

**Senate Bill 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014)**

**Section 93 Stakeholder Workgroup**

**DRAFT Plan**

**November 17, 2014**

- **Section 93 purpose**

By August 1, 2014, the State Department of Health Care Services (DHCS) shall establish a Stakeholder Workgroup to develop a plan to utilize available Major Risk Medical Insurance Fund moneys, including moneys in the Managed Care Administrative Fines and Penalties Fund transferred pursuant to paragraph (2) of subdivision (c) of Section 1341.45 of the Health and Safety Code, and any other available funds in the Cigarette and Tobacco Products Surtax Fund, in order to provide subsidized health care coverage for individuals not eligible for or receiving compressive health care.

- **Workgroup composition**

DHCS) shall establish a Stakeholder Workgroup composed of stakeholders including health care providers, county representatives, labor, health plans and insurance representatives, consumer advocates, immigrant policy advocates, and employers of low-wage workers. (See attached list of Workgroup stakeholders).

### **Background/History**

- **Program history**

The Legislature passed and Governor George Deukmejian signed into law Chapter 1168, Statutes of 1989, which established the Major Risk Medical Insurance Board (MRMIB). MRMIB was originally housed in the Business, Transportation and Housing Agency. The statute tasked the Board with two main objectives:

- 1) To establish and manage the Major Risk Medical Insurance Program (MRMIP) a high risk insurance pool to “secure adequate health coverage” for Californians with preexisting conditions who did not have employer or other private or public program based coverage, and who were being excluded from the individual and small group insurance market because of their preexisting conditions.
- 2) To research and assess the needs of persons not adequately covered by existing private and public health care delivery systems and promote means of assuring the availability of adequate health care services.

The MRMIP, California's high risk health insurance pool, began serving subscribers in January 1991, to provide comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered it at rates they could not afford. MRMIP was administered by MRMIB until June 30, 2014. On July 1, 2014, the MRMIB was eliminated and MRMIP was transitioned to DHCS.

Historically, MRMIP subscribers were charged a monthly premium ranging from 125 percent to 137.5 percent of their plans' standard average individual rate adjusted to MRMIP benefit standards. The premiums are subsidized by the Cigarette and Tobacco Surtax Fund (Proposition 99). In addition, the MRMIP receives funding from the Department of Managed Health Care (DMHC) for penalties imposed on plans. The first \$1 million goes to the Stephen Thompson Fund and the remainder goes to the MRMIP.

Currently, subscribers are charged a monthly subscriber premium which is based on the Silver Plan available through Covered California with individual rate(s) adjusted for MRMIP benefit standards. Because the appropriation from the Cigarette and Tobacco Surtax Fund is limited, the total number of individuals who can participate depends on available funding. There is an enrollment cap of 7,500 individuals. Over half of the funding for MRMIP comes from subscriber premiums. Health plan participation in the program is voluntary. One Preferred Provider Organization and three Health Maintenance Organizations participate in the program.

In September 2003, AB 1401 was passed and set up a four year pilot program call the Guaranteed Issue Pilot Program (GIP). The goal of the GIP was to maximize benefit from limited State dollars by providing market-based industry subsidized mechanisms for the continue coverage of high risk individuals. The intent was to share the cost of the high risk coverage to high risk individuals between plans selling in the individual insurance market and the State, instead of having the full cost of coverage for such individuals subsidized by the State, while giving individuals who had been in MRMIP for three years guaranteed access to that market.

Under the GIP, MRMIP subscribers received a maximum 36 consecutive months of coverage in MRMIP. Three months prior to the end of that period, the MRMIP Administrative Vendor, Blue Cross, would notify subscribers of their pending disenrollment and of their ability to access guaranteed issue coverage in the individual market. Subscribers receive a Certificate of Program Completion, which can be used to shop among all health plans and insurers in the individual market (with the exception of certain county owned plans).

