Managed Risk Medical Insurance Board
Minutes of September 24, 2003, Meeting

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, M.P.H.
Ex Officio Member Present:	Ed Mendoza
Staff Present:	Lesley Cummings, Joyce Iseri, Laura Rosenthal, Lorraine Brown, Irma Michel, Tom Williams, Stuart Busby, JoAnne French, Dennis Gilliam, Sandi Hunt (PwC), Mauricio Leiva, Vallita Lewis, Janette Lopez, Ernesto Sanchez, Doug Skarr, Sarah Soto-Taylor, Mary Watanabe

The meeting was held at the interim City Council Chambers in Sacramento.

Chairman Allenby convened the meeting and announced commencement of the Executive Session. Following completion of the Executive Session, Chairman Allenby continued the public portion of the meeting.

REVIEW AND APPROVAL OF MINUTES OF SEPTEMBER 3, 2003, MEETING

A motion was made and unanimously passed to approve the minutes of September 3, 2003, meeting.

LEGISLATIVE UPDATE

State Bill Summary

Laura Rosenthal updated the Board on changes to bills that had occurred since that last Board meeting. All of the bills are awaiting the Governor's signature with the exception of AB 343 (Chan), which was sponsored by MRMIB. AB 343 is a two-year bill that will be taken up again next year. Chairman Allenby asked if there were any questions or public comment; there were none.

SB 2 (Burton & Speier) Update

Lesley Cummings presented a description of SB 2 as passed by the Legislature. She pointed out some of the key changes between the final version of SB 2 and the version presented at the last Board meeting.

The bill will affect businesses with 50 or more employees, and would be extended to employers of 20 to 49 employees if a tax credit were created. Employers of 200 or more are also required to cover dependants. January 1, 2006, is the effective date for employers of 200 or more; and January 1, 2007, is the effective date of employers of 50 to 199.

Market rules are different for employers with between 2 and 50 employees and those with 51 to 199 employees, while there are no market rules for employers of 200 or more. If the employer fee is found to be invalid, all market reforms become nullified.

Carriers in the market must make reasonable efforts to contract with safety net providers. MRMIB is to contract only with carriers that can demonstrate compliance.

Like authorities provided for MRMIB's other programs, SB 2 exempts MRMIB contracts from DGS contract review and allows the Board to discuss plan and administrative vendor contract strategy in executive session.

Both DHS and MRMIB are required to develop premium assistance programs to provide financial assistance to employees so that they can purchase employer-sponsored coverage in lieu of enrolling in Medi-Cal or HFP. During negotiations on SB 2, advocates expressed concern that (mandated) coverage for dependants in the over-200 group may fall below the coverage level offered by HFP. Chairman Allenby said MRMIB and Medi-Cal would have to create a wrap-around benefit and devise a way to make it available. Ms. Cummings said while creating a wrap-around product would not be difficult, the challenge would be comparing the benefits in the various employers' plans. In addition, the federal government may not approve premium assistance in this context.

She added that some expected a lawsuit to be filed challenging whether SB 2's requirements interfere with federal law under ERISA. If there were litigation, the Board would still likely proceed with program implementation, unless enjoined from doing so. The Governor has until October 12 to sign SB 2.

A companion bill to SB 2, AB 1528 (Cohn), establishes a commission to oversee cost and quality of care. The commission is to issue a report by January 1, 2005 making recommendations for health care quality improvement and cost containment. MRMIB is required to consider these findings.

Dr. Crowell asked if there are provisions in SB 2 for increasing MRMIB's staff.
Ms. Cummings said the bill authorizes a general fund loan for MRMIB's start-up costs, but that the loan must be appropriated by the legislature. Thus, currently there are no funds for start-up. Dr. Crowell asked how such a loan would be repaid if the lawsuit prevails and fees were never collected. Ms. Cummings replied that no provision was made for such a circumstance.

Mr. Mendoza asked for more clarification about the relationship between the commission established by AB 1528 and MRMIB. Ms. Cummings answered that MRMIB does not have a particular role except to consider the commission's findings.

