

Analysis of AB 1526 (Monning)
As Introduced January 19, 2012

PURPOSE

AB 1526 (Monning), as introduced January 19, 2012, would make various changes to the Major Risk Medical Insurance Program (MRMIP) in order to improve subscriber access to comprehensive health coverage and further align the program with the federally funded Pre-Existing Condition Insurance Plan (PCIP). Both programs provide health coverage for individuals with pre-existing medical conditions and are administered by the Managed Risk Medical Insurance Board (MRMIB).

SUMMARY

Specifically, AB 1526 would:

- Allow applicants to MRMIP to submit a letter from a licensed health care provider as evidence of a pre-existing medical condition. MRMIB would accept this letter as an alternative to a denial letter or an offer of health coverage at a higher than standard premium.
- Prohibit annual or lifetime benefit limits in MRMIP.
- Allow MRMIB to determine subscriber contributions (premiums) without any increase attributable to the elimination of annual or lifetime benefit limits.

RECOMMENDED POSITION: SUPPORT

- AB 1526 enables MRMIB to further its mission and legislative principles by significantly improving access to comprehensive health coverage for Californians with pre-existing medical conditions.
- By requiring MRMIB to accept licensed provider letters as proof of a pre-existing medical condition for MRMIP, AB 1526 would eliminate any coverage delays associated with the current requirement that applicants submit a denial letter from a health plan.
- By prohibiting annual or lifetime benefit limits for subscribers in MRMIP, AB 1526 would provide those individuals who most need care with the security of knowing that their health care needs will be met without the risk of incurring debt for this care.
- AB 1526 would eliminate the inequity that an individual who reaches the annual benefit limit must continue paying subscriber contributions in order to remain enrolled and eligible to receive services in the following benefit year.

- AB 1526 would enable MRMIB to administer the program consistent with California's commercial health coverage market, where aggregate annual benefit limits do not exist in mainstream products. This change would also be consistent with recent federal and state health care reform legislation that eliminates annual and lifetime benefit limits for all commercial health coverage.
- Authorizing MRMIB to calculate premiums without any increase attributable to the elimination of annual or lifetime limits ensures that modifying MRMIP benefits to align with current industry standards will not make program coverage even more unaffordable than it already is.
- Finally, AB 1526 would increase MRMIB's administrative efficiencies by enabling MRMIP to further align its eligibility requirements and benefits with those of the federally funded California PCIP, with which it shares a target population and an application.

BACKGROUND

MRMIP is a comprehensive health coverage program administered by MRMIB for Californians who are unable to obtain health coverage in the private individual market or are "rated up" (charged higher than normal premiums) as a result of a pre-existing medical condition. MRMIP has been operating since 1991. MRMIP subscribers pay monthly premiums, called subscriber contributions, at rates between 125 percent and 137.5 percent of the standard market rates for comparable coverage. Subscriber contributions currently cover approximately 78 percent of the total cost of the program. The remaining 22 percent of the program's cost is subsidized by the state, primarily through the Cigarette and Tobacco Surtax Fund (Proposition 99). MRMIB is required by law to administer MRMIP within the amount appropriated by the state budget.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA, Public Law 111-148) into law. Section 1101 of the ACA required the federal government to fund and establish a comprehensive health insurance program for individuals with pre-existing medical conditions. This program is PCIP. The ACA gave the United States Department of Health and Human Services (DHHS) the authority to operate PCIP directly or to contract with states or non-profit organizations to administer PCIP. In order to contract with DHHS to operate the program, a state must agree to maintain the annual amount it expends for its own high risk pool (MRMIP in California) in the year prior to entering into the contract with DHHS. This is often referred to as a maintenance-of-effort (MOE) requirement.

In June, 2010, state legislation (SB 227 (Alquist), Chapter 31, Statutes of 2010, and AB 1887 (Villines), Chapter 32, Statutes of 2010) was enacted, establishing California's PCIP and providing MRMIB with the authority to enter into an agreement with DHHS to administer the program. As part of the MRMIB-DHHS agreement that followed, California communicated its intention to comply with the MOE requirement

and maintain annual MRMIP funding at \$31.8 million. California's PCIP began providing coverage on October 25, 2010.