Plans were required to offer the same basic benefit packages available under MRMIP, but with a higher annual benefit cap (\$200,000 vs. \$75,000) and a new \$750,000 lifetime cap. Plans model the guaranteed issue products on requirements in MRMIP. Plans set premiums at ten

percent above the rate of subscriber premiums in MRMIP. Subscribers have 63 days from the termination of MRMIP coverage to select a new plan, and cannot return to the MRMIP for one year after MRMIP coverage ends.

California's health insurance regulators, DMHC and the Department of Insurance (DOI) regulate and oversee access, benefits structure and premium setting for the guaranteed issue coverage. The regulators also publish information on participating plans on their websites to help subscribers shop for guaranteed coverage. The GIP pilot ended in 2008.

- **ACA Implementation Impact on MRMIP**

The federal Affordable Care Act (ACA) was passed by Congress and then signed into law by the President on March 23, 2010. On June 28, 2012, the Supreme Court rendered a final decision to uphold the health care law.

The legislation enacted various provisions in implementing ACA insurance market reforms, including the following changes which impacted MRMIP, effective January 1, 2014:

- Prohibits health care service plans and insurers from imposing any group or individual contract provision excluding coverage for pre-existing medical conditions.
  - MRMIP does not have pre-existing condition wait lists for dependents age 18 years of age and under and they are not subject to pre-existing condition exclusion or post-enrollment waiting periods.
- Eliminates all life time limits on benefits and coverage.
  - MRMIP has \$75,000 annual and \$750,000 lifetime benefit caps.
- Requires health care service plans and insurers that offer individual coverage to issue coverage to all otherwise eligible individuals that apply for that coverage, regardless of health status.
  - MRMIP requires a denial letter issued within twelve months of the application date. The denial letter does not have to be for a pre-existing condition.
- Requires health care service plans and insurers to use only age, geographic region and family size factors when establishing premium rates for individual coverage.
  - MRMIP uses Covered California's Silver Plan premium rates to develop subscriber rates.

- Requires young adults who are under the age of 26 to remain eligible for coverage under their parent’s health plan.
  - MRMIP offers coverage to subscriber dependents who apply before they turn 23 years of age.
- Requires health care service plans and insurers to limit enrollment to initial and annual open enrollment periods and special enrollment periods resulting from triggering events, such as loss of coverage, marriage, birth, adoption or court order.
  - MRMIP allows enrollment, with a denial letter, throughout the year and it has an annual Open Enrollment which allows subscribers to consider other available plans in the program.
- Specifies that ACA grandfathered plans are not subject to the legislation’s insurance market reform provisions.
  - State high risk pools were given a one-year extension, until December 31, 2014, to meet minimal essential coverage requirements.

The MRMIP conducted a survey of 884 subscribers (100 percent) who were disenrolled during the month of January 2014. The highlights of the 2014 Disenrollment Survey include:

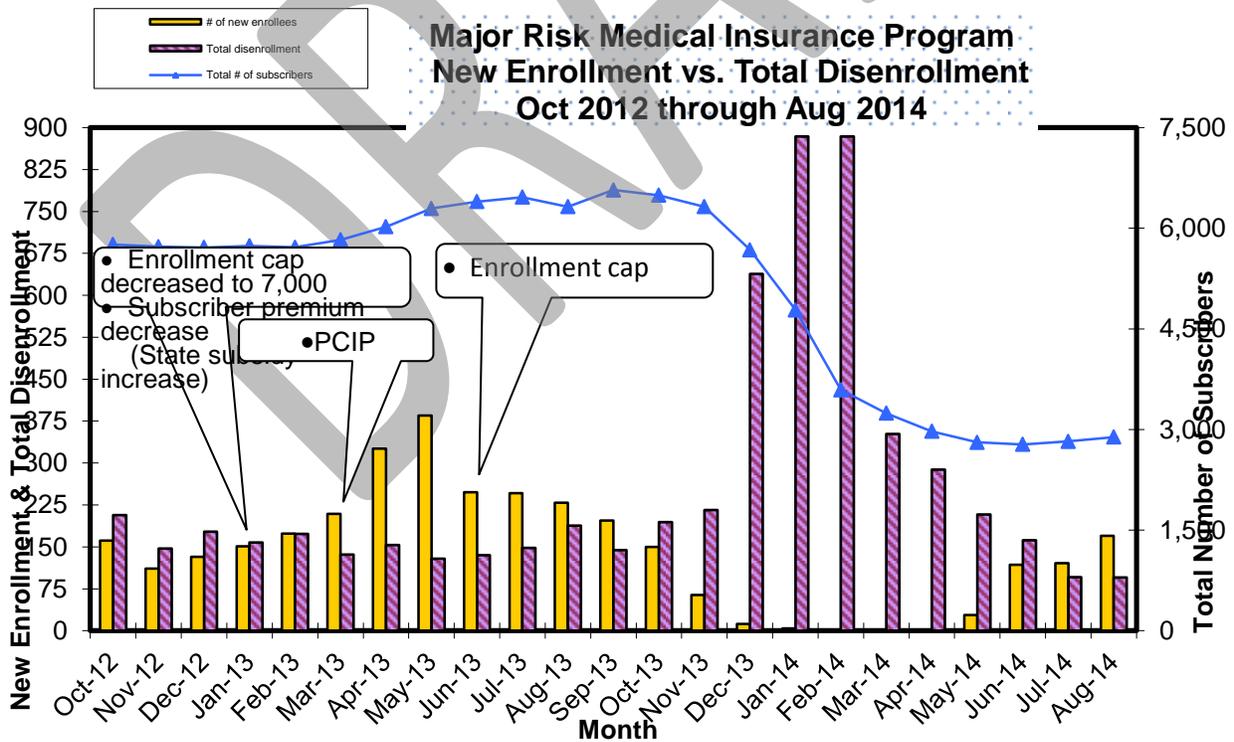
- **884** subscribers disenrolled in 2014 (which was up **459.5 percent** from 158 disenrollments in 2013).
- **65.83 percent** (582 subscribers) responded to the survey and identified their reasons for disenrollment (up from 14.56 percent in 2013).
- **86.77 percent**(505 subscribers) indicated that they obtained other health care coverage (up from 73.91 percent in 2013).
- **3.61 percent** (21 subscribers) cancelled MRMIP to qualify for PCIP (down from 4.35 percent in 2013).
- **70.44 percent** (410 subscribers) were able to obtain coverage through ACA Reform.
- **56.87 percent** (331 subscribers) cancelled MRMIP to qualify for Covered California.
- **13.57 percent** (79 subscribers) obtained coverage in the individual market.

- Three percent decrease shown in average MRMIP premiums due to State law allowing lower premium rates effective January 1, 2014 (increased premium subsidy).

When comparing the reasons why subscribers were disenrolled from the MRMIP, the highest reason was due to subscribers obtaining other health coverage. The second highest reason for disenrollment was due to Program Costs at 8.59 percent (down from 21.74 percent in 2013 and 30.88 percent in 2012). From 2013 to 2014, there was a slight decrease (-three percent) in average MRMIP premiums due to State law allowing continued lower premium rates in 2014 for MRMIP subscribers.

- Average MRMIP premium decrease from 2013 to 2014 was three percent (due to increased premium subsidy).
- Average MRMIP premium decrease from 2012 to 2013 was 12.4 percent (due to increased premium subsidy).
- Average MRMIP premium increase from 2011 to 2012 was nine percent.

- Enrollment Trends (Will be a PDF, as an attachment, etc.)



- **Minimum Essential Coverage Issue and potential tax liability (Sec. 2711. No lifetime or annual limits.)**

The MRMIP subscribers may encounter Minimum Essential Coverage (MEC) issues and potential tax liabilities due to the ACA requirements. The MEC requirements included prohibitions of lifetime or annual limits. Individuals are responsible for ensuring that they, and any dependent, are covered by a health plan that provides MEC or pay a penalty.