Chairman Allenby asked if there were any further questions or public comment. Vivian Huang from the California Primary Care Association (CPCA) said CPCA supports the effort to expand health care coverage and would like MRMIB to make a reasonable effort to ensure that plans contract with safety net providers. CPCA would also like to work with MRMIB in the creation of the premium assistance program. Chairman Allenby asked Ms. Huang what she thought of the way that HFP addresses participation of traditional and safety net providers. She replied that CPCA liked the HFP approach and looks to it as a model for SB 2. Chairman Allenby thanked her for her comments and asked if there were any other questions or comments; there were none.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry (SPE) Reports

Ernesto Sanchez reported that there were 690,000 children enrolled in HFP as of September 24, 2003. He reviewed enrollment data that included the ethnicity and gender of the subscribers, and the top five counties of enrollment. The SPE has processed 1,060,392 cumulative applications to date. Chairman Allenby announced that standard reports such as enrollment reports may be given quarterly instead of monthly due to staff reductions and workload. He asked if there were any questions or public comments; there were none.

Administrative Vendor Performance Report

Ernesto Sanchez presented the Administrative Vendor Performance Report for August. Electronic Data Systems (EDS) is currently the administrative vendor for HFP and SPE. EDS met all seven performance standards for HFP and all four performance standards for SPE. Chairman Allenby asked if there were any questions or public comment; there were none.

Administrative Vendor Transition Status

Lesley Cummings reviewed the workplan for the administrative vendor transition, noting those tasks that had been completed since the last Board meeting. This month's summary includes EDS's tasks as well as Maximus'. Staff continues to be gratified by EDS's professionalism and assistance. Maximus' process is exceeding staff's expectations. A particular area of excellence has been the improvements that Maximus' Center for Health Care Literacy has made to HFP public materials. The next few months of the transition are critical to the success of the January 1 transition. The transition is an enormous challenge and the highest priority at MRMIB.

Randy Fritz of Maximus reviewed recent activities and goals in the key areas of systems, personnel, and facilities. He highlighted the phases for each of these three areas and indicated that tasks are getting completed on schedule and going well. Maximus has recruited some very skilled staff. He is pleased that the Board appreciates the work of the Center for Health Care Literacy. He said it is a delight to work with MRMIB staff. Chairman Allenby asked if there were any questions or public comment; there were none.

Nomination for Advisory Panel Vacancy

Chairman Allenby recommended approval of staff's nomination of Iantha Thompson to serve as the county public health member on the HFP Advisory Panel. A motion was made and unanimously passed to approve Ms. Thompson to the position for the length of its term (ending on July 1, 2004.)

Advisory Panel Summary

On behalf of Jack Campana, Chair of the Healthy Families Advisory Panel, Irma Michel presented a summary of the HFP Advisory Panel meeting held July 29, 2003, in Sacramento. Irma had administered the oath of office to Margaret Jacob, who joined the Panel to represent subscribers with special needs. Ms. Cummings presented the Panel with a summary of the budget and its effect on MRMIB staff. The Panel expressed concern about the reduction in MRMIB resources and decided to write a letter indicating its concern with staff reductions. Lorraine Brown reported on the Quality Improvement Work Group activities. The Panel's next meeting is November 4. Chairman Allenby asked if there were any questions or public comment; there were none.

Outreach Work Group Update

Janette Lopez presented the Outreach Work Group Update. Since, the work group meets quarterly immediately following the HFP Advisory Panel meeting, the next report to the Board will be after the next meeting set for November 4.

Ms. Lopez provided the following outreach update:

(1) Enrollment entities (EEs) comprised of community-based organizations (CBOs), insurance companies, and health plans. In partnership with the 100% Campaign, MRMIB surveyed enrollment entities (EEs) to ascertain how many of them would continue to do application assistance without the fee that had been provided in prior years. Out of 4,500 EEs in past years, 1,352 are continuing and 1,116 will accept referrals for application assistance from the state's toll free number.

(2) Certified application assistant (CAA) trainings. Eight CBOs have committed to do CAA training in lieu of the state funded training provided in past years. The CBOs will be listed on the website at www.mrmib.ca.gov by the end of September. Dr. Crowell expressed concern because the only place in Southern California that would have training is Los Angeles. Ms. Lopez said CBOs are working on getting funding to cover more counties.

(3) Health plan staff training utilizing the same training and materials as for CAAs. In the past, this training was conducted by Richard Heath and Associates (RHA) with the health plans paying the cost of RHA's expenses to do so. Some health plans want to continue the training, and two want to do in-house training. Ms. Lopez indicated that health plans wanting to do in-house training must submit an updated marketing plan which includes this along with the health plan's training module. The remaining health plans are interested in partnering with a CBO authorized by MRMIB to conduct the training.

