California Major Risk Medical Insurance Program

2006 FACT BOOK

The California Managed Risk Medical Insurance Board

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STAFF OF THE
MANAGED RISK MEDICAL INSURANCE BOARD

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The Managed Risk Medical Insurance Board extends great appreciation to the California HealthCare Foundation based in Oakland, California for its financial support of the 2005 Guaranteed Issue Pilot Program Survey.

Major Risk Medical Insurance Program 2006 Fact Book
REPORT HIGHLIGHTS

OVERVIEW

This report results from major activities undertaken by the Managed Risk Medical Insurance Board in 2005. These activities included:

- Conducting two subscriber surveys of participants in Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot Program (GIP) also known as the AB 1401 pilot.
- Evaluating program funding and enrollment capacity, including options for increasing capacity in the high risk pool or otherwise providing insurance coverage for medically uninsurable persons.

Section I through IX of this report present information on MRMIP, its current and past subscribers, and includes comparative data on former subscribers subject to the GIP. Section X of this report presents extensive findings from the study required by AB 1401 (Thomson; Chapter 794/Statutes of 2002) of the GIP and particular focus on those who accepted guaranteed coverage under the pilot and those that did not.

PROGRAM SUMMARY

MRMIP began serving subscribers in 1991. It provides 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. Subscribers are charged a monthly premium ranging from 125% to 137.5% of their plan's standard average individual rate adjusted for the MRMIP benefit standards. The premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Because the appropriation from the Cigarette and Tobacco Surtax Fund is limited, the total number of individuals who can participate depends on available funding.

Under the GIP, when the subscriber's 36 months of enrollment in MRMIP ends, subscribers can select guaranteed continued coverage from insurers in the individual market. About 65% of MRMIP subscribers enroll in GIP coverage, and of these, 80% percent of the persons enroll in the same health plan they were in under MRMIP. Subscriber premiums in the GIP are set at 10% above the MRMIP premium level. This program is a four-year pilot program that will end in 2007.

California is one of thirty-four states operating a high-risk health insurance pool. With 2004 enrollment of 12,221 subscribers (not including the 7,569 GIP subscribers), MRMIP is the third largest pool in the country, exceeded only by

Minnesota's, which had an enrollment of 32,959 and Texas' with an enrollment of 27,573. The MRMIP has served 97,980 individuals since its inception.

OPTIONS COVERING MEDICALLY UNINSURABLE PERSONS

California is one of three states that places caps on enrollment in their high risk pool. Capped enrollment compels persons needing coverage to go without needed health care. Until the implementation of the GIP, there was always a waiting list for enrollment into MRMIP. Sixty-four percent of current MRMIP subscribers say that if MRMIP were not available, they would either have to pay for health care as needed (33%) or receive no health care (31%).

Options California could consider to cover more medically uninsurable are: require carriers to cover these persons at affordable premiums as is required in 15 states; assess carriers a fee; assess carriers a fee and allow tax credits for these assessments as in 10 other states; place a surcharge on providers as 3 states do; increase state support using other revenue sources like 13 others states have done; and pursue potential federal funding recently made available.

All of these options present opportunities and costs; many would require changes in the benefit structure of MRMIP.

FUNDING MRMIP AND GIP

Over one–half of the funding for MRMIP comes from subscriber premiums. A total of $41 million in premiums were paid by subscribers in 2005. The average subscriber premium in MRMIP is $466 per month. Premium payments represent from 19% to 36% of monthly income for MRMIP subscribers. The other financial support for MRMIP comes from Proposition 99 funds. Over two-thirds of the funding for those who enroll in guaranteed coverage under GIP comes from subscribers. In 2004, this amounted to $51 million. More than 30% of subscribers in GIP pay a monthly premium of more than $600. GIP is subsidized equally with Proposition 99 funds and funds from insurers in the individual market. In 2004, total revenue for both MRMIP and GIP was $129 million.

The appropriation for MRMIP has only increased from its original $30 million level to its current level of $40 million in 1997. No additional appropriation was made to support the GIP when it was piloted in 2003. Due to the structure of insurer financial participation under AB 1401, all insurer costs come from plans participating in MRMIP and the vast majority comes from the plan with the greatest MRMIP enrollment. This carrier had sixty-seven percent of the enrollments in GIP and provided over eighty-six percent of the subsidy funded by carriers since the GIP began in 2003.

Results from the MRMIP survey show that over 70% of those in MRMIP would be interested in deductible coverage as an alternative to high-cost premiums.

ELIGIBILITY AND ENROLLMENT

The majority of subscribers in MRMIP—63%—are eligible because they have been denied coverage. When asked about their prior insurance coverage status, 50% indicated they had health insurance prior to enrolling in MRMIP, and when asked why they switched to MRMIP coverage, about 72% said they could not get coverage elsewhere. Most of these subscribers reported they did not have access to employer sponsored coverage due to their part-time job status (24%) or pre-existing medical conditions (22%).

SUBSCRIBER DEMOGRAPHICS

Household Size and Income: Two or less subscriber households comprise 56% of the MRMIP subscriber households. More than 60% have incomes below $60,000. Four out of 10 households in MRMIP have incomes less that 300 percent of federal poverty level, which in 2005 was $38,490 for a family of two.

For the GIP, two or less subscriber households represent 70% of the subscribers, and like in MRMIP, about 60% of the subscribers in GIP earn less than $60,000 annually. For those who timed-out of MRMIP and did not enrolled in GIP, 17% had annual incomes of less than $20,000.

Employment status: For the MRMIP subscribers surveyed 57% described themselves as unemployed. Of those employed, 55% said they were self-employed.

Occupations: Over 45% work in the professional or service industries; 14% indicated they had never been employed.

Education: 35% of MRMIP subscribers attended college.

Gender and Age: In both MRMIP and GIP, most subscribers are women. The average age in MRMIP is 43 and in GIP it is 50. For the subscribers who chose not to enroll in GIP coverage, over 61% were over 50 years old.

MEDICAL COSTS

The vast majority of MRMIP subscribers who have claims (over 80%) have medical costs of less than $5,000 a year. In 2004, 9% of MRMIP subscribers did not make any claims. Close to 80% of those enrolled in coverage under the GIP, had costs of less than $10,000 a year.

The highest categories of expenditures in MRMIP in 2004 and for GIP throughout its existence are somewhat evenly spread among inpatient services, physician office services and prescription drugs, which contrasts with the findings in 1998 which found prescription drugs was the highest cost category above all others.

MEDICAL CONDITIONS

When asked to identify their most critical medical condition, most MRMIP subscribers and persons moved to GIP indicated they had none. Their most prevalent medical conditions are diabetes, cancer and mental disorders. Sixty-five percent of MRMIP subscribers had indicated in the survey that their current health condition is the same as the one that caused enrollment in MRMIP. Persons disenrolled to GIP reported a wide variety of medical conditions, the most frequent being cancer, obesity and mental disorder. In contrast to MRMIP, only fifty-one percent GIP subscribers responded that their current condition was the same condition as when they enrolled in the GIP coverage.

When asked about their health status, 79% of MRMIP subscribers assessed their health as good to excellent; in GIP, only 73% said their health was good to excellent, and when each group's self assessment was correlated to premiums paid, data showed MRMIP subscribers had lower medical claim costs. GIP subscribers, however, had higher costs.

MRMIP SUBSCRIBER SATISFACTION

Eighty-four percent of MRMIP subscribers reported they were satisfied with the program; eight-nine percent were satisfied with their ability to obtain medical care. Seventy-six percent said there were receiving the health benefits they needed.

GIP ACCEPTERS VS. DECLINERS

The pilot, which is partially financed with insurer funds, expanded California's capacity to service medically uninsured persons. Initially, 75% of persons disenrolled from MRMIP under GIP purchased guaranteed issue coverage. As of June 2005, 58% were enrolled in such a plan. The first year of cost data for acceptors indicate that they could command a large share of the $40 million state appropriation, resulting in a significantly reduced MRMIP capacity. A higher percentage of those who declined guaranteed coverage fell in the lowest income bracket. Fewer accepters thought they were in good to excellent health than decliners.

A full copy of this report is available at www.mrmib.ca.gov.

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Section I

Introduction and Overview

INTRODUCTION

This report is intended to provide policy makers with information on Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot Program (GIP) for disenrolled subscribers, to assist policy makers in their deliberations on how to provide coverage to the medically uninsured. It contains information on funding, enrollee demographics, claims costs, and results of two surveys, one on MRMIP subscribers and the other on the experience of those eligible for GIP, those who accepted GIP coverage and those that declined it.

OVERVIEW

The United States Census Bureau estimates that approximately 45.8 million Americans, or 15.7% of the nation's population, were uninsured in 2004[1]. Of these uninsured, a study commissioned by the Centers for Medicare and Medicaid Services (CMS) estimated 6% are both uninsured and federally uninsurable[2]. Another study by the Board's actuary, PricewaterhouseCoopers (PwC), estimates that between 2.5% and 5% of the people in the individual market are uninsured and uninsurable[3]. Based on these estimates, between 165,000 and 396,000 Californians may be uninsurable, uninsured and in need of insurance.

California is one of 34 states operating a health insurance pool to provide coverage to those unable to obtain it in the individual market. California's high-risk pool is the third largest in the country, exceeded only by Minnesota's, which had an enrollment of 32,959 in 2004 and Texas', with an enrollment of 27,573 in 2004. California is one of only three states that has capped enrollment.

MAJOR RISK MEDICAL INSURANCE PROGRAM

The Major Risk Medical Insurance Program (MRMIP), California's high-risk health insurance pool, is administered by the Major Risk Medical Insurance Board (MRMIB) and provides health coverage to individuals who are unable to purchase private coverage because the insurance industry views them as uninsurable. In California, health insurers may decline coverage to individuals based on health risk and have few limitations on what they may charge if they decide to provide it. Insurers are concerned about the possibility of adverse risk in the individual market where individuals pay the full cost of coverage. Therefore, insurers deny coverage or charge high prices for those

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[1] DeNavas-Walt,C.; Lee, C.; and Proctor, B.; Income, Poverty, and Health Insurance Coverage in the United States: 2004; August, 2005: U.S. Census Bureau; page 16.

[2] Frakt, A.; Pizer: S.; and Wrobel, M.; High Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects: Winter 2004-2005, Health Care Financing Review; Volume 26, Number 2; page 74.

[3] Hunt, S.: Individual Health Insurance Options for California; September 2000 (Report presented to the Managed Risk Medical Insurance Board by PricewaterhouseCoopers, the Board's contract actuary.)

individuals they think may have higher costs. This may make health insurance unavailable or unaffordable for many people who have or have had chronic or other health conditions. Individuals participating in MRMIP have been denied individual coverage or are unable to afford the coverage that is available to them.

MRMIP provides comprehensive benefits to subscribers and their dependents. Health plan participation in the program is voluntary. One Preferred Provider Organization (PPO) and three Health Maintenance Organizations (HMOs) participate in the program. The program has statewide coverage and subscribers have a choice of two or more health plans in most urban areas of the state.

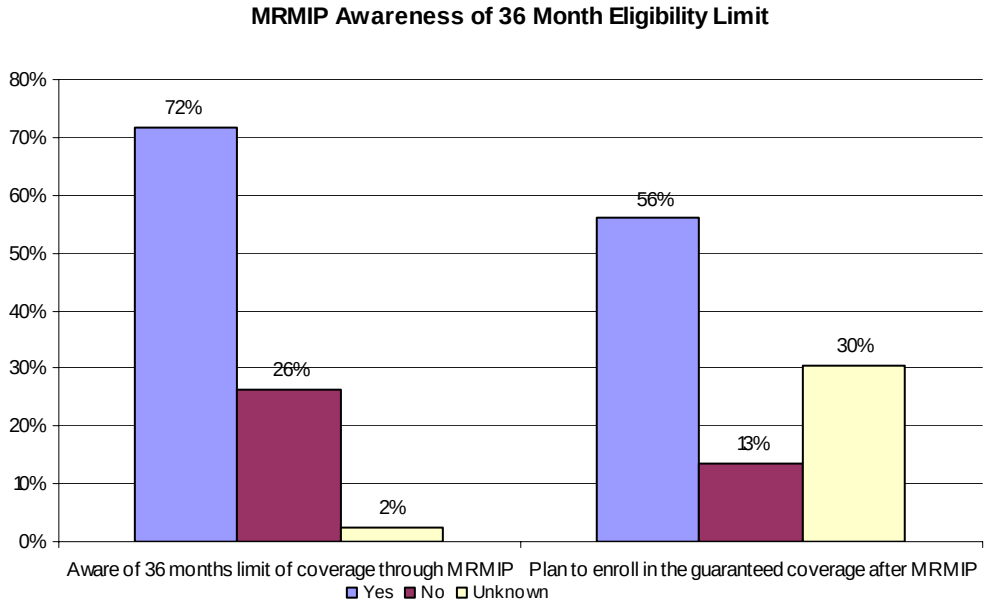
MRMIP began serving subscribers in January 1991, and has served 97,980 individuals since its inception. The average MRMIP subscriber is female, 43 years of age, lives in a household of two persons or fewer, lives in the greater Los Angeles area, and has an annual income between $20,000 and $40,000. Until the program was revamped in 2003 by new legislation (see discussion of the MRMIP Guaranteed Issue Pilot Program (GIP) on the next page) the demand for the program consistently exceeded the program's capacity and, as such, the program almost always maintained a waiting list for new subscribers.

