



**The California Managed Risk Medical Insurance Board**

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July 28, 2009

The Honorable Kevin de Leon  
Chair, Assembly Committee on Appropriations  
State Capitol, Room 2114  
Sacramento, CA 95814

**RE: SB 227 (Alquist) as amended on July 13, 2009 – Health Care Coverage: Support**

Dear Assembly Member de Leon:

The Managed Risk Medical Insurance Board (MRMIB) **supports SB 227 (Alquist) as amended on July 13, 2009, set to be heard in the Assembly Committee on Appropriations.** The bill would, for the first time, ensure long term, stable funding for the Major Risk Medical Insurance Program (MRMIP), allowing expansion of the program to cover more individuals. It would broaden the funding for MRMIP by requiring carriers in the individual and (to a limited extent) the group insurance market to either pay a fee to support MRMIP or provide coverage to medically uninsurable individuals. The bill would limit the maximum subscriber contributions to no more than 125 percent of the standard average individual rate for comparable coverage. It would also eliminate the \$75,000 annual benefit cap; this change would eliminate any known barrier to receiving federal high-risk pool funding. SB 227 would also require MRMIB to establish a sliding scale in establishing subscriber premiums for lower-income individuals. This would allow more access to the program by eligible individuals who find the current subscriber contributions cost-prohibitive.

**Major Risk Medical Insurance Program (MRMIP)**

MRMIP is California's high-risk health insurance pool, providing comprehensive health coverage to persons determined by health plans/insurers to be "medically uninsurable," meaning they were denied coverage because of a health condition or other underwriting practices. California has an estimated 400,000 persons who are denied coverage in the

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individual market. MRMIP served 6,719 persons in May 2009, significantly fewer people than high risk pools in other large states. For example, Minnesota has 31,000 subscribers, Texas has 28,000, Oregon has 15,000 and Wisconsin has 19,000. (2007 data, National Association of State Comprehensive Health Insurance Plans)

### **Pool Financing**

Presently, subscribers pay approximately 60 percent of the pool costs, paying premiums that, by law, are 125 to 137.5 percent of what insurable individuals would pay in the private market for the same coverage. In most years, annual state appropriations of \$40 million (\$30 million in the MRMIP statute and \$10 million through annual or one-time appropriations) have paid for the costs exceeding subscriber premiums. This year, the state budget crisis resulted in the proposed reduction of \$6.6 million in state (Proposition 99) funding for the program for 2009-10. MRMIP can only enroll the number of people that the Board's actuaries estimate can be served with the annual MRMIP appropriation. The capped funding has, unfortunately, routinely required the program to limit enrollment. For much of its history, the program has had significant waiting lists. As a result, many individuals most in need of health coverage and willing to pay a high price for it are unable to purchase it.

SB 227 would require carriers in the individual and (to a limited extent) the group insurance market to either pay a fee to support MRMIP or provide coverage directly to medically uninsurable individuals assigned to the carrier by the state. Although the carrier fee would not provide sufficient funding to cover all eligible individuals, it would provide an ongoing, stable source of funds for MRMIP, allowing expansion of the program to cover more eligible individuals.

### **Removal of the Annual Benefit Limit**

Coverage with an annual benefit limit is not sold in California's mainstream commercial market. However, due to the current capped appropriation for MRMIP, the program imposed a \$75,000 annual benefit limit (originally a \$50,000 limit) for enrollees in order to use available funds to enroll more people and limit subscriber premiums.

A 2006 report, "Major Risk Medical Insurance Program: Benefit Design Review" indicated that California's \$75,000 annual benefit cap is the lowest in all of the nation's high-risk pools; most states do not have annual limits at all. The federal Centers for Medicare and Medicaid Services (CMS) determined that California's annual limit made the state ineligible for federal high risk pool funding. Thus, because of the annual benefit limit, California has forfeited its chance at receiving a share of \$75 million available to states in federal funding.