(4) Outreach efforts conducted by health plans. Health plans have been eager to undertake additional outreach efforts after funding for outreach was eliminated. Some advocates, however, do not view this as an appropriate role for health plans. Plans and advocates had an initial discussion of the issue at the meeting and plan to continue discussions. MRMIB staff have indicated that plans desiring to accept referrals from the toll free number for application assistance must amend their marketing plan (which is subject to MRMIB approval) prior to doing so.

Chairman Allenby asked about the status of the outreach program for schools undertaken by California Teachers Association (CTA). Ms. Michel said that it has been a while since she talked with Hellan Dowden, the person leading that project. She will follow up and report back to the Board. Chairman Allenby asked if there were any questions or public comments; there were none.

Quality Improvement Work Group Report

Lorraine Brown presented a report from the Quality Improvement Work Group (QIWG) on recommendations for future quality monitoring activities for the HFP. Ms. Brown reported that the QIWG was first convened in 2000 to identify and make recommendations on quality measurement activities for HFP. Many of these were subsequently incorporated into the health and dental plan contracts for the contract period 2000-03 (now extended to June 30, 2004). QIWG reconvened in February to review these requirements and provide updated recommendations for reprocurement of the HFP plan contracts.

Ms. Brown reviewed the QIWG's report setting forth its five recommendations:

(1) An additional five (specified) performance measures from HEDIS®, phased in over a three-year period.

(2) Collection of encounter data focusing on the following medical conditions: emergency room admissions for asthma, diabetes type II, treatment of upper-respiratory infections, attention deficit/hyperactivity disorder (ADHD) and depression.

(3) Use of performance targets for preventive services and development of corrective action plans when targets are not met.

(4) Voluntary (as opposed to mandatory) NCQA accreditation, with public recognition provided to those who make this effort.

(5) Establishment of a special committee comprised of health and dental plans to develop incentives to promote quality improvement.

Ms. Brown noted that there was one HEDIS® measure on which the work group had failed to agree: use of interpreters. The HEDIS® measure had been pilot-tested and discontinued. Some on the work group wanted to endorse it, while others, agreeing on the need to measure access to interpreters, wanted to explore other options.

Dr. Crowell asked what happens if SB 853 (Escutia) is enacted, since it deals with plans managed by State Department of Managed Health Care (DMHC). (SB 853 requires DMHC to adopt regulations to ensure enrollees have access to language assistance in obtaining health care services by 1/1/06.) Ed Mendoza said SB 853 requires the DMHC to set standards for language assistance, but it may or may not require data collection. DMHC collects data on availability of interpreters now. DMHC also finds that HFP plans respond positively to over 90% of the questions it asks plans on linguistic access—indicating that access is more available in HFP and Medi-Cal than in the commercial market. Advocates have expressed concern about quality of linguistic services. DMHC is developing a rating system for plans which is ground-breaking—no one else does it—which may be helpful to MRMIB.

Mr. Mendoza expressed concern about the ability to collect encounter data that will be statistically significant by plan. He indicated that DMHC gets reliable rates on smoking only for the four largest plans. Dr. Crowell replied that the Board's concern could be on the aggregate data for the program, as opposed to plan by plan.

Mr. Mendoza added that he thought Medi-Cal regularly requires quality improvement projects from plans. Ms. Brown said she as been talking with Medi-Cal to learn about those projects. Chairman Allenby asked if there were any questions or public comment; there were none.

Draft Health, Dental, and Vision Plan Contract Extension and Amendments for 7/1/04 through 6/30/05

Joyce Iseri presented the first draft of the model health, dental, and vision contracts for 2004-05. Because of the rate freeze enacted in the budget, staff is proposing contract extensions instead of reprocurement, since there would be no rate negotiations. Also because of the rate freeze, new plans will not be added to the program. The model contract presented today will be forwarded to all the health, dental, and vision plans by Friday, September 26. The plans will be given approximately two weeks to comment. Staff will then submit the final version to the Board at its October meeting.

Changes to the contracts, indicated by strikethrough and underlining, are minimal. The length of the document is mostly the result of converting to the new DGS format. Changes are in the following areas:

Pursuant to the passage of AB 1762 in this year's trailer bill, infants who heretofore would be covered by Access to Infants and Mothers (AIM) will instead be covered by HFP. The administrative vendor will automatically enroll the newborn in the same plan as its mother upon notification by the mother that her baby has been born. This change affects plans that participate in both HFP and AIM. Staff will negotiate with these plans for a new rate to cover this small population of subscribers.

