

Summary and Highlights of AB 2 (Dymally), 8/21/08 version

SUMMARY

AB 2 would expand the state's capacity for serving medically uninsurable persons. It does so by requiring carriers in the individual insurance market to either pay a fee to support the Major Risk Medical Insurance Program (MRMIP), the State's high-risk pool, or provide coverage directly to medically uninsurable persons assigned to carriers by the State. AB 2 would set the fee amount in statute. It requires the State to provide \$40 million in Proposition 99 funds for the MRMIP annually, the amount MRMIP has received for the last 12 years. It would make MRMIP eligible for federal high-risk pool funding by eliminating the MRMIP annual benefit cap of \$75,000. It authorizes the Major Risk Medical Insurance Board (MRMIB) to base the amount of MRMIP subscriber premiums on family income. It also makes certain changes to MRMIP eligibility requirements and requires lower cost sharing for preventive services and services that treat chronic conditions. It requires MRMIB to make several reports to the legislature on program implementation, alternative ways to cover medically uninsurable people, and the adequacy of rates charged for preferred provider organization (PPO) coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ANALYSIS

Specifically, AB 2 would:

- Set Insurer Fees. Require carriers in the individual market to serve medically uninsurable persons as assigned by MRMIB or pay a fee/life to support MRMIP to help pay for coverage in MRMIP. If the carrier chooses to accept assigned risk, the carrier can only charge the assigned subscriber 110 percent of what coverage would cost in the individual market. This compares to subscriber premiums in MRMIP of 125 percent to 137 percent of what the cost of coverage would be in the individual market. The requirement for lower premiums in assigned risk coverage will reduce carrier interest in providing such coverage.

Fee amounts are set at up to: 50¢/life/month for the number of lives enrolled on December 21, 2008 with the amount due on July 1, 2009, 75¢/life/month payable July 1, 2010 and \$1.00/life/month with the amount payable July 1, 2011. Thereafter, the fee amount remains \$1/life/month. Carriers can pay quarterly. Carriers must spread these costs across all of their lives in the private individual (non-group) market.

Earlier versions of AB 2 (and AB 1971 before it) provided for a more broadly based carrier assessment than would have been charged in all insurance markets (individual, small group, large group and administrative services). Political opposition to broad based financing from some purchasers, some carriers and labor took this option off the table. The scope of AB 2 was then dramatically cut back, no longer providing sufficient funding for the program with no enrollment caps but rather providing some revenue to sustain and make modest improvements in the program. A more robust reform, financed by fees across all insured markets (including the individual market), would have been preferable. However, it was not possible.

- Create an Alternate Assigned Risk Process. AB 2 requires MRMIB to develop a process to assign medically uninsurable persons to carriers that chose not to pay the fee. The coverage provided must be comparable to coverage provided in MRMIP. MRMIB determines how many lives a carrier must accept, taking into consideration program cost and the amount of fees paid by other carriers. In assigning lives, MRMIB is to take into account carrier service areas and shall provide subscribers with a choice of carriers, if possible.
- Establish a State Maintenance of Effort Requirement. AB 2 requires the state to provide MRMIP with \$40 million annually from Proposition 99 funds beginning July 2009. Presently, MRMIP receives \$30 million per year as a result of its authorizing legislation. The budget has provided additional funds annually, typically \$10 million. The budget for MRMIP has provided \$40 million in Proposition 99 funds since 1996. Prior to that, funding was \$30 million.
- Authorize a General Fund Loan. AB 2 authorizes MRMIB to obtain a General Fund loan, subject to the approval of the Department of Finance. MRMIB is to re-pay any loan with principal and interest by January 1, 2016.
- Eliminate Annual Benefit Limit. AB 2 eliminates MRMIP's annual \$75,000 benefit limit and specifies that the cost of the benefit increase be excluded from subscriber premiums. The annual cost of eliminating the benefit limit is approximately \$400 per person. While less than 1 percent of subscribers exceed the limit annually, those that do experience catastrophic costs that they are unlikely to be able to pay. Thus, eliminating this limit would minimize financial hardship that medically uninsurable individuals may face when forced to pay out-of-pocket costs for high-cost, chronic health conditions. If subsidy funds do not finance the benefit increase, most of the cost would have fallen on subscribers who are already paying premiums generally viewed as unaffordable.