MRMIP provides comprehensive benefits to subscribers and their dependents. The MRMIP currently has an annual \$75,000 annual benefit cap and a \$750,000 lifetime cap.

DHCS is in the process of applying to the Centers for Medicare and Medicaid Services for MRMIP to be recognized as meeting MEC. However, the annual and lifetime benefit caps are a significant issue to overcome in order to be recognized as meeting MEC. DHCS will be notifying all MRMIP subscribers that the MRMIP currently may not meet MEC requirements and of possible tax penalties.

The penalty would be paid as a federal tax liability on income tax returns and is enforced by the U.S. Treasury Department (i.e., Internal Revenue Service). Individuals that fail to pay the penalty will not be subject to criminal penalties, liens or levies.

For the 2015 tax year, the annual penalty for not having MEC will be the greater of a flat dollar amount per individual or a percentage of the individual's taxable income. For any dependent under age 18, the penalty is one-half of the individual amount.

The flat dollar amount per individual is \$325 in 2015 and \$695 in 2016. After 2016, the flat dollar amount is indexed to inflation. The flat dollar penalty is capped at 300 percent of the flat dollar amount. For example:

- A family of three (two parents and one child under age 18) would have a flat dollar penalty of \$1,737 in 2016;
- A family of four (two parents and two children over age 18) would have a flat dollar penalty of \$2,085 in 2016 because the 300 percent cap would apply.

The percentage of taxable income is an amount equal to a percentage of a household's income (as defined by the ACA) that is in excess of the tax filing threshold (phased in at one percent in 2014; two percent in 2015; 2.5 percent in 2016). For example:

- If an individual has a household income of \$50,000, the percentage would be two percent of the difference between \$50,000, and the tax threshold. Assuming the tax

threshold is \$10,000, in 2015, this individual would be subject to a percentage penalty of \$400. Because this percentage penalty is greater than the flat dollar penalty for 2014 (which is \$95), he or she would pay the percentage penalty.

Generally, the annual penalty is capped at an amount equal to the national average premium for qualified health plans which have a bronze level of coverage available through Covered California.

### Subscriber Data

- Demographic breakdown

#### MRMIP Subscriber and Health Plan Data: August 2014 Summary

Percentage of MRMIP Enrollment by Age Category:

<29	20.9%
30-49	40.6%
50-64	36.5%
65+	2%

Percentage of MRMIP Enrollment by Gender:

Female	54.3%
Male	45.7%

Ethnicity:

Caucasian	59.7%	African American	3%
Other	17.3%	Native American	.4%

Latino	11.6%	Not Given/Unknown	0%
Asian & Pacific Islander	8%		

- **Data Analysis**

## MRMIP Subscriber and Health Plan Data

### Subscriber Data:

	August Activity 9/1/14 Effective Date	Current Enrollment
Number of Enrolled Persons:	170	2,887
Number of Subscribers:	135	2,643
Number of Dependents:	35	244
% of Subscribers and Dependents:	79.4% / 20.6%	91.5% / 8.5%

<b>MRMIP Enrollment Cap</b>	7,500*
<b>MRMIP Enrollment Exceeding Cap</b>	0
<b>FY 12/13 New Enrollees To-Date</b>	3,650

\* Effective 6/1/13 Enrollment Cap = 7,500

### Enrollment Data:

	August 2014	Total to Date
Applications Received	138	153,952
Disenrollments	95	110,504

Waiting List Data as of September 1, 2014:

Due to closed enrollment	0
Due to deferred enrollment	5
Total on waiting list:	5

**MRMIP Health Plan Enrollment:**

	<b>Enrollment September 1, 2014</b>	<b>% of Total Enrollment</b>
Anthem Blue Cross	1,575	54.6%
Kaiser South	858	29.7%
Kaiser North	447	15.5%
Contra Costa	7	.2%

Additional Topics:

1. Summary of coverage options through Covered California and Medi-Cal.
2. Potential options for use of MRMIP.