ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Dave Jones, Chair

MONDAY, APRIL 19, 2010
STATE CAPITOL, ROOM 127
2:30 PM

SPECIAL INFORMATIONAL SEGMENT ON FEDERAL HEALTH CARE REFORM

President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act on March 23, and the Health Care and Education Reconciliation Act of 2010, on March 30, 2010. Federal health care reform contains an immensely complex array of provisions that span the health care world, including: numerous private market reforms, reforms and expansions to public programs, establishment of a high risk pool and health care exchange, reforms to employer-sponsored coverage, and much more. In addition to the myriad of complex changes to our health care system, the new federal laws contain an equally complex web of varying implementation time-lines and requirements. Recognizing that less than a month has passed since the President signed this historic legislation, a huge amount of detail remains to be provided and defined through federal regulations and guidance; and this is the case despite the fact that some of the provisions go into effect immediately or in the very near future.

Here in California, several policy bills have been introduced and are moving through the Legislature, to begin implementing various aspects of federal health care reform, including, but not limited to: AB 1602 (Perez) seeks to create the exchange and implement various private market reforms; AB 1887 (Villines) seeks to establish the temporary high risk pool; and SB 900 (Alquist) seeks to establish the exchange within the California Health and Human Services Agency.

At this Subcommittee's last hearing, the Subcommittee Chair, Assemblymember Jones, shared his interest in ensuring that California does not miss out on important opportunities, particularly funding opportunities, presented by federal health care reform, and therefore requested that the Subcommittee learn about and discuss such components of health care reform at this hearing. Therefore, the Subcommittee has asked the following individuals to provide a general overview of federal health care reform and as much information as is currently available on new short-term federal funding opportunities:

- ***Beth Capell – Health Access California***
  Overview of federal health care reform
  Overview of short-term funding opportunities for states

- ***Carolyn Ginno – California Medical Association***
  Federal health care reform's provisions and implementation related to increasing primary care doctors, and other funding opportunities for states

Continued on next page….

- ***Tahira Bazile – California Primary Care Association***
  Federal health care reform's funding opportunities related to community clinics

- ***Shawn Martin – Legislative Analyst's Office***
  Information on short-term funding opportunities for states

2400 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: OVERVIEW OF THE DEPARTMENT OF MANAGED HEALTH CARE

The mission of the Department of Managed Health Care (DMHC) is to help California consumers resolve problems with their Health Maintenance Organizations (HMOs) and to ensure a better, more solvent and stable managed health care system through: 1) Administration and enforcement of California's HMO patient rights laws; 2) Operating the 24-hour-a-day HMO Help Center; and 3) Licensing and overseeing all HMOs in the state.

The Governor's proposed budget for 2010-11 includes expenditures of $49 million. The DMHC receives no General Funds and is supported primarily by an annual assessment of each HMO. The annual assessment is based on the department's budget expenditure authority plus a reserve rate of 5%. The assessment amount is prorated 65 percent and 35 percent to full-service and specialized plans respectively. The amount per plan is based on its reported enrollment as of March 31st. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses.

STAFF COMMENT

The Subcommittee requests that DMHC provide an overview of the department, its programs, and budget.

Federal Health Care Reform

The Subcommittee requests that DMHC provide an overview of the aspects of federal health care reform that will have a direct impact on the department and how they will prepare for implementation of the new federal law.

ISSUE 2: OFFICE OF PATIENT ADVOCATE POSITION AUTHORITY

CONSENT ITEM*

Budget Issue
The DMHC Office of Technology and Innovation (OTI) requests position authority for 2.0 on-going staff positions to do web development for the Office of the Patient Advocate (OPA) and annual development of the Health Care Quality Report Card Portal. Historically this work was done by outside contractors, and existing contract resources will be used to fund the new state positions, resulting in no increase in costs.

Background
The OPA website offers information to consumers on choosing health plans, rankings of health plans and medical groups, and educates consumers about patient rights and responsibilities. The Health Care Quality Report Card compares the nine largest HMOs based on quality of care and is available on-line and in hard-copy booklets.