The increased enrollment capacity resulting from insurance industry financial participation in GIP resulted in the elimination of the waiting list on a sustained basis for the first time since MRMIP began. However, there has been only minimal marketing of the program and enrollment is significantly below estimated need. Over time, it is expected the program will once again reach capacity and the waiting list will have to be reestablished. Additionally, the GIP has a sunset date of September 2007. Thus, this year, policy makers will be assessing the State’s approach to covering the medically uninsurable.

MRMIP Subscribers’ Awareness of Eligibility Limit

Under the GIP (below), MRMIP subscribers are disenrolled after 36 months and given access to private market coverage. Current MRMIP subscribers were asked whether they were aware of the 36 month limit on MRMIP eligibility. Seventy-two percent were aware of the time limit. Fifty-six percent indicated that they plan to enroll in the GIP following MRMIP.

Chart I-1



Source: 2005 MRMIP Subscriber Survey, (N=432)

GUARANTEED ISSUE PILOT PROGRAM

The goal of the MRMIP Guaranteed Issue Pilot Program (GIP) is to get the maximum benefit from limited state dollars by providing market-based industry-subsidized, mechanisms for the continued coverage of high risk individuals. To that end, AB 1401 (Chapter 794, Statutes of 2002) set up a four year pilot, which began on September 1, 2003 and will end on August 30, 2007. The intent of AB 1401 was to share the cost of 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 3 years guaranteed access to that market.

GIP

Under the GIP, MRMIP subscribers get a maximum of 36 consecutive months of coverage in MRMIP. Three months prior to the end of that period, the MRMIP Administrative Vendor, Blue Cross, notifies subscribers of 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 must 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 the plan on requirements in MRMIP. Plans set premiums at 10% 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, the Department of Managed Health Care (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.

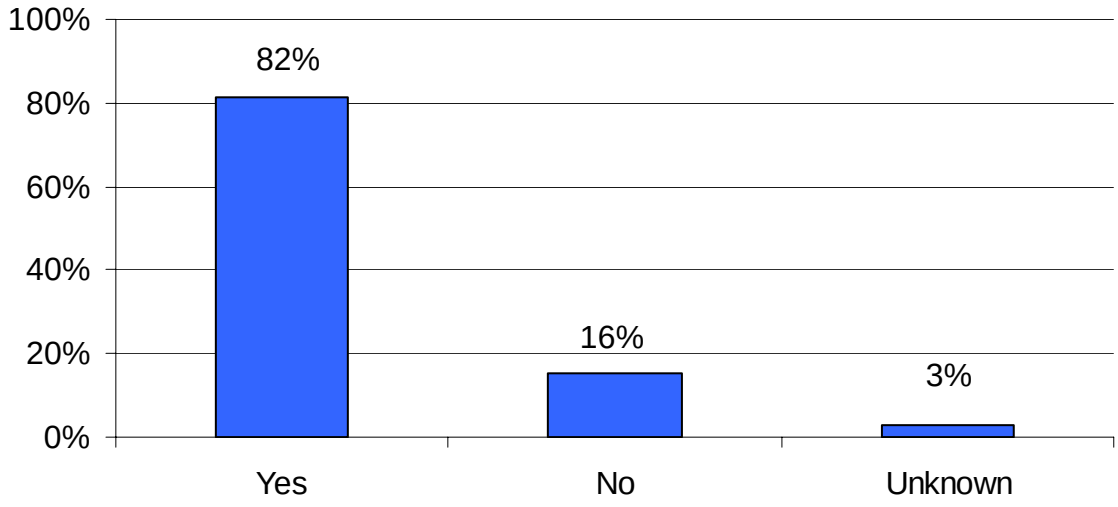
The average GIP subscriber is female, 50 years of age (slightly older that the average in MRMIP), lives in a household of two persons or fewer, lives in the greater Los Angeles area and has an annual income between $20,000 and $40,000.

GIP Disenrollees Awareness of Eligibility Limit

Subscribers who were disenrolled from MRMIP to GIP were asked whether they were aware of the 36 month limit on MRMIP eligibility. Eighty-two percent said they were aware of the time limit.

Chart I-2

GIP (Accepters and Decliners)
Awareness of 36 Month Eligibility Limit



Source: 2005 GIP Independent Survey, (N=400)

GIP Plans

Health plans doing business in the individual market must offer the same benefits as one of the three commercial MRMIP contract plans. These are the Blue Cross Preferred Provider Organization, the Blue Shield HMO or the Kaiser HMO. (Contra Costa Health Plan is the fourth MRMIP contact plan, but the plan is exempt from offering a GIP product.) The premium rate for GIP products is set at 10% over the MRMIP rate for the comparable products.

Each plan's losses in excess of subscriber premiums are shared equally, on an aggregate basis, by the plan and the State. Each plan also receives a standard monthly administrative fee.

MRMIB pays the state's share of GIP losses and plan administrative fees out of the same $40 million annual appropriation that funds MRMIP. The statute requires MRMIB to stay within this appropriation for both programs. If at any point the state does not pay its share of the subsidy to a plan, the plan may charge GIP subscribers higher premiums.

MILESTONES OF THE MAJOR RISK MEDICAL INSURANCE PROGRAM

1991: MRMIP opened in late January with 400 subscribers and an annual appropriation of $30 million from the Cigarette and Tobacco Surtax Fund. The Board set a maximum enrollment level of 10,000 to ensure that the program would operate within its budget. Annual benefits were capped at $50,000 with a lifetime maximum of $500,000. This annual benefit cap doubled the number of people that could be served by the $30 million. By December 1, 1991, enrollment reached maximum capacity and 3,464 applicants were placed on a waiting list.

1992: The waiting list grew to 4,200 applicants in December. The waiting time for entry into the program was approximately 12 months. By the end of the year, the average cost per subscriber was found to be lower than estimated and the enrollment cap was increased to 14,000 individuals.

1994: Blue Cross of California established a MRMIP look-alike program which allowed applicants on the MRMIP waiting list to purchase coverage at unsubsidized rates until they could be admitted to the program.

1996: Some of the health plans participating in MRMIP were experiencing higher than average loss ratios. As a result, these plans required a higher than average subsidy. To help offset the increase in program costs, legislation was enacted that increased subscriber contributions by up to 10% for individuals who selected certain health plans with higher loss ratios.

1997: An additional $10 million in annual Tobacco Tax revenue was appropriated for MRMIP, bringing the total appropriation to $40 million. Blue Shield of California introduced a MRMIP look-alike program to serve persons on the waiting list.

1998: The enrollment level was increased to 21,900 persons.

1999: The maximum benefit and lifetime cap for the program were increased to $75,000 and $750,000 respectively. For the first time, the program's maximum enrollment level was reduced, to 21,124. This reduction was the result of increases in program benefit levels, health care cost inflation and the fixed appropriation available for the program. The California Health Care Foundation provided one-time funding of $2 million to ameliorate the enrollment reduction. This grant preserved 448 enrollment spaces in MRMIP.

2000: The Blue Cross and Blue Shield look-alike products were no longer offered to additional purchasers. Enrollees were allowed to remain in the product until they left on their own or were able to enroll in MRMIP. Enrollment target levels in MRMIP were reduced to 18,332 and the waiting list was at 5,931 by the end of the year. The Legislature appropriated $5 million on a one time basis for Fiscal year 2001-02 to increase the number of people who could be served.

2001: The California Health Care Foundation renewed its grant, funding 453 spaces. However increases in health care costs and an increase in the average number of months that people remained in MRMIP lowered the April 2001 estimate for the maximum enrollment level to 15,715. By November, an all time high of 7,098 persons were on the waiting list.

2002: Governor Gray Davis challenged the Board and the health insurance industry to develop a market based solution that improved access for high risk populations without increasing state spending. In response, the Legislature passed and the Governor signed AB 1401 (Thomson) (Chapter 794, Statutes of 2002). AB 1401 made several changes to insurance laws and established the GIP, with a sunset date of September 1, 2007.

2003: The GIP was implemented in September, 2003. By the end of 2003, 9,594 persons were disenrolled from MRMIP as a result of the 36 month limit. Of these, 7,832 (82 percent) initially selected a GIP product. Maximum enrollment target levels for MRMIP were set at 10,718.

2004: Enrollment in MRMIP slowed dramatically because prices for coverage, based upon prices in the individual market, had risen significantly (37% from 2002 to 2004). By December of 2004, 6,199 people were enrolled in a GIP product. Maximum enrollment target levels for MRMIP remained at 10,718, and enrollment did not reach capacity.

2005: AB 356 (Chapter 356, Statutes of 2005) required that health plans and insurers provide information on MRMIP to all applicants who are rejected for insurance or are offered a higher rate because of their health status. Cost projections for funding individuals in the GIP caused enrollment estimates for MRMIP to be lowered again in April to 9,014. There was insufficient enrollment in MRMIP to reach this limit.

2006: Less than maximum enrollment leads to reduced program costs. Because of lower costs and refined estimates, the maximum enrollment limit is set at 10,227.

Chart I-3 displays the maximum monthly enrollment levels from 1991-2005.

Chart I-3

MRMIP Maximum Enrollment Levels 1991-Present

Dec-91	10,000
Jan-92	11,200
Jan-93	14,000
Sep-93	16,400
May-94	18,040
Nov-97	19,535
Jul-97	19,917
Jun-98	21,900
May-99	21,124
Apr-00	19,100
Oct-00	18,332
Apr-01	15,715
Oct-01	17,653
Apr-02	14,658
Dec-02	16,686
May-03	16,686
Oct-03*	10,782
Apr-04	10,718
Oct-04	10,718
Apr-05	9,014
Dec-05	10,227

* GIP Started
Sources: Various Enrollment Estimates presented to the Board by Coopers & Lybrand and PwC, 1991-2005.

Section II

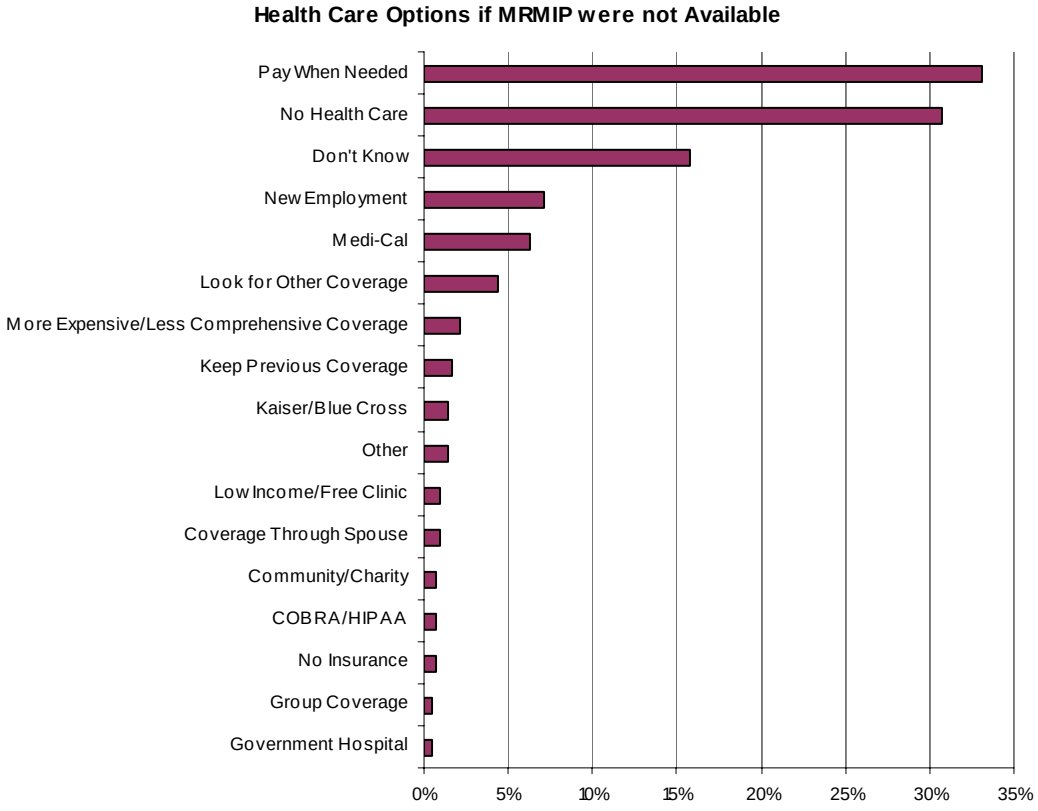
Covering More Medically Uninsurable Persons

COVERING MORE MEDICALLY UNINSURABLE PERSONS

California is one of three states that place caps on enrollment in their high risk health insurance pools. Illinois and Louisiana have enrollment caps for their risk pools. Like California, these states use tax revenue as the primary funding source. Arkansas and Oklahoma statutes, allow for enrollment caps, but the funding, which comes from assessments on carriers, has proved sufficient to keep the programs open. Capped enrollment compels people needing coverage to go without needed health care.

Sixty-four percent of current MRMIP subscribers say that if MRMIP were not available, they would either have to pay for health care when needed (thirty-three percent) or receive no health care (thirty-one percent).