Lastly, although few subscribers have costs exceeding the \$75,000 benefit limit, those

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who do reach or exceed it must pay out of pocket, incur debt, or forego care. As echoed in a principle adopted by the Board (Attachment 1), the program's structure of benefits should be compatible with the medical needs of the population.

SB 227 would eliminate the \$75,000 annual benefit cap and provide the necessary funds so that the cap could be eliminated without requiring a reduction in the number of individuals covered. This would probably make MRMIP eligible for the federal high-risk pool funding, when it again becomes available.

### **Pilot Project for Insurer Participation in Costs**

AB 1401 (Statutes of 2002, Chapter 794) temporarily expanded financing for coverage of medically uninsurable persons by bringing in some carrier dollars. Specifically, the Guaranteed Issue Pilot Project (GIP), which expired on January 1, 2008, (1) required MRMIP to disenroll subscribers after 36 consecutive months and (2) gave disenrolled subscribers the right to purchase similar insurance products in the individual market. Losses (medical and administrative costs over subscriber premium) were shared equally between insurance carriers and the state. Although this structure allowed the Board to eliminate the wait list for several years, insurer financing was not equitably spread across carriers in the market. The carrier costs were disproportionately paid by the insurer who carried the largest share of GIP subscribers.

Although the GIP has sunset and MRMIP ceased the 36-month disenrollments after September 30, 2007, GIP plans must continue to provide coverage to existing GIP subscribers. These continued costs have contributed to the pressure on the state's capped appropriation for MRMIP. Budget cuts and the sunset of GIP to new subscribers resulted in MRMIP waiting lists in December 2007 and many times since. As of June 1, 2009, there were about 400 individuals on the MRMIP waiting list.

By providing a source of additional funding for MRMIP, SB 227 would assist the program in reducing the number of individuals on the waiting list.

### **Affordability of Coverage**

The cost of coverage in MRMIP has become increasingly unaffordable for many eligible individuals as prices in the private individual market have increased dramatically. Past subscriber surveys have consistently pointed to price as a key reason for voluntary disenrollments from the program. By law, MRMIP prices are based on – and must exceed – market rates. Therefore, as the price of coverage in the individual market increases, so does the price of coverage in MRMIP. Cost for coverage in MRMIP for a 50-year-old (with no dependents) ranges from \$5,404 to \$10,425 a year in Los Angeles and from \$5,953 to \$14,731 a year in San Francisco, for example.

There is evidence that providing subsidies to lower income persons assists high-risk

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health insurance pools in maintaining affordable coverage. Thirty-three other states have high-risk pools. Ten of these – Wisconsin, Connecticut, New Mexico, Tennessee, Oregon, Colorado, Washington, Montana, Minnesota and Maryland – provide subsidies for lower income persons to help them afford coverage in these high risk pools (2007 data, National Association of State Comprehensive Health Insurance Plans). While enrollment has been flat and in some cases has declined slightly in many states' high risk pools, those states with low-income subsidy programs are among those that have had growth in their enrollment.

SB 227 contains provisions requiring the MRMIB Board to base the amount of subscriber premiums for lower-income individuals on family income. This would allow access to the program by more eligible individuals who have found the subscriber contributions cost prohibitive.

The bill also limits the maximum subscriber contributions to no more than 125 percent of the standard average individual rate for comparable coverage. Although this is comparable to existing premium levels paid by subscribers, the bill ensures these premiums remain at this level and do not become less affordable for subscribers over time.

### **SB 227 is Consistent with Most of the Board's Guiding Principles**

The Managed Risk Medical Insurance Board adopted principles to guide its decision in taking a position on bills affecting MRMIP. Attachment 1 summarizes these guiding principles.

In considering these principles and SB 227, MRMIB staff concluded that while SB 227 probably would not provide sufficient funding to make comprehensive coverage available to all medically uninsurable individuals willing to purchase it, it would provide a new, stable funding source that would substantially increase the number of medically uninsurable Californians who could purchase coverage. It would also spread the cost of providing coverage across a somewhat larger group of insurers and health care plans.