The DMHC explains that over time the department realized the following about contracting out for this work: 1) the work can be performed by state employees and therefore is in violation of Government Code 19130; and 2) the transitions to new contractors created increased, unnecessary work and the loss of efficiency. The OTI began doing this work in 2008 at the expense of OTI work leading to an increasing backlog of requests made of the OTI. These positions will relieve OTI of this workload and allow it to give attention to its regular responsibilities.

Staff Recommendation: Approve BCP as requested (on consent).

ISSUE 3: OFFICE OF HEALTH PLAN OVERSIGHT PERMANENT POSITIONS

CONSENT ITEM*

Budget Issue
The DMHC Office of Health Plan Oversight (HPO) requests an augmentation of $199,000 and the conversion of two limited-term positions to permanent full-time positions. The limited-term positions are due to expire on June 30, 2010.

Background
These limited-term positions were established in 2006-07 to resolve industry and stakeholder concerns about the department's capacity to review and approve license amendment filings in a timely manner. According to DMHC, review and approval times decreased with the creation of the limited-term positions which justified extending the positions for a second two-year time period. State law requires DMHC to review and comment on amendments within 30 days of receipt in order to preserve its enforcement authority. DMHC states that each amendment requires a high level of analytical expertise.

DMHC explains that the past four years have provided evidence of both the effectiveness of these positions as well as the sustained workload demanding these positions on a long-term basis.

Staff Recommendation: Approve BCP as requested (on consent).

ISSUE 4: CALL CENTER POSITION AUTHORITY

CONSENT ITEM*

Budget Issue
The DMHC's Help Center (HC) is requesting position authority to establish 4 positions to handle calls after hours and on weekends and holidays. The HC previously contracted out for this coverage yet the contractor has raised its rates to a level that makes the contract cost-prohibitive. The cost of these positions ($208,000 annually) will be covered with existing contract resources.

Background
The HC fields calls from consumers who are seeking assistance with their healthcare coverage. The contract that was established at the start of the HC in 2000 allowed the HC to answer calls 24 hours a day, every day of the year. However, with the rising cost of the contract, the department has ended the contract and begun handling the full workload in-house. However, DMHC also explains that the vast majority of calls come in during regular business hours and therefore the over-time can be handled by a minimum of staff in the form of a triage system that either defers callers to regular business hours or routes emergency calls to an on-call nurse consultant.

Staff Recommendation: Approve BCP as requested (on consent).

ISSUE 5: INCREASED WORKLOAD FROM NEW REGIONAL CENTER REQUIREMENT

Budget Issue
DMHC is requesting expenditure authority of $910,000 for FY 2010-11 and $910,000 for FY 2011-12, for nine 2.5 year limited-term positions to handle increased workload resulting from ABX4 9 which prohibits Regional Centers (RCs) from providing services to consumers unless the consumer can demonstrate that their health insurer has denied coverage for the services provided by the RC.

Background
As a result of ABX4 9, insured RC consumers will need to obtain formal denials from their health plans, and therefore DMHC anticipates a significant increase in complaints and Independent Medical Review applications as consumers seek to secure the required coverage denial documentation.

Annually, the 21 RCs throughout the state serve approximately 240,000 consumers. The Lanterman Act requires the Department of Developmental Services (DDS) and the RCs to be providers of last resort.

DMHC states that they have not seen a substantial increase in workload since implementation of ABX4 9 on July 1, 2009, however they are unsure why and still anticipate the increased workload in the future. According to legislative staff, DDS states that they also have not yet seen the workload increase expected to result from this new statutory requirement.

STAFF COMMENT

This request is for expenditure authority for new positions that can and will be established administratively if and when the anticipated increased workload actually materializes.

Staff Recommendation: Staff recommends denying this request at this time given the absence of evidence of an increase in workload. Should this increase materialize at some point in the future, the DMHC could submit a new request to the Legislature.