Chart II-1



Source: 2005 MRMIP Subscriber Survey, (N=432)

SOURCES OF FUNDING BY STATES

The following section identifies a number of options that could be used to cover more medically uninsured persons. Chart II-2 details how states finance their pools for uninsured persons.

Eliminate the Need for the MRMIP

The State could eliminate the need for the MRMIP by enacting rules requiring carriers to provide coverage in the individual market and limiting the differential they could charge for people viewed as higher risk. Insurers have long resisted the provision of guaranteed issuance in the individual market, citing concerns about adverse selection, increased costs in the individual market, and consequent higher numbers of uninsured. To address these concerns, reform advocates have proposed several mechanisms to mitigate against adverse selection. These include limiting the guaranteed issuance rights of individuals to their birthday months, or putting high risk individuals on a waiting list for a period of time prior to entering the individual insurance market. Several states-Kentucky, Washington, New Hampshire and South Dakota-have tried different types of guaranteed issue strategies. These states have shifted to using high risk pools because of negative impacts. For example, insurers dropped out of the individual market or the state, resulting in the loss of price competition as the individual market shrank.

Assessment of Health Insurers

This is the most common option used by states to fund their high-risk pools. Under this approach, enrollment in pools is not capped and commercial insurers are assessed to fund the subsidy needed to cover all high-risk pool subscribers. Assessments of health insurers bring a larger, more flexible revenue source, which spreads the cost of covering the medically uninsured across the health insurance industry.

Currently, **seventeen states** use health insurer assessments to fund all or part of their high risk pools.

Assessment on Health Insurers with a Tax Credit

Under this approach, insurers are assessed for the costs of the program, but the assessments to insurers are offset against the state premium taxes or income taxes paid by insurers. Variations of this approach include placing a cap on the amount of the assessment that could be offset in any year, or establishing a minimum assessment amount that must be paid prior to receiving a tax credit. The tax credit would apply only to amounts above the minimum assessment. The state indirectly funds the pool through the loss in tax revenue.

Currently, **ten states** utilize assessments offset by tax credits.

Service Charge on Health Care Providers

Under this approach, a surcharge is placed on health care providers, usually hospitals and ambulatory surgical centers, to fund the pool. An advantage to this approach is that the assessment burden is widely spread throughout the health care delivery

system. In addition, persons covered under Employee Retirement Income Security Act (ERISA) plans are indirectly included in the assessment formula.

Three states use this approach, with one using it in conjunction with assessments on health insurers.

Increased Commitment of State Funds

The concept behind state funding for high risk pools is the belief that the state has a role in subsidizing insurance coverage for people with pre-existing health conditions, leaving the individual insurance market to serve those identified by the market as "good risks". State Funding for high risk pools is assumed to preserve the viability of the individual insurance market for low–risk individuals. However, use of state general or special fund, puts the risk pool in competition with other state priorities, especially when there are downturns in state tax revenues.

California is one of **fourteen states** that allocate general revenues, income tax revenues, unclaimed property funds, tobacco taxes, or tobacco settlement revenues to fund part or all of their high-risk pools. Only **two states** rely solely on state funds. California was the third until enactment of AB 1401.

The primary source of funding for MRMIP has been from Cigarette and Tobacco Surtax (Prop. 99) revenues. As Prop. 99 revenues decline, sustaining or increasing the current $40 million appropriation comes at the expense of other Proposition 99 programs. Alternatively, state general funds could fund MRMIP.

Chart II-2

Sources of Funding Used by States with High-Risk Pools

State	Allocation of State Funds	Assessment of Health Insurers	Assessment of Health Insurers with Tax Credit	**Other**
Alabama			X	
Alaska		X		
Arkansas			X	
California	X			Health insurer funds for GIP
Colorado	X			Also Unclaimed Property Fund
Connecticut		X		
Florida		X		
Idaho	X	X		
Illinois	X	X		
Indiana	X	X		
Iowa			X	
Kansas			X	
Kentucky	X	X		
Louisiana	X	X		Service charge on providers
Maryland				Assessment on Hospitals
Minnesota	X	X		
Mississippi		X		
Missouri			X	
Montana			X	
Nebraska	X			Uses a premium tax as the funding source rather than an assessment.
New Hampshire		X		
New Mexico			X	
North Dakota			X	
Oklahoma		X		
Oregon		X		
South Carolina			X	
South Dakota	X	X		Reduced Provider Rates at 115% of Medicaid
Tennessee	X			
Texas		X		
Utah	X			
Washington		X		Remittance of Excess Loss Ratio by Individual Carriers
West Virginia				Assessment on Hospitals
Wisconsin		X		
Wyoming			X	

Source: Communicating for Agriculture. Comprehensive Health Insurance for High-Risk Individuals, Nineteenth Edition, 2005. p. 41-46.

FEDERAL FUNDS

Congress recently passed, and President Bush signed, an extension and expansion of a federal grant program for high risk pools originally established in 2002 (HR 4519). The legislation amended provisions that have prevented California and several other states from qualifying for grants, and it seems likely that California can now qualify. The federal budget for Federal Fiscal year (FFY) 2006 provides $90 million nationally for high risk pools. There is no funding for future years at this time.

FFY 2006 funding is for start-up grants, operational loss grants and bonus grants for program improvements such as premium reduction or benefit enhancement. A majority of these funds are flexible and could be used to reduce MRMIP's operational costs, reduce subscriber premiums (for the population at large or for lower income Californians), and increase program benefits (e.g., by increasing the benefit cap or establishing disease management programs). MRMIB staff estimate California's share of the funds could be between $4 million to $8 million.

Chart II-3

Analysis of Potential State High Risk Health Insurance Pool Funding for 2006 in the Federal Budget Reconciliation Act

Amount of Annual Funding [1]	Description of Funds	Allocation Methodology	California's Allotment
$15,000,000	Seed grants to States that do not currently have a qualified high risk pool	Maximum of $1,000,000 for each grantee at discretion of Secretary of HHS	Maximum of $1,000,000
$20,000,000	Grants for losses incurred by the state in conjunction with operation of the pool (state program expenditures)	Allotted in equal amounts to each state that applies for a grant	Maximum of $606,000 and minimum of $400,000
$15,000,000	Grants for losses incurred by the state in conjunction with operation of the pool (State program expenditures)	Allotted to each state that applies for a grant based on their number of uninsured compared to total uninsured nationally	$2,730,000 or 18.2% based on 2002 CPS data
$15,000,000	Grants for losses incurred by the state in conjunction with operation of the pool (state program expenditures)	Allotted to each state that applies for a grant based on the number of individuals participating in the high risk pool compared to total participants	Maximum of $1,280,000 if GIP participants are counted, Minimum of $732,000 if not
$25,000,000	Supplemental Consumer Benefits as defined below [2]	Allocation formula to be developed by Secretary, but a maximum of 10% or $2,500,000 per Grantee	Maximum of $2,500,000

1) All allotments are available for two federal fiscal years.

2) The state shall use amounts received under the Supplemental Consumer Benefits Grant to provide one or more of the following benefits:

(A) Low-income premium subsidies.

(B) A reduction in premium trends, actual premiums, or other cost-sharing requirements.

(C) An expansion or broadening of the pool of individuals eligible for coverage, such as through elimination of waiting lists, increasing enrollment caps, or providing flexibility in enrollment rules.

(D) Less stringent rules, or additional waiver authority, with respect to pre-existing conditions.

(E) Increased benefits.

(F) The establishment of disease management programs.

Federal CMS staff has expressed concern about MRMIP's $75,000 benefit cap and have suggested that it might have to be revised to be more in keeping with traditional insurance if MRMIP is to qualify for federal funds. PwC, the Board's actuary, has estimated that the actuarial value of the MRMIP Benefits would increase approximately 4.5% if the benefit cap were increased to $250,000 and 5.5% if the cap were increased to $500,000. However, PwC also reports that early data from the GIP (which has a $200,000 cap) suggest that the true cost to MRMIP of increasing the limit would be higher, in the range of 10% to 12%, for an increase to $250,000. Data are not available to directly estimate the costs associated with an increase to $500,000, but PwC estimates the subsidy cost would increase by at least 15%. The difference between increases in actuarial value and increases in actual costs results from the way premiums are calculated. Specifically, subscriber premium amounts are based on a standard commercial premium, while the state's subsidy costs relate to actual expenditures for the enrolled population.

LOWER PROGRAM COSTS

The Board can also develop ways to lower program costs. Options for cost reductions include reducing the maximum annual benefit level, eliminating specific benefits; or reducing payments to health plans. Program costs might also be reduced by adding advanced disease management programs to the MRMIP benefit structure.

Section III

Funding for MRMIP and GIP

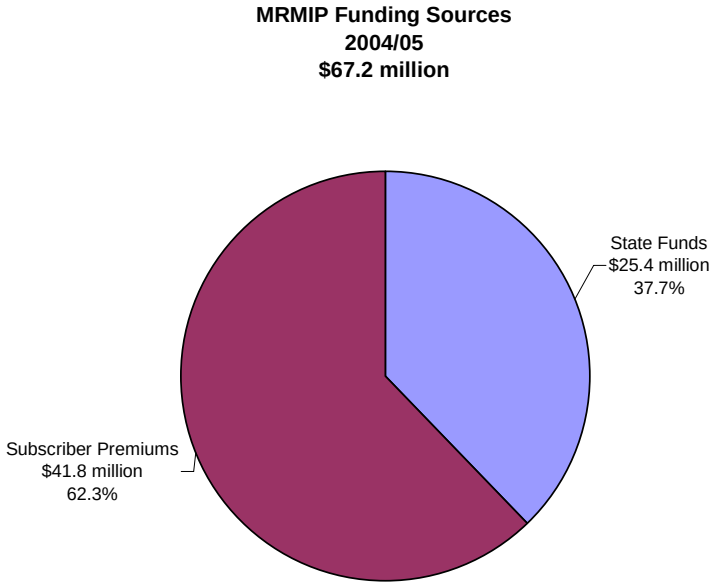
FUNDING FOR THE MRMIP AND GIP

Funding for MRMIP and GIP comes from subscriber premiums, subsidies from the Cigarette and Tobacco Products Surtax Fund (Proposition 99) and, for the GIP, subsidies from participating plans.

MRMIP

As show in Chart III-1, sixty-two percent of MRMIP program revenues are from subscriber premiums.

CHART III-1

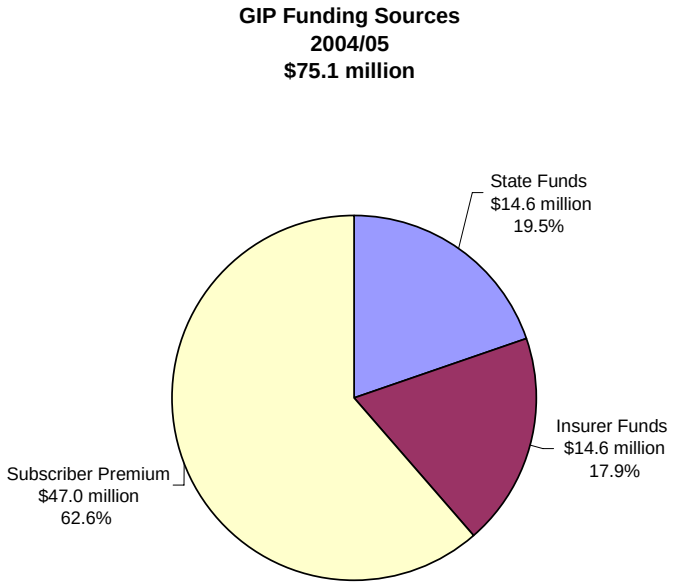


Sources: MRMIP from State accounting system (CALSTARS)

GIP

Sixty-three percent of the GIP revenues are from subscriber premiums.

CHART III-2



Sources: MRMIP from State accounting system (CALSTARS) and GIP paid invoices submitted

STATE APPROPRIATION

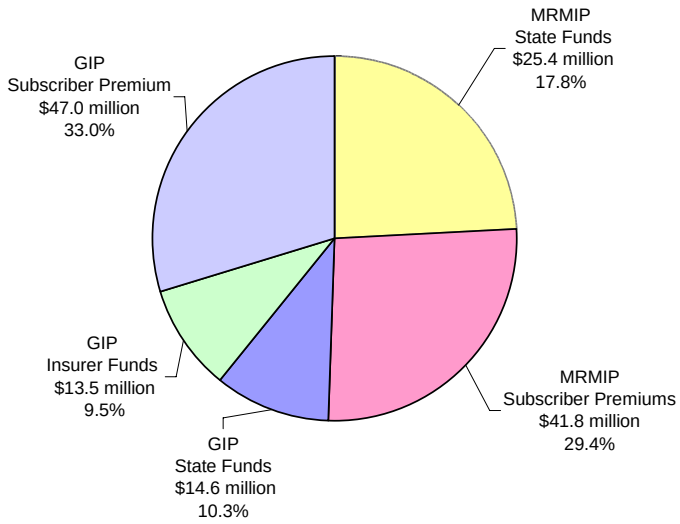
The original appropriation for MRMIP was $30 million/year from Proposition 99 funds. In 1997, the appropriation amount was increased to $40 million. Funding has remained at the $40 million level with the exception of a legislatively mandated augmentation of $5 million for FY 2000-01. In 1998, Governor Davis called for the health insurance industry to develop a private sector means to cover unmet need for medically uninsurable persons. In response to Governor Davis, the insurance industry sponsored the AB 1401 legislation which resulted in the GIP.