Another amendment to the contract provides MRMIB with a period of 60 days, rather than 30 days, to review plan marketing materials. Plans will only have to submit updates to currently approved marketing materials.

For the term of the contract extensions only, NCQA accreditation will not be required. Reporting requirements for alcohol and drug treatment services have been omitted since these services will be captured by the HEDIS® survey.

The one-year contract extensions will be kept confidential for one year, except for rates which will be confidential for four years.

Dr. Crowell asked about inclusion of plan requirements for performance improvements in the area of adolescent wellness and substance abuse treatment. Ms. Cummings said that, as had been discussed with the Board, staff had sent letters to plans requesting performance improvements in these areas. Dr. Crowell asked if the requirements could be incorporated in the contract. Ms. Cummings replied that they could.

Chairman Allenby asked if there were any further questions or any public comments; there were none.

Rural Health Demonstration Project Solicitation – First Draft

Mauricio Leiva presented the first draft of the Rural Health Plan Demonstration Project (RHDP) solicitation being made available to the public for review and comment. Staff will be asking the Board to approve the final solicitation at the October 22 meeting. A bidders' conference will be held October 27, 2003, from 2:00 to 4:00 p.m. at MRMIB's office. Proposals will be due December 5, 2003. An electronic version of the contract will be made available.

New legislation authorized the use of Prop 99 funds to provide the state's share of funds for the projects, provided in the past from the general fund. The total funds available for FY 2003-04 are $2.8 million. The solicitation will cover two one-year contract periods. As in the past, the RHDP will target rural and frontier areas of the state and populations, including children of migrant seasonal farm workers, American Indians, fishing and forestry workers.

Mr. Leiva highlighted key areas of the draft. Interested parties can provide written comments on the draft from September 24 through October 9, after which time the draft will be finalized and re-presented to the Board.

Mr. Mendoza asked if there is a report on previous projects. Mr. Leiva replied that there is a report on the projects on the MRMIB website at www.mrmib.ca.gov (HFP: Special Reports). Mr. Mendoza asked if the project goal is to increase access, and if so, how it is measured. Ms. Brown added that statistics are collected on the types of services provided and whether the funding helps clinics extend their services after 5:00 p.m., on weekends, and by mobile health and/or dental vans. Success is measured by whether clinics are able sustain themselves and provide services they would not be able to provide otherwise.

Chairman Allenby asked whether projects funded in the past]that were not self-sustaining would be eligible to submit proposals under this reprocurement. Mr. Leiva replied that many of the projects funded in the past had been able to become self-sustaining, but it was not a hard and fast requirement. Staff takes into consideration various factors such as the rate of success, demonstrated benefits of a project, whether the clinic or hospital can secure or provide additional funding, and the potential for becoming self-sustaining. Chairman Allenby asked if there were any questions or public comment; there were none.

2003 Open Enrollment Summary

Sarah Soto-Taylor presented the open enrollment summary for 2003. She first detailed changes in plan coverage areas that affected families plan choices for open enrollment and went on to discuss the summary report highlighting plan transfers in open enrollment.

The number of subscribers who transferred plans, either voluntarily or by requirement (because of plan coverage changes), was 36,903 (5.56%) for health plans, and 11,424 (1.72%) for dental plans. 64% of the health plan subscribers were required to change because their plan was no longer available, compared to approximately one-third last year.

Most subscribers changing health plans were satisfied with them, but they were not very satisfied with their dental plan. (Note: HFP has only one vision plan.)

The three top reasons they gave for changing health plans were:

- Problem getting a doctor I'm happy with
- Not being able to see a doctor when the need is urgent
- Not satisfied with medical care received

The three top reasons given for changing dental plans were:

- Problem getting a dentist I'm happy with
- Appointments to see dentist have to be made too long in advance
- Not satisfied with dental care received

In reviewing historical data, Ms. Soto-Taylor noted the average scores in the customer satisfaction survey have not changed much. The two top reasons for changing health plans remained the same. For the third top reason, this year subscribers indicated they were not satisfied with their medical care, compared to last year's third top reason that appointments with the doctor had to be made too far in advance. The top three reasons for changing dental plans were the same this year as they were last year.

