence, a cost-shift to those unlucky individuals who have medical expenses above \$75,000 annually. These individuals must bear the cost or liability for services above \$75,000 or must go without needed health care, while continuing to pay their MRMIP premiums in order to retain eligibility for the following calendar year.

For those who must forego necessary medical services or who receive needed services but are unable to pay, the result may be devastating. Recent media coverage has emphasized that health care costs are a predominant cause of personal bankruptcy in the United States. Increasing benefits by eliminating the annual cap will increase subscriber premiums but will spread the costs of medical care more evenly among all MRMIP subscribers: those few whose

medical needs now exceed the annual benefit cap and those whose medical costs are below the cap.

The requirement in AB 2 that MRMIP coverage include a lifetime cap on benefits of one million dollars or less continues to provide some protection for carriers paying the fee; it limits the fee the carriers may be required to pay. At the same time, it provides a limit that, unlike the current annual benefit cap, is compatible with benefits sold in the private market. Similarly, making the six-month pre-existing condition exclusion, or an alternative three-month waiting period, mandatory is compatible with products currently sold and again limits the fee the carriers may be required to pay. Currently, MRMIP imposes a three-month pre-existing condition exclusion or waiting period.

Increasingly, products sold in the commercial individual market include high-deductible health insurance products. The bill does not require MRMIB to sell such products but gives the board authority to investigate whether such products serve the best interests of subscribers. MRMIB will use some of its federal "seed grant" to explore the appropriateness of such products for medically uninsurable individuals purchasing coverage in a high-risk pool.

The bill also would make explicit that the MRMIB's authority to establish benefits within MRMIP includes disease management and other cost containment strategies. While the board does not currently lack this authority, making it explicit sets an expectation that the board will explore important issues affecting both the appropriate delivery of health care services to the target population and the cost of coverage for the state and subscribers.

Advisory Bodies

The bill would create two advisory bodies: (1) a MRMIP advisory panel to address implementation of the carrier fee as well as quality and cost-effectiveness of health care; and (2) a task force to advise the MRMIB and the Legislature on quality and cost-containment strategies for MRMIP.

The advisory panel would include eight members: four representing carriers, two representing medically uninsurable consumers, one representing the physician community and one representing business. The panel would consider both fee implementation and issues of quality and cost-effectiveness. The MRMIB would be obligated to respond in writing if it rejected a written recommendation from the panel. MRMIB would convene the panel prior to April 1, 2008. The panel composition would provide carriers with an additional opportunity to scrutinize MRMIB's determinations affecting the fee, while providing doctors and consumers the opportunity to scrutinize the adequacy of the fee as it affects quality of care.

The quality and cost containment task force – which MRMIB would convene prior to February 1, 2008 – would include representatives from carriers, health care providers, agents and brokers, consumers and subscribers. It would advise the Legislature and the board on a range of issues, including disease management; case managements; quality monitoring; provider rate limits and discounts; strategies to encourage enrollment only by medically uninsurable persons; incentives for enrollment, such as tax-favored, high-deductible health plans; and strategies to ensure ongoing enrollment rather than enrollment when the need for health care arises. The board would report to the Legislature prior to April 1, 2008, concerning the task force's recommendations and any ensuing program and policy changes.

Broker and Agent Commissions

The bill would require MRMIB to pay brokers and agents a two percent commission covering the first 12 months of enrollment for HIPAA-eligible individuals. The bill would permit commissions for other individuals under other circumstances.

Extending the GIP Sunset Date

The bill would extend the sunset date of the GIP by six months, from January 1, 2008, to July 1, 2008; under the terms of the bill, MRMIP would no longer disenroll subscribers with 36 months of continuous coverage after April 30, 2008. In addition, MRMIB could stop the 36-month terminations at an earlier date if MRMIB were able to negotiate carrier funding similar to that provided under the GIP.

In addition, instead of continuing to provide private market coverage to MRMIB subscribers who have been terminated pursuant to the GIP, the bill would amend existing law to re-incorporate GIP subscribers into MRMIP. The bill also would require MRMIB to provide notice of the upcoming sunset to all former subscribers who were terminated pursuant to the GIP and would require GIP carriers to send current subscribers an informational notice produced by MRMIB.

Elimination of the GIP is consistent with the board's principle that coverage should be available to everyone willing to purchase it; the GIP "stretched" the capped state appropriation but ultimately did not raise enough funds to make coverage available to all eligible individuals. In addition, elimination of the GIP is consistent with the board's principle that coverage should be affordable; there is evidence that high GIP premiums limited GIP enrollment. Elimination of the GIP also avoids the disruption that MRMIP subscribers experience when they are disenrolled from MRMIP and given the right to purchase GIP coverage. The proposed provisions for terminating the GIP appear administratively sound; the notice requirements provide GIP subscribers with information that should minimize disruption during the transition.

As drafted, the sunset provisions include one technical difficulty that can be easily remedied. The bill correctly recognizes that the 36-month terminations must stop earlier than the GIP sunset date; this is because, following termination of an individual's MRMIP coverage, the GIP statute gives the individual 63 days to purchase guaranteed-issue coverage. If the 36-month terminations were to continue until the GIP sunset date, individuals would be terminated without being able to obtain GIP coverage. However, the bill as drafted specifies that April 30, 2008, is the last date for 36-month disenrollments. This is one month too late. Since MRMIP 36-month disenrollments take place only on the last day of a month, the bill should be amended to substitute March 31 for April 30 in order to permit all GIP-eligible individuals to enroll in GIP products for 63 days after MRMIP disenrollment.

Time Lines and Other Technical Issues

This analysis addresses the "introduced" version of the bill. It is understood that, before its enactment, the bill will need modification to ensure that the administrative details in this updated version of last year's AB 1971 are sound. This may entail amendments to ensure that all time lines, including the GIP sunset date, are consistent and continue to make sense as they are updated from AB 1971. In addition, the funding mechanism – which now includes subsidies from carriers participating in MRMIP as well as carriers choosing only to pay a fee – may require additional detail to be fully administrable.

FISCAL IMPACT

AB 2 would result in several significant program changes that would increase enrollment, premiums and claims costs, as well as administrative costs. As the bill develops, MRMIB staff will analyze the fiscal impact.

SUPPORT/OPPOSITION

None noted at this time.

ARGUMENTS**Pro:**

- The bill would provide sufficient funding to make comprehensive health coverage available to all eligible individuals who are willing to purchase it.
- The bill would eliminate annual benefit caps that result in cost-shifting to medically uninsurable individuals and would make benefits in the MRMIP more compatible with the needs of the target population.
- The bill would spread the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the group and individual market – and would include their administered lives as well as their insured lives; this limits the impact on any one group of end users (health insurance purchasers).
- The bill would, to a limited extent, permit the MRMIB to address premium affordability in calculating the necessary funding for the MRMIP.
- The bill would remove disincentives for carriers to participate in the MRMIP and thereby promote consumer choice of health plans within MRMIP.
- The bill would create certainty about the time line for ending the GIP, thereby permitting MRMIB staff to carry out the board's statutory obligations in an orderly manner.

Con:

- The bill would continue the approach (shared by California and most other states) under which individuals pay more for health coverage simply because of health conditions that are generally beyond their control.
- The bill would limit the extent to which the MRMIB could consider affordability in determining premiums and would continue to mandate that high-risk individuals, including those with low incomes, pay higher than market rates.
- Expanding the bill's fee proposal so that TPAs also are subject to the fee would appear to spread the cost of subsidizing uninsurable individuals more broadly, limiting the impact on any one group of purchasers.

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