MRMIB did not receive additional funds for the GIP, so the existing $40 million appropriation must fund the estimated costs of the state subsidy for the pilot. Any money remaining is used to fund slots in MRMIP. Presently, about $14.6 million of the appropriation is spent on the pilot and $25.4 million on MRMIP. Chart III-3 shows the total distribution of Prop. 99 funding and subscriber funding per program.

Total revenue for FY 2004/2005 was approximately $142.3 million.

CHART III-3

MRMIP and GIP Funding Sources
2004/05
$142.3 million



Sources: MRMIP from State accounting system (CALSTARS) and GIP paid invoices submitted by health plans.

HEALTH INSURER FINANCING FOR GIP

Insurers in the individual market agreed to share equally with the state in the subsidy costs for the GIP population. However, the costs of this subsidy are not borne by the industry in general but rather by the plans with which GIP subscribers enroll. Only 4 insurers in the individual market participate in MRMIP (Blue Cross PPO, Blue Shield HMO, Kaiser and Contra Costa Health Plan).

Enrollment in MRMIP is distributed as follows:

Chart III-4

Blue Cross PPO	52%
Kaiser HMO	41%
Blue Shield HMO	6%
Contra Costa Health	1%

Source: MRMIP 2005 Enrollment Data

Only three of these insurers (Blue Cross PPO, Blue Shield HMO and Kaiser) participate in the GIP. Eighty-percent of people purchasing GIP coverage tend to remain in the same plan that they had while in MRMIP. This means that the insurers'

share of subsidy cost is concentrated in the plans that are in MRMIP. Another major factor affecting the amount of subsidy required is the type of coverage an insurer provides. Generally, PPO's have higher costs than HMO's. The Blue Cross PPO is the only PPO in MRMIP and the only PPO that offers GIP.

Chart III-5 shows the enrollment in GIP products in June 2005. The chart shows that 67% of enrollment was in Blue Cross and that there was minimal enrollment in plans that do not participate in MRMIP.

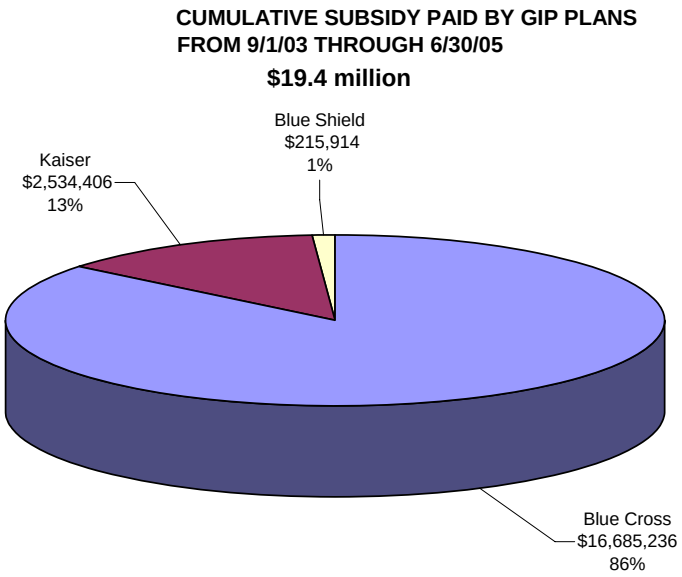
Chart III-5

Blue Cross PPO	67%
Kaiser HMO	30%
Blue Shield HMO	2%
Health Net HMO	1%

Source: GIP Participating Plans Reporting Enrollment

Chart III-6 shows the breakdown by plan of the almost $20 million in subsidies provided by plans through June 30, 2005. It shows that Blue Cross has provided the greatest share of subsidy funds.

Chart III-6



Source: GIP Participating Plans Reporting Enrollment

SUBSCRIBER PREMIUMS

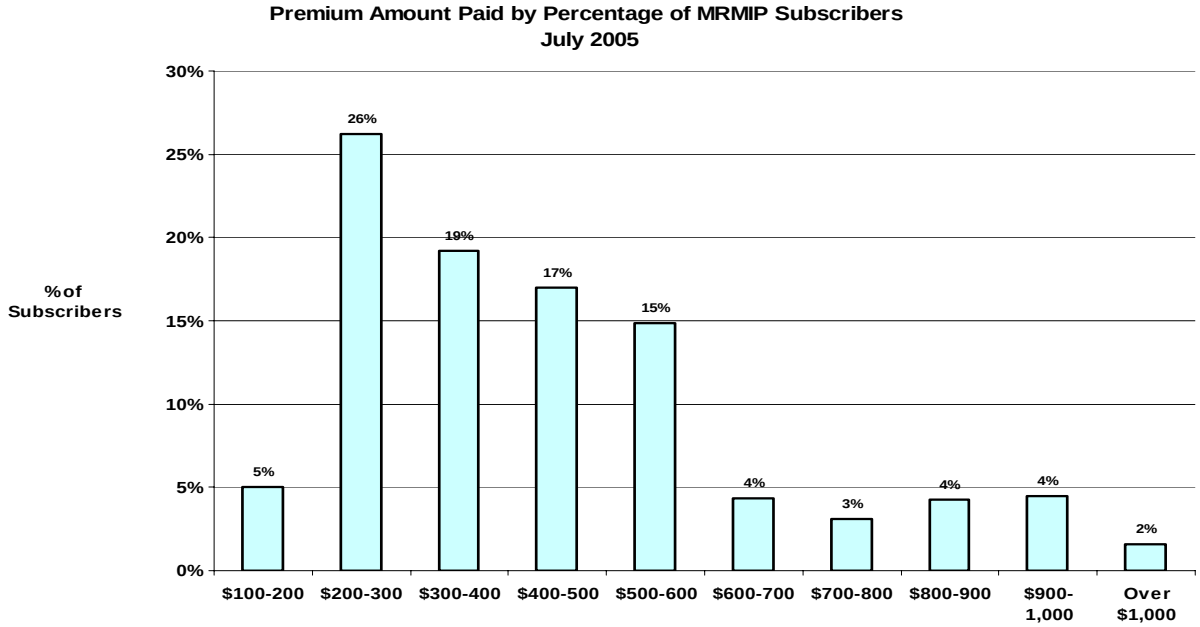
For MRMIP

Premiums for MRMIP subscribers are established through a multi-step process and subsidized by the State through the Cigarette and Tobacco Surtax Fund (Proposition 99). They are based on current market prices for individual private insurance coverage of each plan participating in MRMIP, adjusted by each plan for the MRMIP benefit structure. The adjusted base rates are then reviewed by the Board's contracted actuary. Each participating health plan's price for the MRMIP benefit package is calculated and then multiplied by a factor of between 125% and 137.5% to reflect the higher costs of people viewed as uninsurable. The factor used to multiply each plan's premium is determined by the average amount of subsidy funds required by the plan. If the plan requires subsidy funds at or below the program average subsidy, the plan's prices are multiplied by 125%. If the plan requires higher than average subsidies, the plan's prices may be multiplied by up to 137.5%. This variation provides an incentive for MRMIP subscribers to select those plans that require no more than the average subsidy.

MRMIP premium rates are also used by DMHC and DOI to establish the rates that can be charged by Preferred Provider Organization (PPO) plans for continuation products under the federal Health Insurance Portability and Accountability Act (HIPAA).

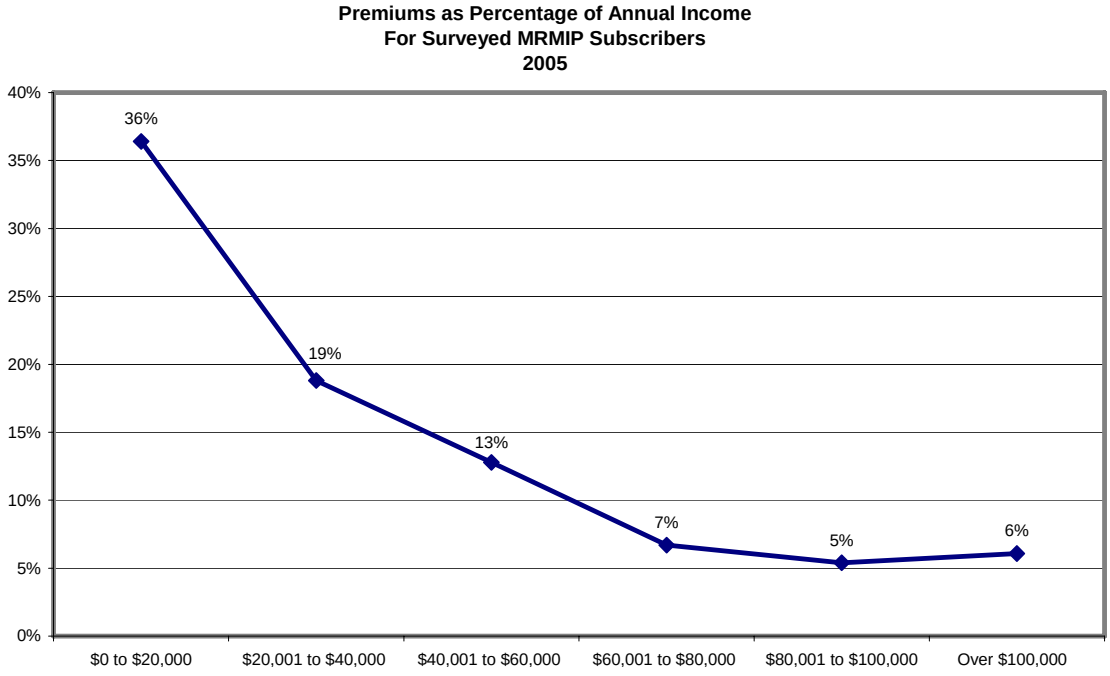
Based on the average MRMIP subscriber (female, Los Angeles county, 43 years of age, subscriber only), the average premium paid is from $332 to $545 a month. In 2004-05, subscribers contributed $42 million to the cost of the MRMIP. Chart III-7 shows the percentage of MRMIP subscribers in July 2005 by premium amount paid.

Chart III-7



Source: MRMIP Premiums Data, 1999-2005

Chart III-8



Sources: 2005 MRMIP Premium Data and 2005 MRMIP Subscriber Survey, (N=432)

For GIP

Premiums for subscribers in the GIP are determined when a plan or insurer in the individual market selects the benefit structure of one of the plans participating MRMIP plans as the model for its Program coverage. Premiums that can be charged by the plans are set at 10% above the rate for the selected MRMIP model plan.

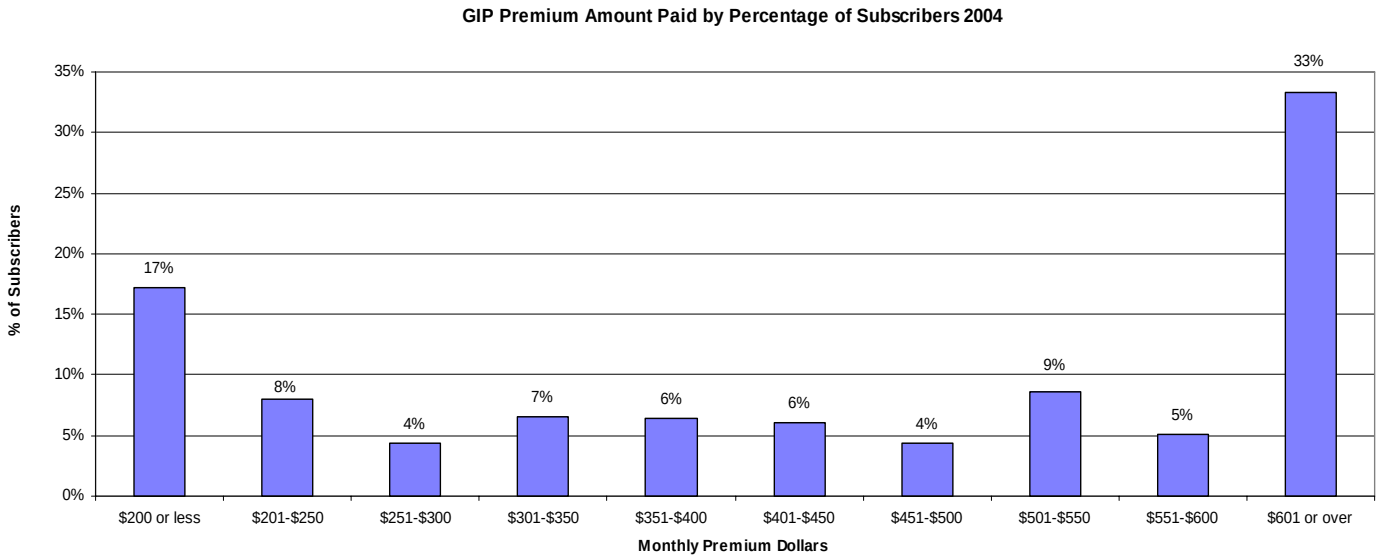
Premium Affordability

A comparison of MRMIP subscriber premiums to eleven other state pools whose products are most comparable to MRMIP shows that MRMIP rates are significantly higher. This is primarily due to the higher base cost of individual insurance in California on which the rates are built, but also because MRMIP's product design is unique among risk pools in offering first dollar coverage with no deductible. However, even when MRMIP rates are reduced to reflect lower costs associated with higher deductibles, MRMIP rates are 5-20 percent higher. This is true even though most of these states rate up the coverage in the pool with a higher factor than the 125% used in California. [Note: MRMIP rates were compared to the largest plan the pool had for products with a $2,000 or $2,500 deductible for the 45 through 64 age bands.]