There are several features that make PCIP more attractive than MRMIP for individuals with pre-existing medical conditions. Premiums in PCIP range from approximately one third to two thirds of those in MRMIP. No less significant, however, is that there are no annual or lifetime benefit limits in PCIP. In contrast, MRMIP covers medical services up to an annual benefit limit of \$75,000 and a lifetime benefit limit of \$750,000. Unfortunately, because of a federal requirement that PCIP applicants be without health coverage for six consecutive months, the program is not available to every individual who is eligible for MRMIP, and is not available to individuals who are already in MRMIP. This creates a significant disparity in the cost and coverage between the two programs, as individuals enrolled in MRMIP must pay more to receive less in benefits.

Consistent with the eligibility requirements of MRMIP, the California PCIP initially required either a denial letter or a health plan's offer of individual coverage at a premium higher than would be charged in MRMIP. However, in August 2011, California's agreement with DHHS contract was modified to allow enrollment based on a letter from a licensed health care provider testifying to a medical condition. This change was consistent with the requirements of the federal PCIP, which DHHS operates in 23 states and the District of Columbia.

Although MRMIP provides comprehensive benefits through contracting health plans, MRMIP benefits are inconsistent with California industry norms applicable to commercial coverage because of the annual and lifetime limits. Even prior to the ACA, annual limits were nonexistent in mainstream products within California's commercial health insurance market. Under the ACA and SB 51 (Alquist, Chapter 644, Statutes of 2011) health plans offering individual and employer group coverage are now prohibited by law from imposing lifetime limits and are severely restricted in their ability to impose annual limits on essential health benefits.

ANALYSIS

Under current law, an individual who applies for MRMIP is required to submit either a denial letter from a health insurer or health care service plan or an offer of individual coverage at a higher premium than that individual's MRMIP plan choice. This requirement can lead to unnecessary delays in the start of coverage.

By contrast, an individual who applies to the federally funded PCIP may provide a letter from his or her doctor or other licensed health care provider stating that the individual has or had a medical condition. AB 1526 would allow a MRMIP applicant to provide a licensed health care provider letter as evidence of a pre-existing medical condition, as in PCIP.

Historically, the state appropriation for MRMIP has often been inadequate to fund the program fully. In order to ensure that MRMIP operates within the state's appropriation, MRMIB administers an actuarially developed enrollment cap, which is calculated and

presented to the MRMIB Board twice a year. When enrollment levels reach the cap, MRMIB establishes a waiting list. MRMIB last administered a waiting list in early 2010, just prior to the enactment of the ACA.

At the inception of the MRMIP program in 1991, MRMIB established, by regulation, a \$50,000 annual benefit limit and a \$500,000 lifetime limit. The annual and lifetime benefit limits were increased to \$75,000 and \$750,000, respectively, in 1999. At the time these limits were established, it was understood that only the rare medical procedure would exceed them; this is no longer the case.

The annual limit was initially adopted to maximize enrollment and was later maintained because, under the current MRMIP statute, eliminating it would require substantial premium increases. Specifically, under current law, MRMIB is required to calculate the MRMIP subscriber contribution rate as 125 percent to 137.5 percent of the standard average risk rate for comparable coverage in the commercial market.

Although less than one percent of subscribers reach the annual or lifetime benefit limits each year, those who do are, by definition, very sick and in immediate need of medical services. They risk either being unable to access medical care or incurring debt as a result of receiving needed health care. In addition, in order to maintain coverage for the following benefit year, individuals who reach the annual benefit limit must continue paying subscriber contributions, even as the program ceases providing services during the current year in return for those contributions. As required by the provisions of the ACA, no similar annual or lifetime benefit limits are allowed in the commercial health coverage market.

AB 1526 would prohibit MRMIB from imposing lifetime and annual benefit limits under MRMIP, therefore eliminating the current lifetime and annual benefit limits. Furthermore, in order to avoid any increases in subscriber contributions associated with this benefit change, AB 1526 would allow MRMIB to calculate the subscriber contribution amount without including any increase attributable to the cost of removing the lifetime and annual benefit limits. As a result, under AB 1526, MRMIB could increase the MRMIP subsidy within the amount appropriated in the state budget to cover any increased costs that result from the elimination of the lifetime and annual benefit limits.