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: OVERVIEW OF THE MANAGED RISK MEDICAL INSURANCE BOARD

Purpose and Description of Department:
The Managed Risk Medical Insurance Board (MRMIB) administers the following programs, which provide health care coverage through private health plans to certain groups without health insurance: 1) Healthy Families Program (HFP); 2) Access for Infants and Mothers Program (AIM); 3) Major Risk Medical Insurance Program (MRMIP); and 4) County Healthy Initiative Matching Fund Program (CHIM). HFP, AIM, and MRMIP will all be discussed in detail later in this agenda.

CHIM provides health coverage for eligible children up to age 19 in families with incomes between 250 and 300 percent of the federal poverty level that are not eligible for Medi-Cal or the Healthy Families Program. Coverage is provided through county-sponsored insurance programs, which provide comprehensive benefits similar to the Healthy Families Program. Program costs are funded by matching county expenditures with federal funds for participating counties that have been approved by the federal government. The Managed Risk Medical Insurance Board manages the intergovernmental transfer of federal funds, and the counties administer the program.

Summary of MRMIB Budget
The Governor's 2010-11 budget proposes total expenditures of just over $1 billion ($128.3 million General Fund) for all programs administered by MRMIB as shown in the charts below.

3-Year Expenditures By Program

Program	Actual 2008-09	Estimated 2009-10	Proposed 2010-11
Major Risk Medical Insurance Program	$22,335,000	$65,127,000	$36,953,000
Access for Infants & Mothers	$129,712,000	$77,448,000	$122,195,000
Healthy Families Program	$1,124,901,000	$1,142,384,000	$928,821,000
County Health Initiative Matching Program	$2,351,000	$1,710,000	$1,789,000
Total Expenditures	**$1,279,299,000**	**$1,286,669,000**	**$1,089,758,000**

3- Year Expenditures By Fund			
Fund	**Actual 2008-09**	**Estimated 2009-10**	**Proposed 2010-11**
General Fund	$389,001,000	$216,983,000	$128,376,000
Unallocated Account, Cigarette and Tobacco Products Surtax Fund	$1,898,000	$32,000	$34,000
Perinatal Insurance Fund	$54,644,000	$36,271,000	$54,993,000
Major Risk Medical Insurance Fund	$22,335,000	$65,127,000	$36,953,000
Counties Children and Families Account, California Children and Families Trust Fund	-	- (Included in reimbursements)	$55,632,000
Federal Trust Fund	$786,941,000	$779,667,000	$666,867,000
Reimbursements	$23,571,000	$86,106,000	$8,830,000
County Health Initiative Matching Fund	$823,000	$598,000	$626,000
Mental Health Services Fund	$86,000	$173,000	$159,000
Children's Health and Human Services Special Fund (AB 1422)	-	$101,712,000	$137,288,000
Total Expenditures (All Funds)	**$1,279,299,000**	**$1,286,669,000**	**$1,089,758,000**

STAFF COMMENT

The Subcommittee requests MRMIB to provide an overview of the department, its programs, and budget.

ISSUE 2: OVERVIEW OF THE HEALTHY FAMILIES PROGRAM (HFP)

Overall Background

The Healthy Families Program (HFP) is California's version of the federal Children's Health Insurance Program (CHIP) and was implemented in 1997-98. The HFP provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. Eligibility is conducted on an annual basis. In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 to 300 percent of poverty) are immediately enrolled into the HFP and are automatically eligible for coverage until the age of two. Once they reach two years of age, those who are in families with incomes over 250 percent of FPL are no longer eligible to remain in the HFP.

Benefit Package

The benefit package is modeled after that offered to state employees. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but historically consumer choice has been available. Children in the HFP also have access to the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. Finally, a child in the HFP is eligible to receive *supplemental* mental health services provided through County Mental Health Plans.

HFP Funding

California receives a 66 percent federal match for each state dollar provided. Federal CHIP funding is an *"allotment,"* and as such, this program is *not* an entitlement. In addition to the federal allotment and State General Fund support, premium payments received from families for the enrollment of their children (i.e., subscribers) are used to offset expenditures. Finally, two additional sources of funding were initiated in 2009 including a contribution from First 5 California and revenue from a tax on Medi-Cal managed care companies.