Further, because of the annual cap, CMS has determined that MRMIP does not qualify as a qualified high-risk pool for purposes of federal funding. This is because no carriers in California's individual market have annual benefit limits, and most offer a significantly higher lifetime maximum benefit. Thus, elimination of the limit will allow MRMIP to qualify for high-risk pool funds provided in the future.

- Increase Lifetime Benefit Limit. AB 2 requires an annual maximum lifetime benefit limit of no less than \$1 million, beginning January 1, 2010. The present lifetime limit is \$750,000.
- Establish Voluntary Re-enrollment of GIP Subscribers. AB 2 requires MRMIB to establish a process allowing GIP enrollees to re-enroll in MRMIP. Presently, GIP subscribers are precluded from re-enrolling in MRMIP unless they have been without coverage for a year. Re-enrollment is limited to periods when there is no one on the MRMIP waiting list. MRMIB is to offer slots in MRMIP based on the date each person was disenrolled from MRMIP (oldest date of termination is first offered). MRMIB is also

to determine the maximum number of individuals who may return from each GIP carrier consistent with the proportion of GIP enrollees covered by each carrier. To the extent that persons now in GIP re-enroll in the MRMIP, GIP carriers would experience decreased costs.

- Potentially Reduce Premiums for Lower Income Persons. AB 2 authorizes MRMIB to reduce premiums for MRMIP subscribers at no more than 110 percent for subscribers with family incomes level at or below 300 percent of the Federal Poverty Level (FPL) (currently \$42,000 for a family of two persons). Current law sets rates between 125 percent and 137.5 percent regardless of income. The ability of MRMIP to implement this provision depends on funding. It does not appear that funding from AB 2 will be sufficient to implement this provision.
- Establish an Advisory Panel. AB 2 creates an 11-member volunteer Advisory Panel to advise MRMIB on MRMIP. The panel, appointed by MRMIB, must include representatives of four carriers providing coverage in the individual market (at least three of which participate in MRMIP), two MRMIP subscribers, two health care providers with expertise with treating chronic diseases, at least one of whom is a doctor, and three organizations representing health care consumers and medically uninsurable persons. In addition, there would be two ex-officio (non-voting) members: the Department of Managed Health Care (DMHC) Director and the Department of Insurance (DOI) Commissioner or their designees. The panel is to be ready to meet on or by February 1, 2008.
- Reduce Cost-Sharing for Certain Services. AB 2 requires lower subscriber cost-sharing for primary and preventive health services, and for services that treat chronic conditions, beginning January 1, 2010. Current law does not differentiate MRMIP subscribers' cost-sharing by type of service.
- Increase Pre-existing Condition Exclusion Period. AB 2 increases MRMIP's pre-existing condition exclusion (pre-ex) for PPO subscribers from 3 to 6 months as of January 1, 2009 and sets the exclusion period in statute. Presently, MRMIB has discretion in setting the pre-ex as long as it does not exceed 6 months. As is presently the case, pre-exes would not be applied to those who had prior coverage within specified time periods.
- Delete Cap on Deductible. AB 2 deletes provisions of existing law that limit the MRMIP to an annual maximum deductible of \$500. It does not establish a new maximum but leaves the deductible level up to the Board.
- Increase Eligibility Requirements. AB 2 requires that applicants provide evidence of rejection by two carriers for eligibility to enroll in MRMIP, effective January 1, 2010. Current law requires only one.
- Requires a Transition Plan. AB 2 requires MRMIB to develop a plan to transition to an alternate sustainable long-term mechanism for coverage of medically uninsurable

individuals by January 1, 2013. This could involve risk-adjustment or re-insurance. The report on the plan is due to the Legislature by July 1, 2011.