Dr. Crowell commented that a fairly high percentage of subscribers (20%) selected the category of "other" to capture why they had changed plans. She asked if staff should not attempt to get more specific information. Ms. Soto-Taylor replied that staff could develop additional questions (beyond the present 12) for the survey in order to find out what other reasons subscribers may have. Dr. Crowell suggested that the administrative vendor could conduct a phone survey and reword some of the questions already in use. Ms. Soto-Taylor indicated that she would talk to the new vendor about this possibility.

Ms. Gotlieb noted that over time the statistics showed an improvement in satisfaction. She specifically noted that that need for an interpreter has significantly dropped from 6% in 1999 to 1% this year. She said the results of the survey would indicate to the HFP Advisory Panel that cultural and linguistic needs seem to be getting addressed successfully.

Mr. Mendoza asked if the data could be categorized geographically, and if staff is able to ascertain when subscribers find a doctor they do like and how long subscribers have been with a given plan. Ms. Soto-Taylor replied that this data was not available for this

enrollment period, but the survey being developed for the new administrative vendor could include questions targeted for that information. Chairman Allenby asked if there were any further questions or any public comment; there were none.

Traditional and Safety Net Provider as Primary Care Physician Report 2002

Doug Skarr presented the Traditional and Safety Net (T&SN) Provider as Primary Care Physician Report 2002. Statute requires health plans to report to MRMIB annually on the number of subscribers selecting T&SN providers as their primary care physician in the last calendar year. Mr. Skarr highlighted key points of the report, noting that 62% of subscribers had selected a T&SN provider as their primary care provider in 2002. Chairman Allenby asked if there were any questions or public comment; there were none.

SB 59 (Escutia) Update

Lorraine Brown provided an update on SB 59 (Escutia) legislation which requires MRMIB to report to the legislature on how federal SCHIP funds could be used to address the needs of vulnerable children. Staff is soliciting public input on this topic at Board and HFP Advisory Panel meetings, and from stakeholder organizations. She listed some of the categories of vulnerable children, such as children who are immigrants, homeless, in foster care, with limited English proficiency, low-income, and autistic. CMS has approved three public initiatives through state plan amendments, all of which funded the initiatives under their state's administrative cap. Ms. Cummings explained the 10% administrative cap rule on outreach and public health initiatives Presently, California has room under the cap, but this may not be so if outreach is reinstated or if some types of AB 495 (Diaz) projects are funded. Ms. Brown said staff will be taking public input until October 22. The final report needs to be submitted to the legislature in January. Chairman Allenby asked if there were any questions or public comment; there were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Ernesto Sanchez reported that there are currently 4,959 mothers and 10,985 infants enrolled in the program. He briefly reviewed the enrollment data that included ethnicity, infant gender percentage, and the counties with the highest percentage of enrollment. Chairman Allenby asked if there were any questions or public comment; there were none.

Fiscal Report

Chairman Allenby said staff had presented the balance sheets for the end of the fiscal year at the September 3 meeting. Due to the lateness of signing the budget, more current data was not available. He announced that the standard fiscal reports may be given quarterly instead of monthly.

Extension of Care 1st Administrative Vendor Contract

A motion was made and unanimously passed to approve the extension of the Care 1st administrative vendor contract through June 30, 2004, for an estimated value of $750,000.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Ernesto Sanchez reported that there are 6,869 people currently enrolled in the program, of whom 346 are new enrollees. As of September 1, 2003, there were 85 on the waiting list. The new enrollment cap is 9,990.

As a result of AB 1401 (Thomson), effective September 1, the MRMIP began graduating members with 36 continuous months in the program into guaranteed issue coverage in the private market. The number of 36-month disenrollments to date is 9,197.

Fiscal Report

Chairman Allenby indicated this report was not available for the same reason indicated for the AIM fiscal report.

Disenrollment Survey

Ernesto Sanchez presented the annual disenrollment survey report that reviews the reasons subscribers give for leaving MRMIP in a given month. Since January is the month when new rates go into effect, and therefore the month with the highest level of disenrollments, it is the month surveyed. The most frequent reason given for disenrolling was the cost of premiums (51%). In January 2003, the average premium increase was 25.5%. There is a decline in the ability to access coverage, in addition to a decline in affordability. 44% of enrollees left because they were able to access new coverage, a decline compared to 64% in 2001. . Dr. Crowell said it is disturbing to see the increase in rates and the number of people who cannot afford the premiums.