At its March 22, 2006, public meeting, the MRMIB Board adopted the following set of principles to use as a reference point in considering whether or not to support legislation affecting 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.

AB 1526 advances at least three of the Board's stated principles:

- Availability of coverage: Allowing individuals to submit licensed provider letters as evidence of a pre-existing condition will avoid unnecessary delays in obtaining coverage, thus increasing availability.
- Structure of benefits compatible with medical needs of the population, without disincentives to use needed services: Prohibiting annual or lifetime benefit limits would eliminate the risk of either being unable to access medical care or incurring debt as a result of receiving needed health care.
- Affordability: MRMIB would be authorized to calculate subscriber contribution rates without any increase attributable to the elimination of the annual and lifetime benefit limits

In addition, the MRMIB's Board has adopted the following mission statement: "The California Managed Risk Medical Insurance Board (MRMIB) provides and promotes access to affordable coverage for comprehensive, high quality, cost effective healthcare services to improve the health of Californians." This legislation would allow MRMIB to eliminate two significant obstacles to achieving this mission. By allowing individuals to submit licensed provider letters as evidence of a pre-existing condition, this legislation would increase access. By prohibiting annual or lifetime benefit limits without requiring an associated premium increase, this legislation would significantly improve coverage and cost-effectiveness.

FISCAL IMPACT

AB 1526 would be cost-neutral to the state because MRMIB is required by law to administer MRMIP within the amount appropriated by the state budget and California has agreed to maintain the MRMIP appropriation pursuant to the ACA Maintenance of Effort provision.

In its proposal to contract with DHHS to administer PCIP (later incorporated into the California contract with DHHS), California communicated its intention to comply with the MOE requirement and maintain annual MRMIP funding at \$31.8 million. Yet MRMIP continues to experience a downward trend in enrollment as an increasing number of eligible individuals are opting to enroll in PCIP. As of February 1, 2012, MRMIP enrollment was 6,196, well below the current enrollment cap of 8,000.

According to MRMIB's consulting actuary, if the lifetime and annual benefit limits are removed and MRMIB is allowed to calculate subscriber premiums without reference to

this benefit modification as proposed in AB 1526, MRMIP would need to increase annual expenditures by approximately \$16 million. Staff estimates that this amount can be budgeted within the current appropriation without lowering the enrollment cap.

PRO / CON ARGUMENTS

- Pro**
- By allowing licensed provider letters as proof of a pre-existing medical condition, this bill would enable applicants who are otherwise eligible for MRMIP to avoid unnecessary delays in obtaining coverage.
 - By eliminating the annual and lifetime benefit limits in MRMIP, this bill would provide those individuals who need care most with the security of knowing that their health care needs will be met without the risk of incurring debt.
 - AB 1526 would eliminate the inequity that an individual who reaches the annual benefit limit must continue paying subscriber contributions in order to be enrolled and eligible to receive services in the following calendar year.
 - By eliminating the annual and lifetime benefit limits in MRMIP, this bill would enable MRMIB to fulfill its mission and stated principles, providing comprehensive health coverage compatible with the medical needs of the population without disincentives for using needed services.
 - This bill would provide an increased level of MRMIP benefits without decreasing affordability.
 - This bill would enable MRMIB to administer MRMIP in the spirit of recently enacted state and federal reforms prohibiting annual and lifetime benefit limits in the commercial health insurance market.
 - This bill would improve MRMIB's administrative efficiencies by further aligning MRMIP benefits and eligibility requirements with PCIP, with which it shares an application.
 - As a result of the maintenance of effort requirement for PCIP and the requirement that MRMIB administer MRMIP within its appropriation, this bill would be cost-neutral to the state.
- Con**
- If MRMIP claims costs are higher than estimated after eliminating the annual and lifetime benefit limits under this bill, MRMIB may be required to lower the enrollment cap thus preventing coverage for some individuals who may not be eligible for PCIP. However, all individuals who enroll in MRMIP will have the security of knowing that their health coverage will not cease at the time they most need services.

SUPPORT/OPPOSITION

Support

AARP
AFSCME

Opposition

No known opposition

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