- Requires an Implementation Report. AB 2 also requires that MRMIB report to the Legislature by July 1, 2011 on the implementation of AB 2, including the number of persons enrolled in the MRMIP, program costs and revenues, the average cost per subscriber, and a comparison of the average cost increases of MRMIP coverage compared with the rate changes in the private market.
- Requires a Report on HIPAA. Requires MRMIB to report to the Legislature by September 1, 2009 about the status of benefits and premiums provided to persons eligible for coverage under HIPAA. Under existing law, premiums for HIPAA PPOs in California are based on MRMIP premiums. The report is to assess whether or not tying HIPAA PPO rates to MRMIP is appropriate. MRMIB is required to use the services of an actuary in preparing the report and to consult with the new panel, created under AB 2, and the regulators during its preparation.
- Provides Emergency Regulation Authority. AB 2 provides MRMIB, the DOI and DMHC with emergency regulatory authority, as needed to implement this bill.

FISCAL IMPACT

Revenues

AB 2 sets fee amounts at up to: 50¢/ life/month payable for the budget year, 75¢/life/month for the budget year plus one and \$1.00/life/month for every year thereafter. The table below shows revenue estimates by fiscal year.

State Budget Year	Number of Covered Lives (In millions)	Fee/life/month	Annual total (in millions)
2009/10	1.8	50¢	\$10.8
2010/11	1.8	75¢	\$16.2
2011/12 and thereafter	1.8	\$1.00	\$21.6

Estimate Assumptions: All carriers will elect to pay fees rather than provide assigned risk coverage. There are 1.8 million lives in the individual market. MRMIB has no data on whether the number of lives will increase over time, so estimate assumes 1.8 million annually. If the number increases, revenues would be higher.

Note: SB 1379 (Ducheny), enrolled and pending action by the Governor, would transfer \$10 million to MRMIP for the current budget year. It is unclear how much revenue it will provide in future years.

Federal Funding: Once MRMIB eliminates the annual benefit limit, CMS will consider MRMIP a qualified high-risk pool. MRMIP will then be eligible for federal funds provided for high-risk pools.

Costs

MRMIB must manage MRMIP within the funds provided. MRMIB estimates that with the revenue from SB 1379 and AB 2 (assuming enactment of both bills), it will be able to:

1. Eliminate the waiting list for MRMIP in the current year;
2. Increase the number of funded slots by 25 percent (1,790) through 2011/12. This would increase the enrollment cap from the present 7,100 to 8,890.
3. Fund the increased costs associated with removing the annual benefit cap through 2011/12; and
4. Fund support and administrative cost as described below.

It is unlikely that MRMIB would have sufficient funds to reduce premiums for subscribers with family incomes under 300 percent of FPL.

Note that the estimates above are MRMIB's. Prior to actually enrolling more subscribers or expanding benefits, MRMIB will consult with its actuary. Time has prevented consultation for purposes of this estimate. Presently, the subsidy for MRMIP is \$3,300/year, an amount which will increase by medical trend estimated at 10 percent/year. The estimated cost of lifting the annual benefit limit is \$400 annually/subscriber beginning January 1, 2010 (half year).

State Maintenance of Effort: AB 2 requires the state to provide MRMIP with \$40 million annually from Proposition 99 funds beginning July 2009. Presently, MRMIP receives \$30 million per year as a result of its authorizing legislation. The budget has provided additional funds annually, typically \$10 million. The budget for MRMIP has provided \$40 million in Proposition 99 funds since 1996. Prior to that, funding was \$30 million.

General Fund Loan: AB 2 authorizes a General Fund loan. MRMIB will experience costs in 2008/9 (see below). These costs could either be paid for with a General Fund loan or with revenue received from SB 1379.

Administrative Costs

MRMIB estimates that at least 4.5 additional positions will be needed to implement AB 2's requirements. Estimated costs are \$184,000 in 2008/09 and \$475,000 annually thereafter.