Recent History of Budget Actions

The HFP budget has experienced substantial reductions and changes over the past few years. In 2008, several cost-containment measures were enacted which are outlined in the chart below. A total reduction of over $160 million ($57 million General Fund) was anticipated to be achieved over a two-year period. The 2009 Budget Act, passed and signed in February 2009, included $404 million General Fund for the HFP. However, reflecting the worsening state fiscal crisis, the subsequent budget reductions passed and signed in July of 2009 included a $124 million General Fund reduction to the program, and then an additional $50 million reduction via the Governor's veto.

Summary of Reductions for Healthy Families Program Enacted in 2008

Actions Taken in 2008	2008-09 Reduction Amount	2009-10 Reduction Amount	Two-Year Total Reduction
Increase premiums by an average of $1 per member per month**	$10.7 m ($2.9 m GF)	$62.5 m ($23.2 million GF)	$73.2 m ($26.1 m GF)
Reduce plan rates by 5 percent	$24.8 m ($8.8 m GF)	$57.1 m ($20.2 m GF)	$81.9 m ($29 m GF)
Annual $1,500 benefit limit for dental coverage	--	$5.3 m ($1.9 m GF)	$5.3 m ($1.9 m GF)
Totals	**$35.5 m ($11.7 m GF)**	**$124.9 m ($45.3 m)**	**$160.4 m ($57 m GF)**

***Premiums vary by income, family size and type of plan.*

2008 Shortfall

Near the end of calendar year 2008, the HFP experienced a funding shortfall that resulted primarily from the delay in savings from delayed implementation of these 2008 cost containment measures due to the delay in passage of the state budget, among other factors. The MRMIB board considered instituting a waiting list for the program. However, the First 5 California provided approximately $17 million to MRMIB to make up the shortfall, and a waiting list was not implemented. First 5 dollars could only be used for new enrollees, 0-5 years old.

2009 Reductions and Solutions

The 2009 Budget Act includes a $174 million General Fund reduction to the Healthy Families Program. With this reduction, the General Fund appropriation was just over fifty percent of the estimated need to fully fund the program. In July of 2009, MRMIB stopped enrolling new children and started a waiting list that, within a few months, grew to approximately 90,000 children. In addition to the waiting list, MRMIB was preparing to begin disenrollment of children from the program in October of 2009. However, two stop-gap funding mechanisms were agreed to last year and are currently supporting the program: 1) First 5 California contributed approximately $80 million to cover the costs of children ages 0-5; and 2) AB 1422 (Bass, Chapter 157, Statutes of 2009) expanded an existing tax on insurance companies to include managed care plans in order to raise additional revenue for the HFP. AB 1422 sunsets on December 31, 2010, however the Governor has proposed extending the sunset, a proposal that will be formally considered at a later hearing that covers Department of Health Care Services issues. The Governor's proposed 2010-11 budget for this program assumes that AB 1422 will be extended and that First 5 California will cover the costs of children ages 0-5, as they did last year.

2010-11 Program Budget

The Governor's proposed 2010-11 budget, which assumes the proposed reduction in eligibility from 250 to 200 percent FPL, an increase in premiums, and

elimination of the vision benefit (all discussed later in this agenda), includes a total budget of $919 million ($126 million General Fund). Please see the table below for additional details.

HEALTHY FAMILIES PROGRAM EXPENDITURE PROJECTIONS			
EXPENDITURES	**CURRENT YEAR 2009-10 NOVEMBER ESTIMATE**	**BUDGET YEAR 2010-11 NOVEMBER ESTIMATE**	**DIFFERENCE**
General Fund	$214,768,000	$125,915,000	-$88,853,000
Federal Funds	$731,617,000	$592,174,000	-$139,443,000
Proposition 10	$77,212,000	$55,632,000	-$21,580,000
Reimbursements	$8,394,000	$8,334,000	-$60,000
Children's Health and Human Services Fund (AB 1422)	$101,712,000	$137,288,000	$35,576,000
TOTAL FUNDS	**$1,133,703,000**	**$919,343,000**	**-$214,360,000**

Caseload

MRMIB projects HFP caseload to be 1,041,100 by the end of the 2010-11 fiscal year. Caseload increased substantially through much of 2008 and 2009.