Another view on affordability comes from MRMIP's annual disenrollment survey. In this survey, all subscribers who disenroll in January (the month that premium increases take effect) are asked their reasons for disenrolling. The primary reason, other than obtaining other coverage, is an inability to afford premiums. In 2003, when premiums increased 26%, 44% of disenrollments were associated with affordability. In 2004, premiums increased 12.3% and 46% of disenrollments were associated with affordability. In 2005, the premium increase was 6% and 23% disenrolled due to affordability. Chart III-8 on the previous page shows what percentage of income MRMIP subscribers pay for their coverage. Chart VI-7 on page VI-46 details the distribution of MRMIP subscribers by income.

Based on the average GIP subscriber (female, Los Angeles county, 50 years of age, subscriber only), the average premium paid is from $458 to $796 a month.

Chart III-9

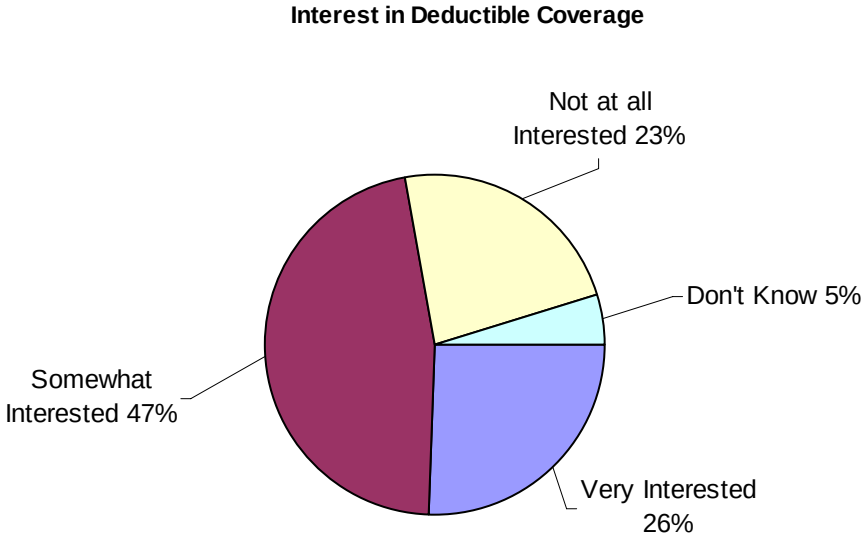


Source: GIP Premium Data: 2004

Subscriber Interest in Deductible Coverage

In the MRMIP subscribers' survey, subscribers were asked about their interest in deductible coverage. Over seventy percent expressed some interest.

Chart III-10



Source: 2005 MRMIP Independent Survey, (N=432)

Subscribers were asked whether they were interested in paying a deductible to reduce their monthly premium. The survey question provided specified deductible amount with a correlating percent reduction of premium.

Chart III-11

Deductible Amount	Percentage of Premium Reduction	Survey Interest
$500	9%	38%
$1,000	15%	34%
$2,500	24%	24%
$5,000	31%	11%
None are appealing		16%
Don't know		8%

Source: 2005 MRMIP Independent Survey, (N=312)

Section IV

Expenditures

EXPENDITURES

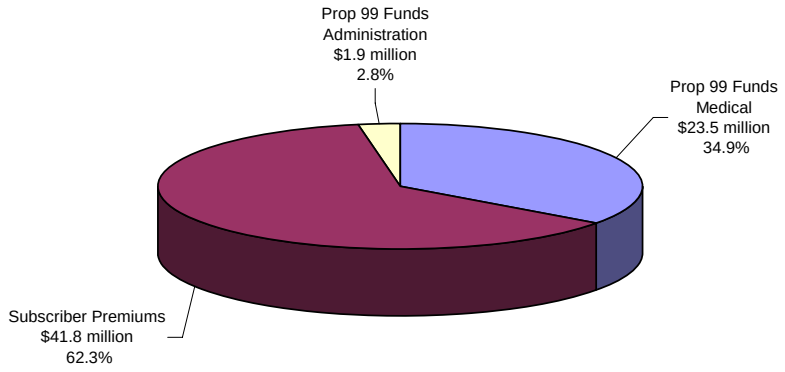
CURRENT PROGRAM EXPENDITURES FOR MRMIP

There are three categories of expenditures budgeted for MRMIP. These expenditures are:

- State administrative costs, which covers the cost of oversight and ongoing administration of MRMIP and GIP.
- Payments to the administrative contractor, Blue Cross of California, for eligibility determinations, enrollment services, services for transferring people into the GIP, premium collection and payments to insurance agents and brokers for application assistance. Blue Cross of California is paid a flat fee at the time of application and another flat fee for processing the disenrollment and GIP notification at the end of 36 months of continuous coverage. Blue Cross is also paid a per member per month fee for ongoing administrative and an annual per packet fee for administering open enrollment.
- Health care costs, which include a monthly administrative fee paid to participating plans.

Chart IV-1

2004-05 MRMIP Expenditures
$67.2 million

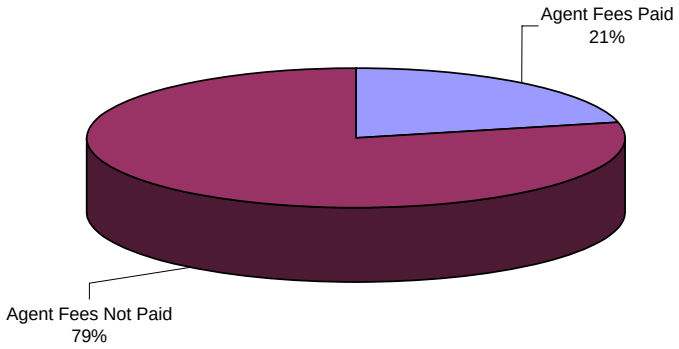


Sources: Prop. 99 funds from State Accounting System (CALSTARS) and Premiums from health plan reporting.

MRMIP pays a one-time $50 application assistance fee to insurance agents and brokers who assist applicants in completing their MRMIP applications.

Chart IV-2

Percentage of Applications for Which an Application Assistance Fee Was Paid Jan-Nov 2005



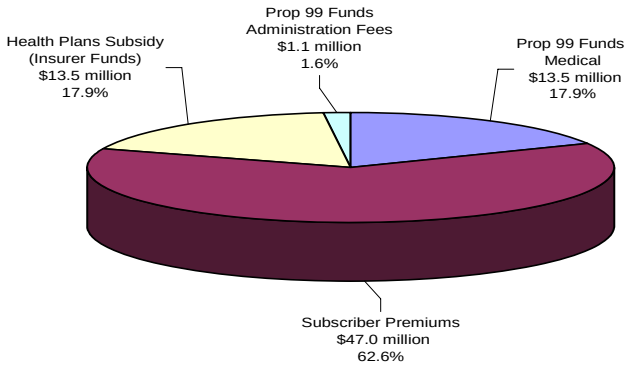
Source: MRMIP Enrollment Data, 2005

CURRENT PROGRAM EXPENDITURES FOR GIP

- State administrative costs are subsumed under MRMIP.
- The plan selected by a termed out MRMIP subscriber handles eligibility determination, enrollment, and premium collection. The plan is paid an administrative fee.
- Health care costs.

Chart IV-3

2004-05 GIP Expenditures
$75.1 million



Source: Program's paid invoices. Note: GIP's annual settlements are pending until the end of 2006.

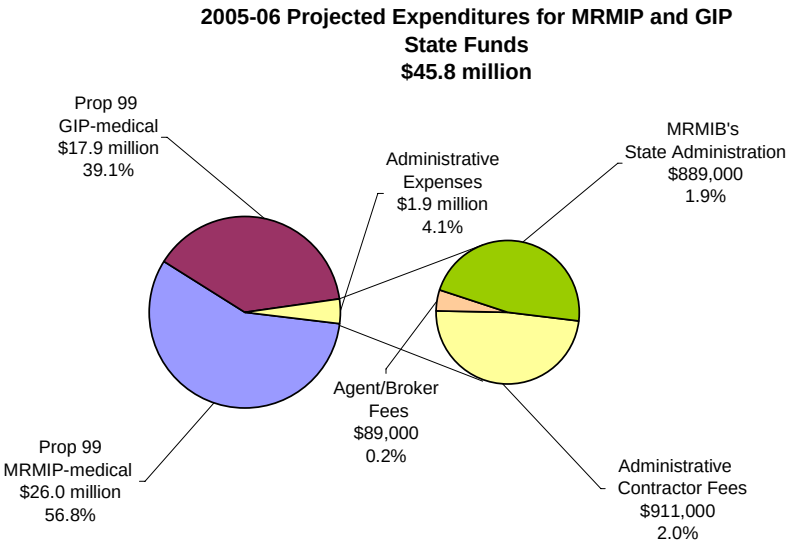
PROJECTED PROGRAM EXPENDITURES

Administrative Cost

In FY 2005-06 nearly ninety-six percent of the program dollars are projected to be spent on MRMIP and GIP health plan costs for program subscribers. Four percent of program funds are expected to be spent on administrative expenses. These expenses include:

- State administrative costs (1.9 percent);
- administrative contractor fees (2 percent); and
- agent/broker fees (0.2 percent).

Chart IV-4



Sources: MRMIP and GIP expenditures from PwC Estimate. Administrative Expenses from 2006-07 Governor's Budget.

Health Care Costs for MRMIP

MRMIB has shared risk contract arrangements with three health plans and an "administrative services only" contract with one health plan. Shared risk contracts require participating plans to provide all required MRMIP benefits to enrollees using the premium paid by enrollees and State payments based on a targeted loss ratio. If plans remain under the target loss ratio, they are paid an additional dollar amount as an incentive. If the plan's actual loss ratio exceeds the target, the plan assumes the excess risk. Ninety nine percent of MRMIP enrollees are in shared risk plans. The administrative services only contract contains no financial risk for the health plan, with the State paying for all losses above the enrollee premiums.

Health Care Costs for GIP

MRMIB and the plans share equally in any costs above those paid for by subscriber premiums.

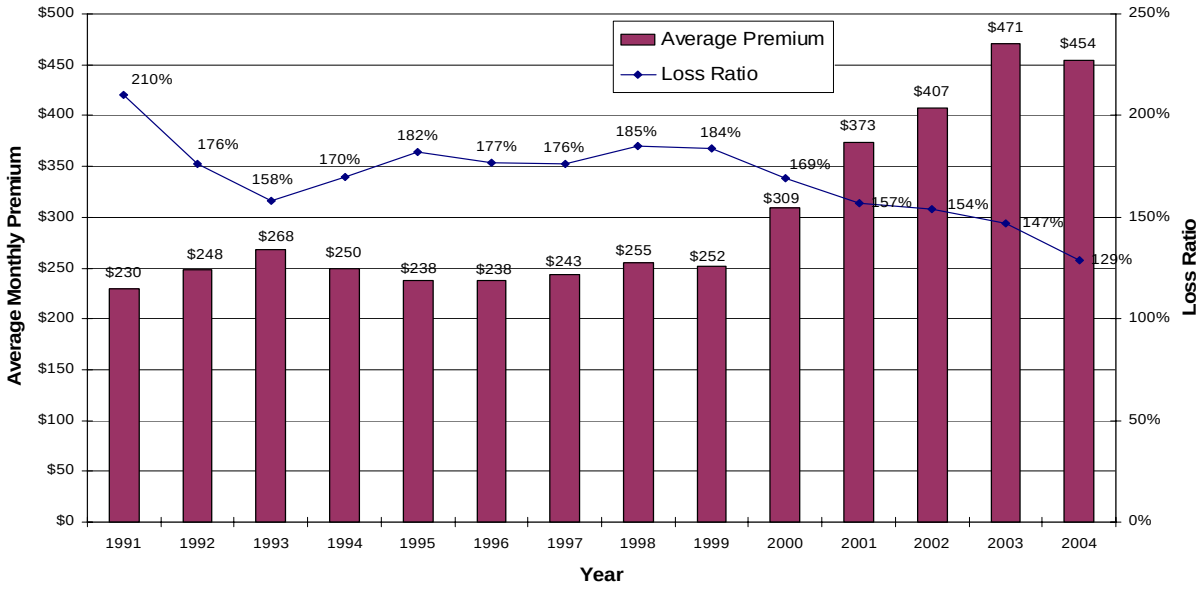
PROGRAM LOSS RATIO

For MRMIP

The program loss ratio determines the amount of state funding used to subsidize subscriber premiums. The loss ratio for the MRMIP program declined to 129% in 2004 because of the transfer of long term subscribers to GIP and increases in subscriber premiums tracking increases in the private market. For every one dollar in premium paid by a subscriber, 29 cents in subsidy funds were needed from the state.