Marvin Robinson, a MRMIP subscriber, addressed the Board on the escalating premium increases in the program. His premium has increased an average of 25% three times, beginning with $390 per month to $633 per month currently. It is expected to increase again on January 1 when new rates go into effect. By the time he is graduated out of

the program after 36 months, he estimates the premium to reach $1,000 per month. In describing his financial situation and the sacrifices he has had to make in order to pay his premiums, such as selling his vehicle, he pointed out that the program is not affordable for low- and middle-income individuals; yet individuals in these income ranges are not "poor enough" to qualify for Medi-Cal. He calculated that an individual would need to make $80,000 in order to afford health insurance under this program.

Despite the risks involved with working due to his heath condition, he has had no choice but to seek some type of employment in order to pay his premiums and escalating co-pays. He described the seriousness of his medical condition, emphasizing the need for routine medical care in order to prevent the need for crises care or the possibility of becoming totally disabled.

Mr. Robinson said his purpose in coming before the Board was to make a plea not just for himself but on behalf of all similarly situated people. He questioned how funds are being spent, such as tobacco money, which he believed was earmarked for health programs. He also questioned if law makers are aware of, or sensitive to, the serious problem of a widespread lack of affordable, accessible health care.

Chairman Allenby expressed his gratitude to Mr. Robinson for raising a very important issue. He regrets the Board does not have the authority to make the changes Mr. Robinson is raising. He told Mr. Robinson he articulated the problem very well and encouraged him to meet with his elected officials.

Chairman Allenby asked if there were any questions or further public comment; there were none.

AB 1401 (Thomson) Update

Vallita Lewis presented a report on the implementation status of the post-MRMIP graduate product pursuant to AB 1401. It is a four-year pilot program from September 1, 2003, to September 1, 2007, accomplished as a joint effort of MRMIB, the Department of Insurance (DOI), and the Department of Managed Health Care (DMHC).

AB 1401 was enacted for the purpose of utilizing a market-based solution to allow a greater number of individuals to be served by the MRMIP with the fixed annual appropriation of $40 million. MRMIP serves individuals who are unable to secure health insurance due to pre-existing conditions. AB 1401 limits participation in MRMIP to 36 consecutive months and then guarantees insurance coverage in the private market.

On September 1, 2003, over 9,100 MRMIP subscribers with 36 months of continuous participation in MRMIP graduated from the program. As a result, staff received a number of letters expressing a variety of concerns, most notably regarding cost.

Ms. Lewis detailed the activities undertaken to prepare MRMIP subscribers for the change in coverage, including revisions to the MRMIP handbook, repeated direct

mailings, and posting FAQ's and other information on MRMIB's website. She described internal procedures MRMIB had put in place to address operational issues, and coordination activities with DMHC and DOI. There are 11 products offering guaranteed issue coverage. Seven of the products are health plans regulated by DMHC; four of the products are insurance carriers regulated by DOI. The benefit package is identical to MRMIP. The premiums are set at 110% of the MRMIP rates. Information is also available on MRMIB's website at www.mrmib.ca.gov under MRMIP/Upcoming Changes to MRMIP.

Ms. Gotlieb praised staff for all the work accomplished in implementing AB 1401. She asked if subscribers can switch plans when leaving MRMIP to go into private coverage. Ms. Lewis answered that they can choose. However, Ms. Cummings added this is the one instance where a subscriber can switch. There are no open enrollment opportunities once a subscriber has selected a plan. There are just a few situations where a subscriber can switch, such as moving to another area, for example.

Dr. Crowell also commended staff on their efforts. She asked about tracking whether subscribers remained in the program. Ms. Lewis affirmed that all participating plans are required to submit reports. The first report is due April 1, 2004. Dennis Gilliam added that reporting is linked to invoicing. Ms. Lewis said Blue Cross has indicated that, to-date, over 3,000 of their subscribers who have graduated have submitted applications to continue with them. This represents approximately 63%.

The Board requested they be provided with (1) a copy of the materials being sent to the graduating subscribers, (2) a list of the frequently asked questions, and (3) an update at the November meeting.

Ms. Gotlieb expressed concern over the fact that subscribers only have one opportunity to change plans. Laura Rosenthal responded that the enrollment process is regulated by laws governing the private sector, so it is outside of the administration of MRMIP. The law itself would have to be changed in order to change the enrollment policy. Chairman Allenby asked if there were any further questions or public comment; there were none.

There being no further business to come before the Board, the meeting was adjourned. The next Board meeting is tentatively scheduled for October 22, 2003.