### **SB 227 in the Context of National Health Care Reform**

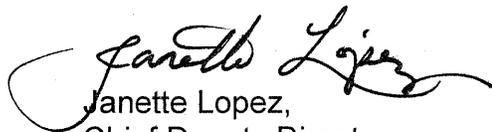
The Board is hopeful that the President and Congress will be able to enact major health care reform this year. It is possible that national health care reform would reduce or eliminate the need for a separate program for medically uninsurable individuals. In the meantime, however, the need for MRMIP to continue to provide comprehensive health insurance coverage for these individuals will remain. Whether there remains a long term need for MRMIP will depend on the details of any reforms enacted.

We urge you to support increased financing for affordable coverage for the medically uninsurable by voting for passage of SB 227 (Alquist).

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If you have any questions, please contact Ginny Puddefoot, Deputy Director of Health Policy, Legislation and External Affairs, at (916) 324-0571 or at [gpuddefoot@mrmib.ca.gov](mailto:gpuddefoot@mrmib.ca.gov).

Sincerely,



Janette Lopez,  
Chief Deputy Director,  
for Lesley Cummings, Executive Director

cc: Assembly Committee on Appropriations  
Senate Member Elaine Alquist  
Mary Ader, Assembly Committee on Appropriations Consultant  
Deborah Kelch, Assembly Health Committee Consultant  
Kirk Feely, Assembly Republican Fiscal Consultant  
Lark Park, Senate Health Committee Consultant  
Kimberly Belshé, California Health and Human Service Agency  
Bob Sands, California Health and Human Service Agency  
Scott Carney, California Health and Human Service Agency  
Jennifer Kent, Office of Governor Arnold Schwarzenegger

### Attachment 1:

#### **Principles Adopted by the Managed Risk Medical Insurance Board for Legislation Concerning the Managed Risk Medical Insurance Program (MRMIP) with related provisions of Senate Bill 227 (Alquist)**

- **Provide sufficient funding to make comprehensive health insurance coverage available to all medically uninsurable individuals who are willing to purchase it.**

SB 227 would provide an additional source of revenue—an assessment on carriers in the individual market and (to a limited extent) in the group insurance market—for that would allow MRMIP to provide coverage for more eligible Californians.

- **Eliminate annual benefit caps that result in cost-shifting to medically uninsurable individuals, thereby making benefits in MRMIP more compatible with the needs of the target population.**

SB 227 would eliminate the annual benefit cap of \$75,000, which would make the benefits provided by MRMIP more compatible with the needs of the medically uninsurable.

- **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 so that the ultimate cost does not fall disproportionately on a small number of health insurance purchasers.**

SB 227 would spread the cost of subsidizing coverage for high-risk individuals across a somewhat larger pool of health insurers and health care service plans, by requiring carriers in the individual market (and to a limited extent) in the group market to either provide coverage to high-risk individuals or pay a “per life covered” fee.

- **Permit MRMIB to address premium affordability for low-income subscribers in calculating necessary funding for MRMIP.**

SB 227 would ensure that MRMIP does not become less affordable to moderate income individuals by capping the maximum allowable premium at its current level of 125 percent of the standard market rate for a comparable plan. (Although current law allows premiums to be between 125 and 137.5 percent of the standard market rate for comparable coverage, in practice the premiums have been set at 125 percent.)

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SB 227 would also permit the Board to address premium affordability in calculating the necessary funding for MRMIP.

- **Remove disincentives for carriers to participate in MRMIP and thereby promote consumer choice of health plans within MRMIP.**

SB 227 would require carriers to either provide coverage to high-risk individuals or pay a “per covered life” fee as noted above. However, the fee would not be high enough to provide carriers with an incentive to offer coverage to high-risk individuals, and so would not be expected to increase consumer choice either in MRMIP or in the private individual market.