Chart IV-5

Average MRMIP Subscriber Monthly Premiums & Annual Program Medical Loss Ratio for 1991 - 2004



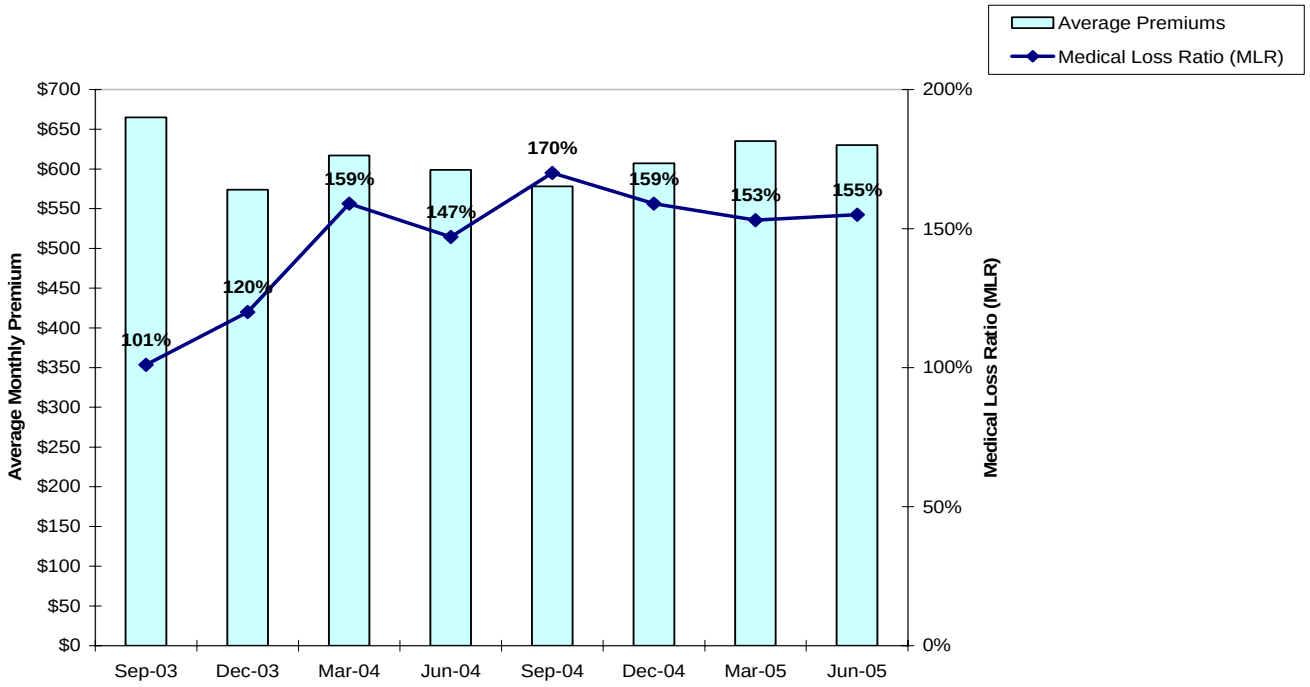
Source: MRMIP Claims and Premiums data: 2004

For the GIP

The loss ratio for GIP subscribers is proximate to what the MRMIP loss ratio was prior to implementation of the pilot.

Chart IV-6

Average GIP subscriber Monthly Premiums & Program Medical Loss Ratio



Source: Interim Reports filed with MRMIB by participating plans. Data as of January 2006.

Section V

Eligibility and Enrollment

ELIGIBILITY AND ENROLLMENT IN MRMIP AND GIP

ELIGIBILITY CRITERIA FOR MRMIP

Individuals must meet four basic criteria to participate in the Major Risk Medical Insurance Program. Individuals must be:

- A resident of California;
- Ineligible for Medicare, Parts A and B, unless they are eligible solely because of end-stage renal disease;
- Ineligible to purchase health insurance for the continuation of coverage through COBRA or CalCOBRA; and
- Unable to secure adequate health insurance coverage.

Applicants demonstrate their inability to obtain adequate insurance coverage by documenting that one or more of the following occurred during the previous 12 months:

- Having been denied individual insurance;
- Having been involuntarily terminated for health insurance coverage for reasons other than nonpayment of premium or fraud;
- Having been offered individual coverage at a premium rate higher than that charged by MRMIP;
- Having been covered in a similar high-risk pool sponsored by another state.

Most individuals who are eligible for MRMIP are unable to secure adequate insurance coverage because they have been denied individual coverage. Chart V-1 below shows that according to information from MRMIP applications the majority of subscribers were eligible for MRMIP due to denial of insurance coverage.

ELIGIBILITY CRITERIA FOR GIP

Individuals must meet two basic criteria to participate in the GIP. They must:

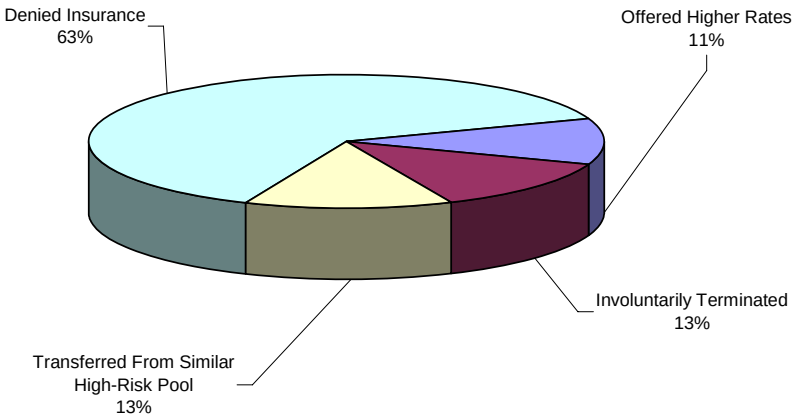
- Have been a MRMIP subscriber for 36 consecutive months;
- Enroll in a guaranteed issue product within 63 days of disenrollment from MRMIP.

WHY SUBSCRIBERS ENROLL IN MRMIP

Most subscribers enroll because they cannot get coverage in the individual market.

Chart V-1

Reasons Why Subscribers are Eligible for MRMIP

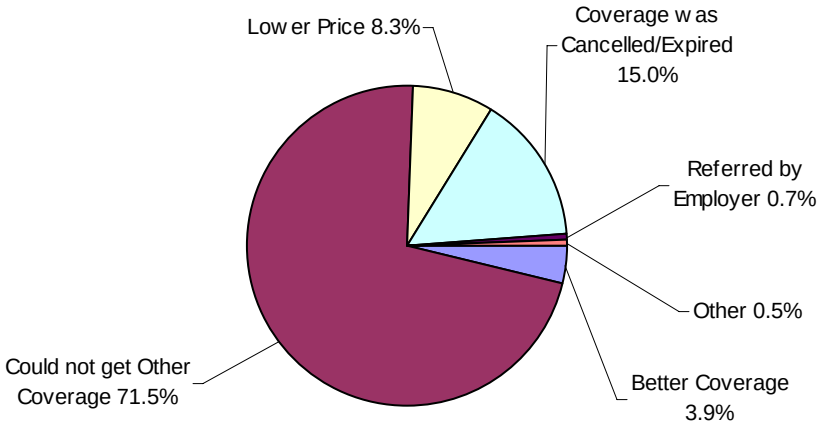


Source: MRMIP Enrollment Data, 2005

Additionally, the majority of subscribers surveyed indicated that the major reason they switched to MRMIP was that they were unable to get other coverage (72%).

Chart V-2

Reasons Why Suscribers Switched to the MRMIP

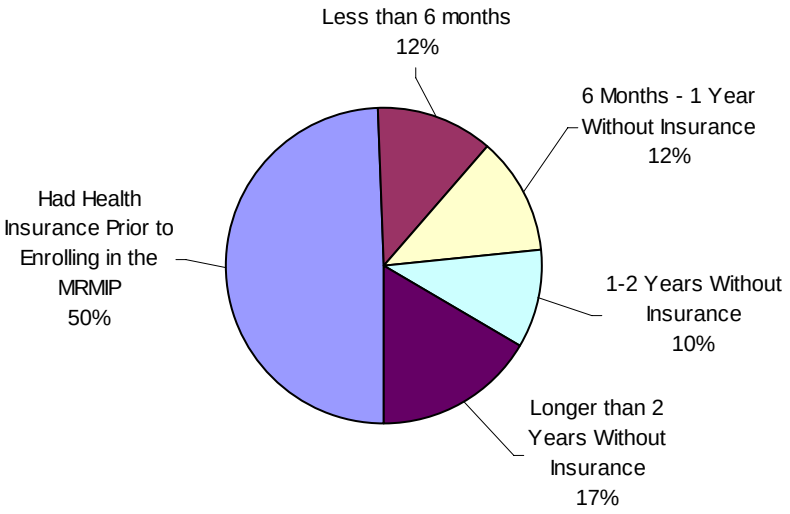


Source: MRMIP Independent Survey, 2005, (N=432)

Fifty percent of MRMIP subscribers had insurance coverage prior to enrolling in MRMIP.

Chart V-3

Period of Time Without Coverage Prior to Enrolling in MRMIP

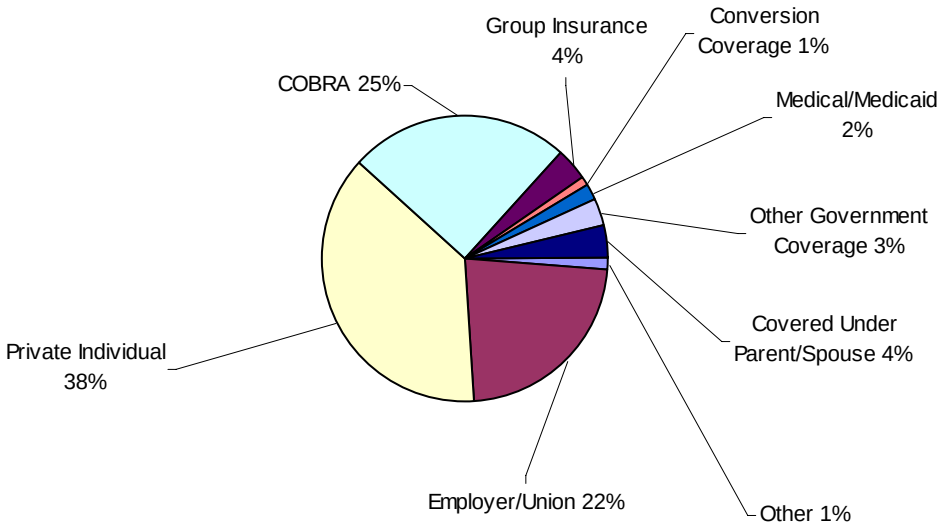


Source: 2005 MRMIP Independent Survey, (N=432)

For subscribers that had coverage prior to MRMIP, most had individual coverage (thirty-eight percent).

Chart V-4

Type of Insurance Subscribers Had Prior to MRMIP

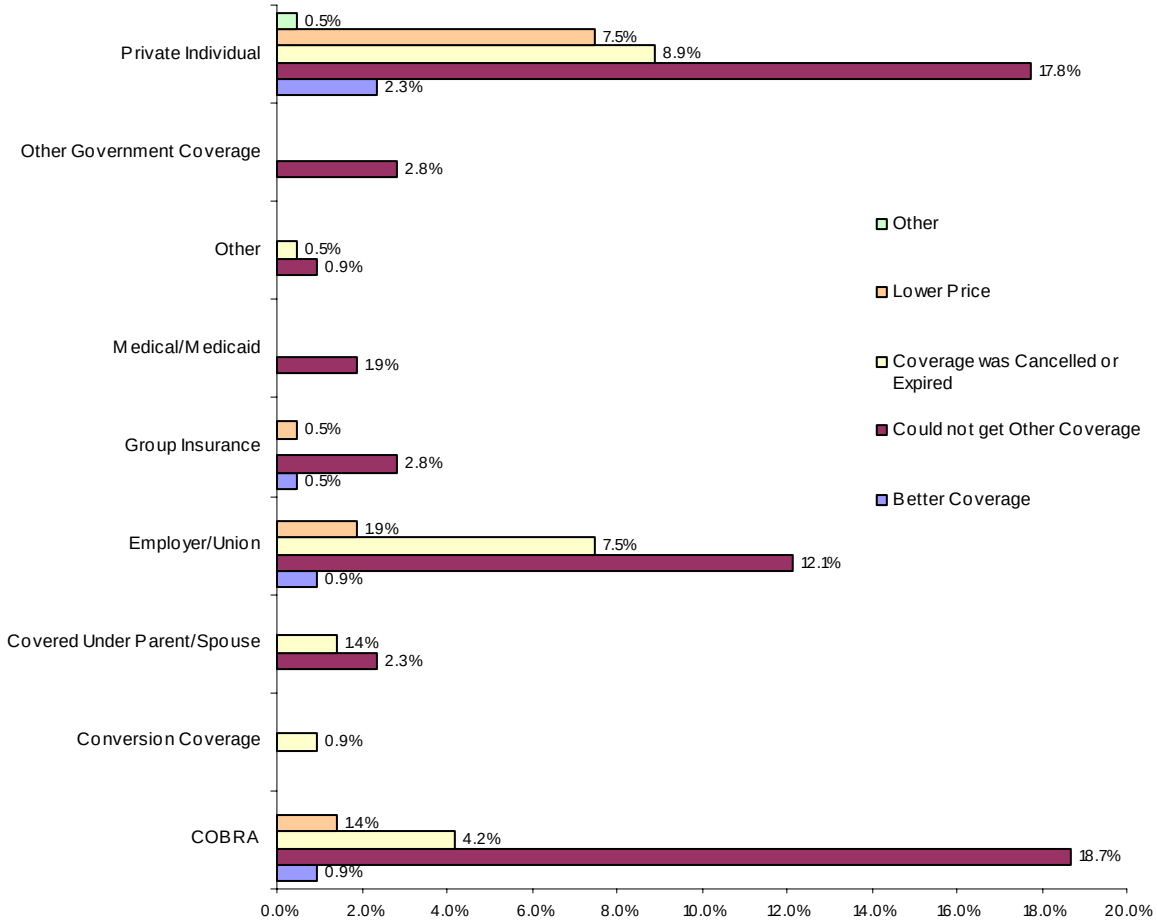


Source: 2005 MRMIP Independent Survey, (N=214)

The major reason these subscribers enrolled in MRMIP was the inability to obtain other coverage.