Federal Health Care Reform

Federal health care reform has minimal impact on the federal CHIP program, and therefore the Healthy Families Program. Of most significance, the new law requires states to retain current eligibility criteria for both the CHIP and Medicaid programs.

STAFF COMMENT

The Subcommittee requests MRMIB to provide an overview of the short and long-term impacts of federal health care reform on the federal CHIP program, and specifically on California's Healthy Families Program.

ISSUE 3: ELIMINATION OF THE HEALTHY FAMILIES PROGRAM

Budget Issue
Included in the Governor's "trigger" proposals, pending receipt of sufficient federal funds, the Governor proposes full elimination of the Healthy Families Program, for projected General Fund savings of $211.5 million and the loss of $824.8 million in federal funds. Elimination of the program would result in the elimination of health coverage for 1,041,100 (by June 30, 2011) low-income children.

Background
The Governor proposed elimination of this program in 2009 which was rejected by the Legislature.

Federal Health Care Reform
The federal health care reform legislation includes maintenance of effort ("MOE") requirements that prohibit states from reducing eligibility in their CHIP programs, the consequences of which would be the loss of all CHIP and Medicaid matching funds, amounting to several billion dollars for California.

All fifty states have CHIP programs, however Arizona recently enacted legislation to eliminate their program, due to their state fiscal crisis; however, the federal CMS has indicated that this is in violation of federal health care reform. Nevertheless, MRMIB states that CMS has not yet issued guidance on the CHIP MOE and therefore it is unclear as to whether this proposal would definitely violate the federal health care reform MOE; MRMIB believes that they may know definitively by May Revise.

Staff Recommendation – Staff recommends rejection of this proposal as it violates federal law, would lead to the loss of substantial federal funding, and puts at risk the health of more than one million children.

ISSUE 4: ELIGIBILITY REDUCTION IN THE HFP FROM 250% TO 200% FPL

Budget Issue

The Governor proposes to reduce eligibility in Healthy Families from 250 percent to 200 percent of the federal poverty level (FPL) for a reduction of $252.4 million ($63.9 million GF) in 2010-11. This would result in 203,300 children immediately losing their health, dental and vision coverage, as well as an estimated 5,670 children (21 percent of new enrollment) being denied enrollment each month. Finally, an estimated 556 children who are enrolled in both the HFP and the CCS program, due to a CCS-eligible chronic health condition, would lose both their HFP coverage and CCS coverage, which provides them with access to coordinated care and medical specialists.

Background

It is anticipated that children dropped from coverage would receive only episodic health care services. Emergency room visits would likely increase, as well as absences from school. Infants in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into Healthy Families and can remain until age two. AIM would *not* be impacted by this proposal and therefore an estimated 14,900 AIM-linked infants would continue to be eligible for Healthy Families under this proposal. However, infants (0-2 years) who are enrolled in Healthy Families who are not AIM-linked, and whose family incomes are above 200 percent of FPL, would lose coverage.

CHIP Programs in other states:

- 18 other states provide coverage to kids up to 200 percent of FPL or less;
- 9 other states provide coverage to kids up to between 200 and 250 percent of FPL;
- 12 other states provide coverage to kids at or above 250 percent of FPL;
- 7 out of 10 "highest cost of living" states provide coverage to kids up to 300 percent of FPL; and
- New York provides coverage to kids up to 400 percent of FPL.

STAFF COMMENT

The Legislature rejected this proposal last year. This is an eligibility reduction and clearly would violate the federal health care reform MOE, thereby costing California billions in federal dollars.

Staff Recommendation – Staff recommends rejection of this proposal as it violates federal law, would lead to the loss of substantial federal funding, and puts at risk the health of hundreds of thousands of children.