In addition, \$395,000 will be needed in 2008/09 and \$500,000 annually thereafter to fund:

- Increased costs of the administrative vendor for the increased enrollment and system changes required by AB 2;
- Consultants to assist with required reports; and
- Additional actuarial services

With these costs, the percentage of funds spent on administration will equal approximately 4 percent of overall program revenue (\$2.1 million).

SUPPORT/OPPOSITION**Support (08/25/08)**

AARP
 American Cancer Society
 American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO
 Blue Shield of California
 California Alliance for Retired Americans
 California Association of Health Underwriters
 California Medical Association
 California Managed Risk Medical Insurance Board
 California Seniors Coalition
 Health Access California
 Health Net
 Hemophilia Council of California
 Mayor Antonio Villaraigosa, City of Los Angeles
 Older Women's League of California
 Western Center on Law and Poverty

Opposed (8/25/08)

Aetna
 Cal-Tax
 California Department of Insurance Commissioner
 California Manufacturers and Technology Association
 California Right to Life Committee, Inc.
 Howard Jarvis Taxpayers Association

No Position

Association of California Life and Health Insurance Companies (ACLHIC)
 PacifiCare

VOTES

House	Location	Date	Vote
Assembly	Floor	8/30/08	46-29-5
Senate	Floor	8/26/08	23-14-3

Senate Bill 1379 (Ducheny):
Funding for the Major Risk Medical Insurance Program (MRMIP) and
the Steven M. Thompson Physician Corps Loan Repayment Program (STPCLRP)

Background

Under current policy and practice, the Department of Managed Health Care (DMHC) assesses and collect fines from health plans. Due to a loop-hole in the law, currently these fines are used to reduce health plans' annual fees paid to the DMHC.

SB 1379, an urgency measure, would instead transfer the first \$1 million of the fines to the Steven M. Thompson Physician Corps Loan Repayment Program (STPCLRP), and any additional funds would support the MRMIP. In 2008, it would transfer \$10 million to the MRMIP, and \$1 million to the STPCLRP.

The STPCLRP, administered by the Office of Statewide Health Planning and Development, assists physicians who practice in medically underserved areas with repaying educational loans.

Highlights

SB 1379 would:

- In the 2008/2009 State Budget Year:
 - Create the Managed Care Administrative Fines and Penalties Fund, a Special Fund, within the State Treasury. The DMHC would deposit any fines or paid by health plans into the new Fund.
 - Transfer \$1 million from the new Fund to the STPCLRP, administered by the Office of Statewide Health Planning and Development. This program assists physicians who practice in medically underserved areas with repaying educational loans.
 - Transfer \$10 million from the new Fund to the MRMIP.
- Beginning September 1, 2009, and annually thereafter, transfer the first \$1 million of health plan fines collected by the DMHC from the new Fund to the STPCLRP. Any additional funds in the new Fund would then be transferred to the MRMIP.

Fiscal Impact

Revenue from these DMHC fines will not be a source of predictable, ongoing funding for the MRMIP. However, to the extent that additional funding is received it will assist the MRMIP in providing health coverage for MRMIP subscribers. The history of such fines and penalties from 2000-2001 State Budget Year through current State Fiscal Year is shown on the next page.

State Fiscal Year	Fines Collected by DMHC
2000-01	\$ 409,000
2001-02	\$ 640,000
2002-03	\$2,116,000
2003-04	\$ 779,000
2004-05	\$1,141,000
2005-06	\$ 965,000
2006-07	\$3,907,000
2007-08	\$7,018,000
2008-09	\$13,000,000

Positions Taken

Support:

California Medical Association (sponsor)
California Academy of Family Physicians
California Healthcare Districts
Regional Council of Rural Counties

Opposition:

California Association of Health Plans

Votes

House	Location	Date	Vote (no-yes-no vote)
Senate	Floor	8/29/08	38-1-1
Assembly	Floor	8/25/08	73-0-7