Chart V-5

Reasons Subscribers Switched to MRMIP by Type of Prior Insurance

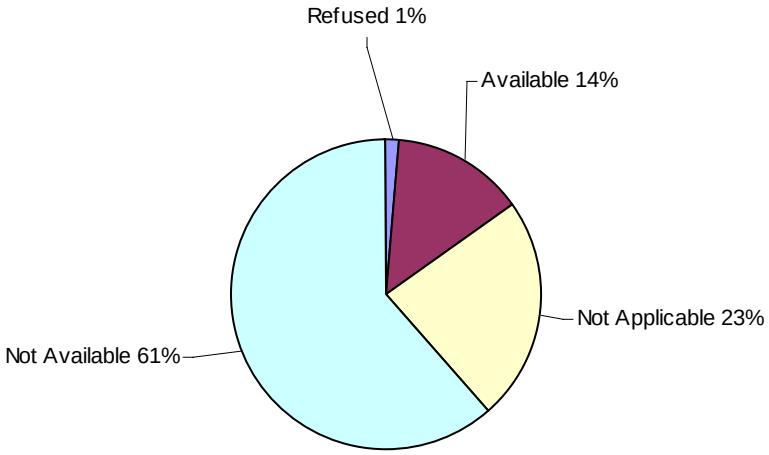


Source: 2005 MRMIP Independent Survey, (N=214)

Most MRMIP subscribers did not have access to employer sponsored coverage.

Chart V-6

Health Insurance Coverage under Employer and/or Spouse's Employer

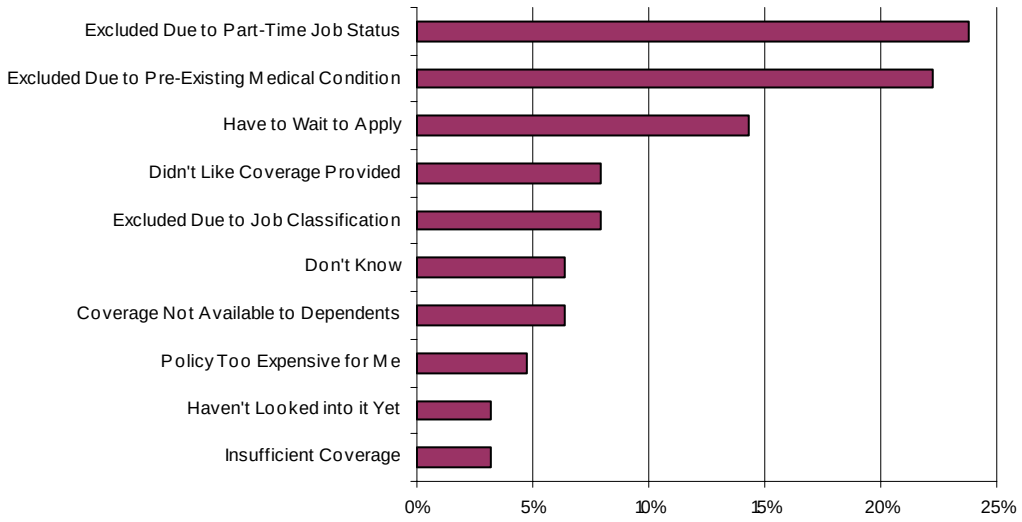


Source: 2005 MRMIP Independent Survey, (N=432)

Of those subscribers who reported that coverage was available through their employer or spouse, most reported they were ineligible due to part time job status (twenty-four percent), or were excluded due to pre-existing medical conditions (twenty-two percent).

Chart V-7

Reasons Subscribers Did Not Obtain Health Insurance under Employer and/or Spouse's Employer

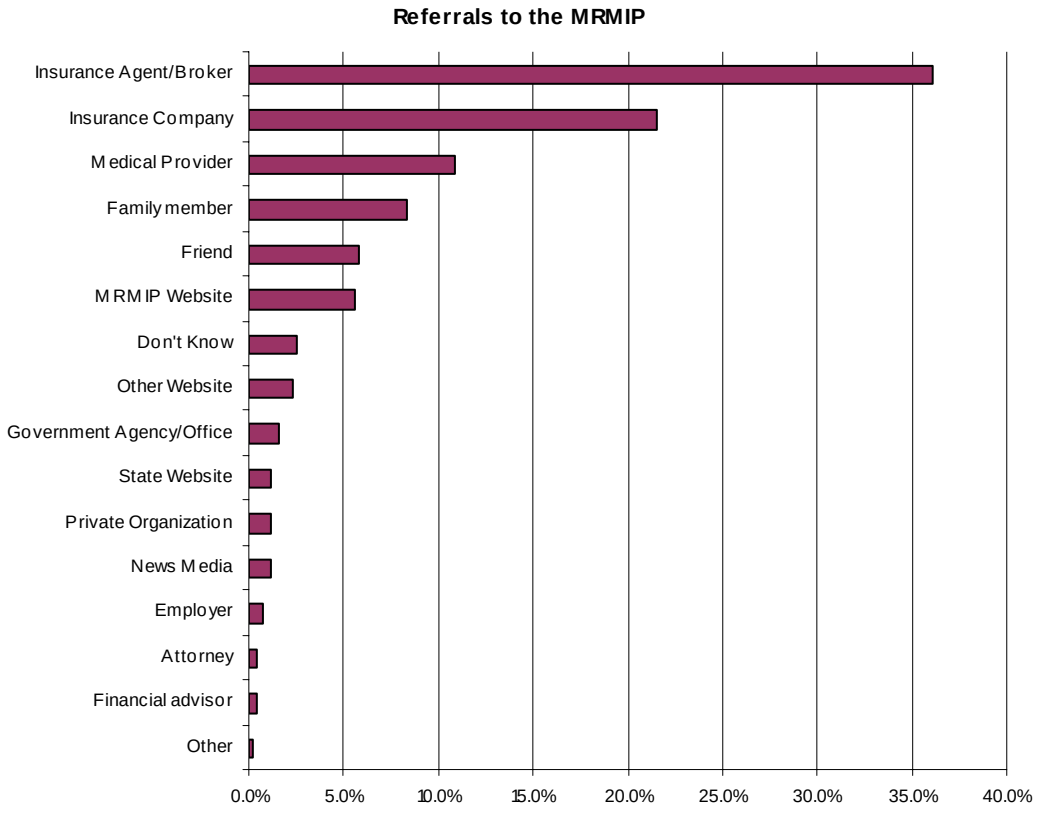


Source: 2005 MRMIP Independent Survey, (N=60)

MRMIP REFERRALS

Traditionally, there has been no marketing program for MRMIP under the logic that the program operated at capacity. Legislation authored by Assemblywoman Chan and enacted in 2005 (Chapter 356, Statutes of 2005, AB 356) requires insurers to notify individuals of MRMIP when they deny coverage. Presently, the majority of MRMIP subscribers have been referred to the program by either insurance agents/brokers (over 35%) or by an insurance company (over 20%).

Chart V-8

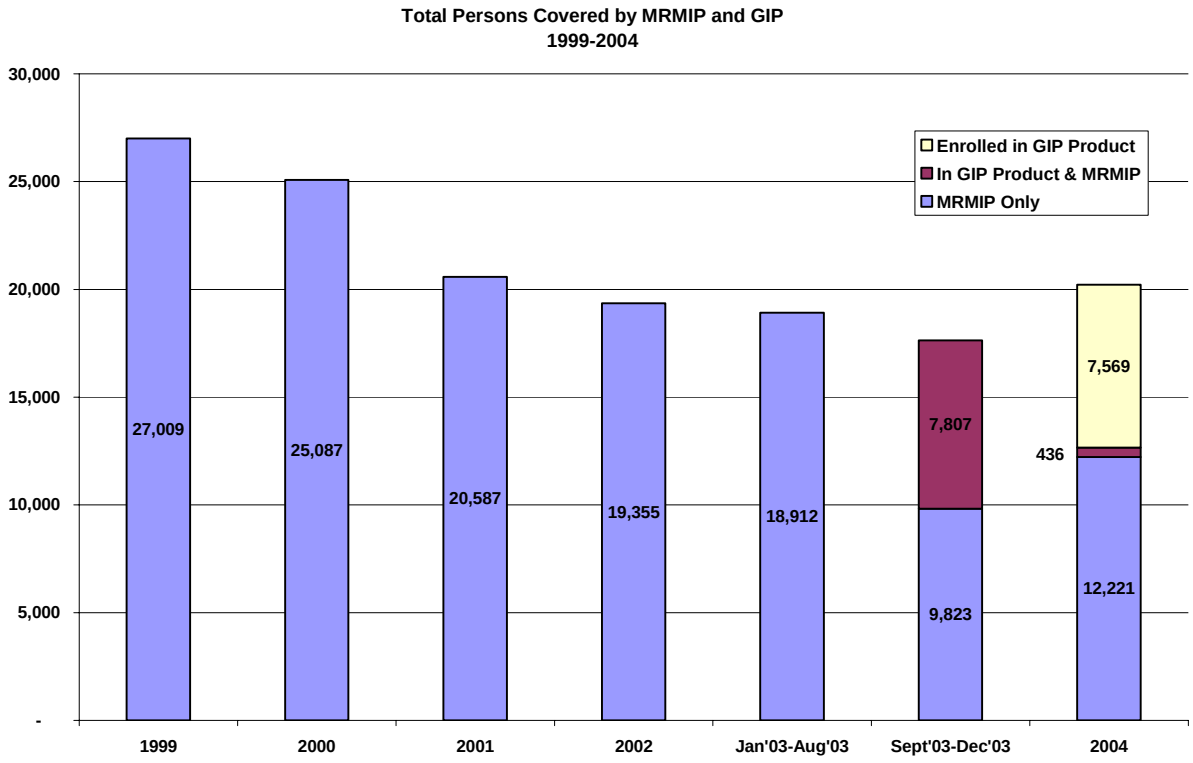


Source: MRMIP Independent Survey, 2005, (N=432)

ENROLLMENT STATISTICS FOR MRMIP AND GIP

Since its inception in 1991, MRMIP has served 97,980 individuals. MRMIP total enrollment in 2004 was 12,221 subscribers. 7,569 people enrolled in a guaranteed issue product in 2004 and 436 MRMIP subscribers were in transition to enrollment in a guaranteed issue product.

Chart V-9

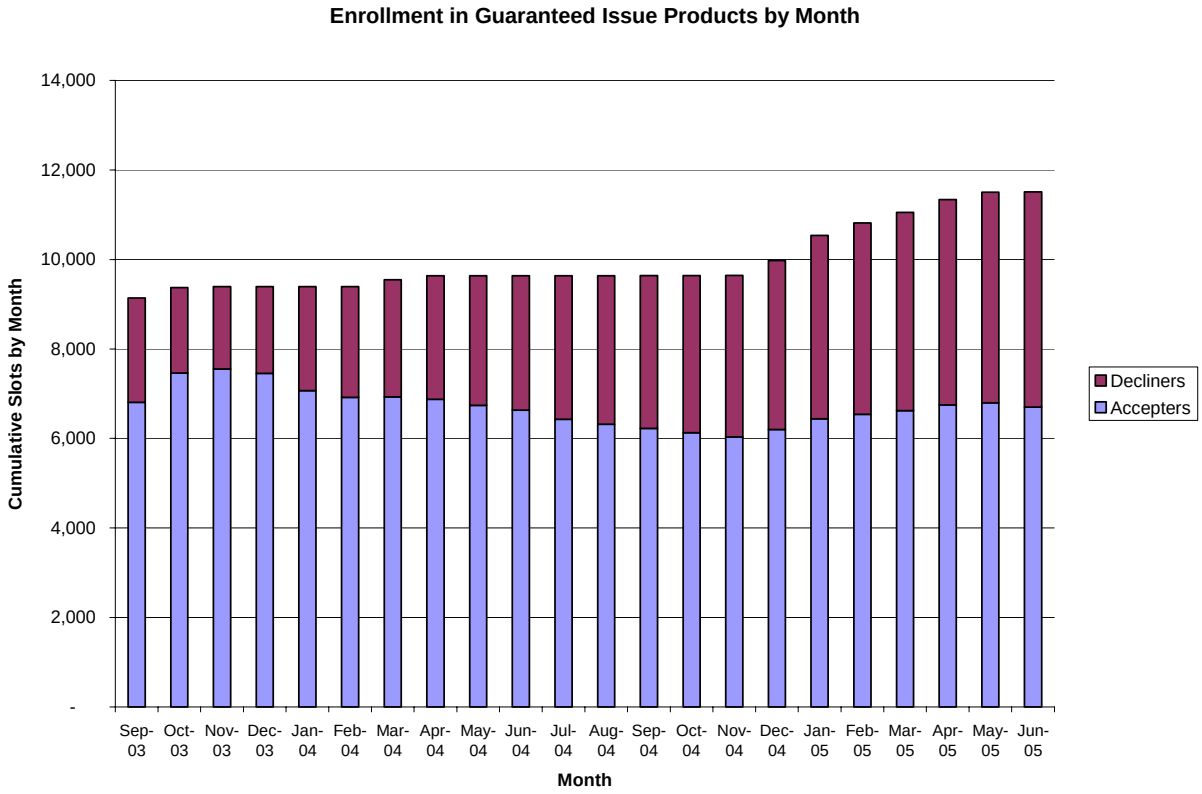


Source: MRMIP Historical Enrollment Data, 1999-2004; GIP Enrollment September 2003 - December 2004

GIP Enrollment

As of June 2005, over 11,000 people were disenrolled from MRMIP due to the 36 month eligibility limit. Of these 6,000 enrolled in guaranteed issue GIP products. The overall take-up rate for GIP is sixty-five percent.