ISSUE 5: PREMIUM INCREASE IN THE HFP

Budget Issue

The Governor proposes to eliminate vision coverage and increase monthly premiums for families with incomes from 151 percent to 200 percent of the poverty level, effective July 1, 2010, for a combined reduction of $65.8 million ($21.7 million GF). For purposes of projecting savings, MRMIB has coupled these two proposals together in order to protect confidential rate information associated with its vision benefit contracts.

Background

All families pay a monthly premium and co-payments. The amount paid varies according to a family's income and the health plan selected. Certain premium discount options can offset some costs. Monthly premiums for families from 151 percent to 200 percent of poverty would be increased by $14 per child (to $30 for one child; $60 for two; and a family maximum of $90 for three or more). Families under 150 percent would not have a premium increase. A state plan amendment would be required. Premiums and co-payments were increased as of November 1, 2009, except for families under 150 percent. Families at 150 to 200 percent had premiums increased by $4 per child (to $16 for one; $32 for two; and a family maximum of $48 for three or more). The Governor's proposal increases it further. Premiums and co-payments were also increased for families from 201 percent to 250 percent as of November 1, 2009. This category is not proposed to be increased due to its assumed elimination. The chart below, provided by MRMIB, shows recent and proposed premium increases.

Premium Increase		**Before Feb 1, 2009**	**After Feb 1, 2009**	**After Nov 1, 2009**	**After July 1, 2010**
Category A (134% FPL – 150% FPL)	1 Child	$7	$7	$7	$7
	2+ Children	$14	$14	$14	$14
Category B (151% FPL – 200% FPL)	1 Child	$9	$12	$16	$30
	2 Children	$18	$24	$32	$60
	3+ Children	$27	$36	$48	$90
Category C (201% FPL – 250% FPL)	1 Child	$14	$17	$24	No premium due to proposal to reduce eligibility to 200% of FPL
	2 Children	$28	$34	$48	
	3+ Children	$42	$51	$72	

Note: Community Provider Plan (CPP) subscribers will receive a $3 discount on premiums, maximum of $9 discount per family per month.

The Governor's savings estimate on the premium increase assumes that no families will decline to enroll or drop coverage as a result of the higher premiums. This is consistent with the state's experience with the last two significant premium increases.

Federal Health Care Reform
Some health care analysts have interpreted federal health care reform provisions such that increases in premiums would violate the MOE, while increases in co-payments would not violate the MOE. MRMIB states that they are uncertain in the absence of CMS guidance and hope to know definitively by May Revise.

STAFF COMMENT

The Subcommittee may wish to ask the Administration for alternative premium and co-payment increase proposals, including savings estimates for increasing premiums for the 200-250 percent category.

Staff Recommendation – Staff recommends leaving this item open until more information about the state's fiscal condition, as well as more detail on federal health care reform, have been received that can inform this decision.

ISSUE 6: ELIMINATION OF VISION BENEFIT IN THE HFP

Budget Issue
An elimination of vision coverage would result in approximately 1 million children losing access to eye exams and glasses. Elimination of vision coverage in Healthy Families would mean that only medically necessary vision-related services, such as eye surgery and treatment for eye injuries, would be covered. Eye exams and glasses would not be covered. The specific projected savings is unknown due to the fact that, as stated in the previous issue, for purposes of projecting savings, MRMIB has coupled the vision and premium proposals together in order to protect confidential rate information associated with its vision benefit contracts.

Background
Vision coverage is an "optional benefit" under the CHIP program -- optional for states to offer it as a benefit under their CHIP programs.

STAFF COMMENT

Questions for MRMIB

1. How many states offer vision benefits under their CHIP programs?

2. How many participating plans offer vision services as part of their benefit package, separate from the HFP vision benefit contracts?

3. Could the state require HFP participating health plans to cover vision services?

4. How are vision benefits covered through Medi-Cal (i.e., through similar contracts or through participating managed care plans?)

Staff Recommendation – Staff recommends leaving this item open until more information about the state's fiscal condition, as well as more detail on federal health care reform, have been received that can inform this decision.

ISSUE 7: ELIMINATION OF PROP 99 FUNDING FROM AIM

Budget Issue

Included in the Governor's "trigger" proposals, pending receipt of sufficient federal funds, the Governor proposes to eliminate all $49.3 million in Proposition 99 funding from the AIM program. AIM is supported by Proposition 99 and federal funds, and receives no General Fund. The Prop 99 funds would be used to backfill General Fund dollars in Medi-Cal. MRMIB states that elimination of all Prop 99 funding would result in elimination of this program.

Background

AIM provides comprehensive health care to pregnant women and educates women about the dangers of tobacco use. Only pregnant women whose family income is between 200 and 300 percent of the federal poverty level are eligible for the program. Pregnant women with incomes below 200 percent of the federal poverty level are eligible for the Medi-Cal program. The AIM Program provides coverage through participating health plans and covers eligible women through their pregnancy and 60 days postpartum. Subscribers pay a premium equal to 1.5 percent of their family income and the plan subsidizes the remaining cost of coverage.

STAFF COMMENT

The Subcommittee requests MRMIB to describe how the AIM program, and the population it serves, will be affected by federal health care reform in the long-term.

Staff Recommendation:. **Staff recommends leaving this item open until more information about the state's fiscal condition, as well as more detail on federal health care reform, have been received that can inform this decision.**

ISSUE 8: ELIMINATION OF PROP 99 FUNDING FROM MRMIP

Budget Issue

Included in the Governor's "trigger" proposals, pending receipt of sufficient federal funds, the Governor proposes to eliminate all $32.3 million in Proposition 99 funding from the MRMIP program. MRMIP is supported by revenue from fees on managed care companies imposed by the State, through the Department of Managed Health Care, Proposition 99 funds, and program participant premiums. No General Fund funds support this program. The Prop 99 funds would be used to backfill General Fund dollars in Medi-Cal. MRMIB states that elimination of all Prop 99 funding would result in elimination of this program.

Background

MRMIP provides health coverage to residents of the state who are unable to secure adequate coverage for themselves and their dependents because insurers consider them to be "medically uninsurable" -- at high risk of needing costly care. The program procures coverage for subscribers through participating health plans. Subscribers pay monthly premiums and the program subsidizes the remaining costs.

MRMIP has 7,100 individuals, per its enrollment cap, and a waiting list of approximately 185 people. Very little outreach is done for this program which suggests that there could be many more eligible, uninsured individuals in California, who are not enrolled, and are not on the waiting list. It costs approximately $3,300 annually to insure an individual through MRMIP.

Federal Health Care Reform

One of the earliest requirements of federal health care reform is for states to establish a temporary high risk pool to provide coverage to currently uninsured individuals with pre-existing conditions, the population currently served by MRMIP in California. The new law requires implementation within 90 days of the effective date of the Act, and specifies that eligible individuals must:

1. Be a citizen or national of the United States or here lawfully;
2. Not have had health insurance for the previous six months; and
3. Have a pre-existing condition.

Health and Human Services Secretary Kathleen Sebelius explained in a letter to all state Governors that HHS's goal is to grant states flexibility in meeting this requirement. Specifically, the letter states:

"We recognize that there are different avenues for states to carry out the statutory requirements for a high risk pool program. A state could consider the following options:

- Operate a new high risk pool alongside a current state high risk pool;
- Establish a new high risk pool (in a state that does not currently have a high risk pool);
- Build upon other existing coverage programs designed to cover high risk individuals;
- Contract with a current HIPAA carrier of last resort or other carrier, to provide subsidized coverage for the eligible population; or
- Do nothing, in which case HHS would carry out a coverage program in the state."

STAFF COMMENT

The Subcommittee requests MRMIB to provide an explanation of the dramatic fluctuations in funding in this program over the past two years, as illustrated in the tables on pages 8 and 9 of this agenda.

The Subcommittee also requests MRMIB to describe in as much detail as is available the temporary high risk pool requirements of federal health care reform and what the possible impacts are to MRMIP.

Staff Recommendation: Staff recommends leaving this item open until more information about the state's fiscal condition, as well as more detail on federal health care reform, have been received that can inform this decision.