Chart V-10



Source: GIP Interim Reports

Enrollment Distribution

MRMIP

The following map shows the 2005 enrollment distribution for MRMIP subscribers.

Map #V-1

The chart below shows the number of MRMIP subscribers and the percentage of total enrollment in each county in 1998 and in 2005.

Chart V-11

	1998		2005	
County	**Subscribers**	**Percentage**	**Subscribers**	**Percentage**
ALAMEDA	797	3.63%	369	4.22%
ALPINE	2	0.01%	0	0.00%
AMADOR	53	0.24%	3	0.03%
BUTTE	224	1.02%	30	0.34%
CALAVERAS	66	0.30%	22	0.25%
COLUSA	23	0.10%	0	0.00%
CONTRA COSTA	618	2.82%	307	3.51%
DEL NORTE	34	0.16%	4	0.05%
EL DORADO	206	0.94%	56	0.64%
FRESNO	523	2.38%	167	1.91%
GLENN	25	0.11%	12	0.14%
HUMBOLDT	215	0.98%	37	0.42%
IMPERIAL	61	0.28%	15	0.17%
INYO	35	0.16%	5	0.06%
KERN	441	2.01%	93	1.06%
KINGS	65	0.30%	22	0.25%
LAKE	71	0.32%	12	0.14%
LASSEN	11	0.05%	1	0.01%
LOS ANGELES	4,043	18.44%	2,358	27.00%
MADERA	104	0.47%	25	0.29%
MARIN	387	1.76%	118	1.35%
MARIPOSA	25	0.11%	0	0.00%
MENDOCINO	142	0.65%	23	0.26%
MERCED	140	0.64%	29	0.33%
MODOC	14	0.06%	1	0.01%
MONO	23	0.10%	4	0.05%
MONTEREY	403	1.84%	70	0.80%
NAPA	99	0.45%	30	0.34%
NEVADA	124	0.57%	27	0.31%
ORANGE	1,808	8.24%	890	10.19%
PLACER	270	1.23%	86	0.98%
PLUMAS	46	0.21%	4	0.05%
RIVERSIDE	897	4.09%	348	3.98%
SACRAMENTO	709	3.23%	238	2.72%
SAN BENITO	46	0.21%	13	0.15%
SAN BERNARDINO	697	3.18%	342	3.92%
SAN DIEGO	2,166	9.88%	846	9.69%
SAN FRANCISCO	728	3.32%	269	3.08%
SAN JOAQUIN	268	1.22%	117	1.34%
SAN LUIS OBISPO	451	2.06%	87	1.00%
SAN MATEO	669	3.05%	223	2.55%
SANTA BARBARA	330	1.50%	119	1.36%
SANTA CLARA	1,157	5.28%	501	5.74%
SANTA CRUZ	391	1.78%	108	1.24%
SHASTA	231	1.05%	42	0.48%
SIERRA	3	0.01%	0	0.00%
SISKIYOU	60	0.27%	11	0.13%
SOLANO	144	0.66%	90	1.03%
SONOMA	460	2.10%	173	1.98%
STANISLAUS	240	1.09%	56	0.64%
SUTTER	64	0.29%	12	0.14%
TEHAMA	72	0.33%	6	0.07%
TRINITY	23	0.10%	1	0.01%
TULARE	295	1.35%	41	0.47%
TUOLUMNE	86	0.39%	9	0.10%
VENTURA	499	2.28%	230	2.63%
YOLO	98	0.45%	30	0.34%
YUBA	48	0.22%	2	0.02%
Total	**21,930**	**100.00%**	**8,734**	**100.00%**

Source: MRMIP Enrollment Data, 2005

GIP

The following map shows the 2004 enrollment distribution for GIP subscribers.

Map #V-2

The chart below shows the number of GIP subscribers and the percentage of total enrollment in each county in 2003 and 2004.

Chart V-12

	2003		2004	
County	**Subscribers**	**Percentage**	**Subscribers**	**Percentage**
ALAMEDA	279	3.80%	241	3.81%
ALPINE	1	0.01%	1	0.02%
AMADOR	6	0.08%	6	0.09%
BUTTE	39	0.53%	35	0.55%
CALAVERAS	16	0.22%	11	0.17%
COLUSA	10	0.14%	5	0.08%
CONTRA COSTA	201	2.74%	172	2.72%
DEL NORTE	4	0.05%	4	0.06%
EL DORADO	65	0.88%	53	0.84%
FRESNO	142	1.93%	118	1.87%
GLENN	4	0.05%	3	0.05%
HUMBOLDT	51	0.69%	39	0.62%
IMPERIAL	14	0.19%	13	0.21%
INYO	3	0.04%	2	0.03%
KERN	105	1.43%	88	1.39%
KINGS	16	0.22%	14	0.22%
LAKE	14	0.19%	30	0.47%
LASSEN	3	0.04%	3	0.05%
LOS ANGELES	1,439	19.59%	1,230	19.46%
MADERA	39	0.53%	28	0.44%
MARIN	160	2.18%	148	2.34%
MARIPOSA	10	0.14%	6	0.09%
MENDOCINO	31	0.42%	23	0.36%
MERCED	34	0.46%	23	0.36%
MODOC	2	0.03%	0	0.00%
MONO	7	0.10%	8	0.13%
MONTEREY	125	1.70%	95	1.50%
NAPA	31	0.42%	35	0.55%
NEVADA	30	0.41%	22	0.35%
ORANGE	674	9.17%	588	9.30%
PLACER	129	1.76%	87	1.38%
PLUMAS	12	0.16%	8	0.13%
RIVERSIDE	312	4.25%	269	4.26%
SACRAMENTO	231	3.14%	180	2.85%
SAN BENITO	17	0.23%	16	0.25%
SAN BERNARDINO	246	3.35%	388	6.14%
SAN DIEGO	743	10.11%	604	9.56%
SAN FRANCISCO	255	3.47%	224	3.54%
SAN JOAQUIN	92	1.25%	80	1.27%
SAN LUIS OBISPO	136	1.85%	103	1.63%
SAN MATEO	252	3.43%	196	3.10%
SANTA BARBARA	122	1.66%	117	1.85%
SANTA CLARA	413	5.62%	345	5.46%
SANTA CRUZ	114	1.55%	113	1.79%
SHASTA	56	0.76%	49	0.78%
SIERRA	0	0.00%	0	0.00%
SISKIYOU	13	0.18%	7	0.11%
SOLANO	45	0.61%	35	0.55%
SONOMA	195	2.65%	140	2.21%
STANISLAUS	60	0.82%	50	0.79%
SUTTER	18	0.24%	11	0.17%
TEHAMA	22	0.30%	11	0.17%
TRINITY	7	0.10%	4	0.06%
TULARE	57	0.78%	37	0.59%
TUOLUMNE	14	0.19%	7	0.11%
VENTURA	185	2.52%	164	2.59%
YOLO	34	0.46%	25	0.40%
YUBA	12	0.16%	7	0.11%
Total	**7,347**	**100.00%**	**6,321**	**100.00%**

Source: GIP Enrollment Data 2004

Section VI

Demographic Information about MRMIP and GIP Subscribers

DEMOGRAPHIC INFORMATION ABOUT MRMIP AND GIP SUBCRIBERS

The average MRMIP subscriber is female, 43 years of age, lives in the greater Los Angeles, in a household of two persons or less, and has an annual income between $20,000 and $40,000.

The average person who purchased guaranteed issue coverage under GIP is female, 50 years of age, lives in the greater Los Angeles area, in a household of two persons or less, and has an annual income between $20,000 and $40,000.

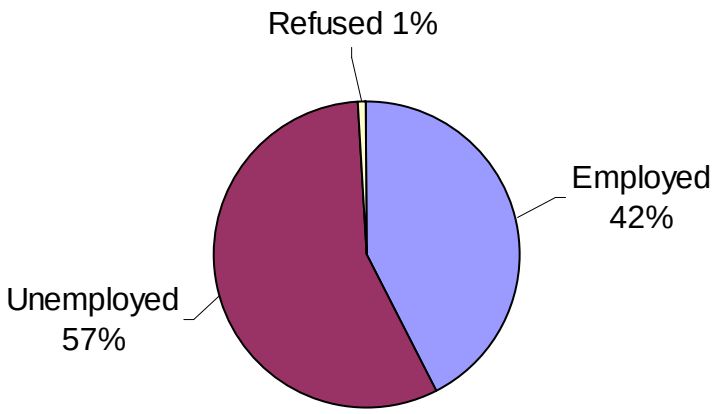
EMPLOYMENT

In 2003, a larger proportion of California's men than women had access to job-based insurance, both of which were up slightly from 2001. This difference in access to benefits reflects the greater prevalence of part-time work among female workers. While 94% of employed men work full-time, only 84.7% of employed women have full-time jobs[4].

In the MRMIP survey, the majority of MRMIP subscribers identified themselves as unemployed. Employment questions were not included in the GIP survey.

Chart VI-1

Employment Status of MRMIP Subscribers



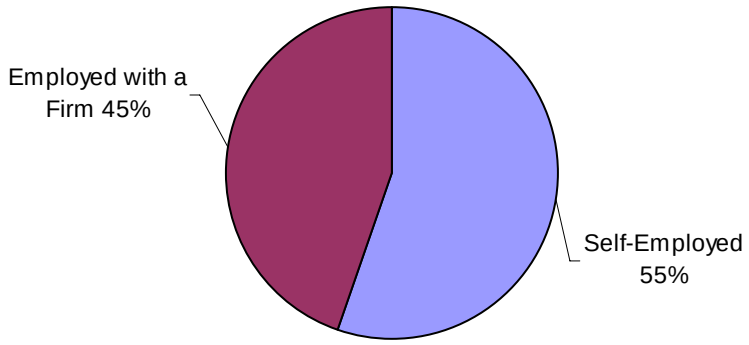
Source: MRMIP 2005 Independent Survey, (N=432)

[4] Brown, E.R.; Lavarreda, S.A; Rice, T; Kincheloe, J.R.; Gatchell, M.S.;The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2005; page 40.

Of the forty-two percent who said they were employed, fifty-five percent said they were self-employed.

Chart VI-2

Source of Employment of MRMIP Subscribers

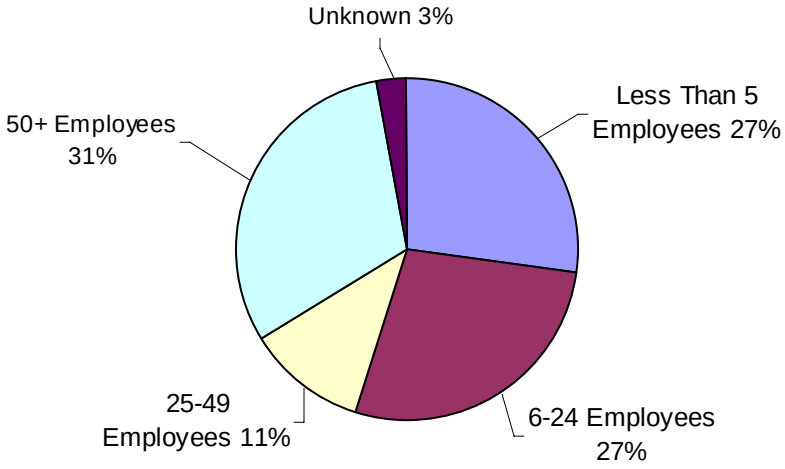


Source: MRMIP 2005 Independent Survey, (N=237)

Those subscribers who were employed in a firm came from employers of all sizes.

Chart VI-3

Firm Size of Employed MRMIP Subscribers



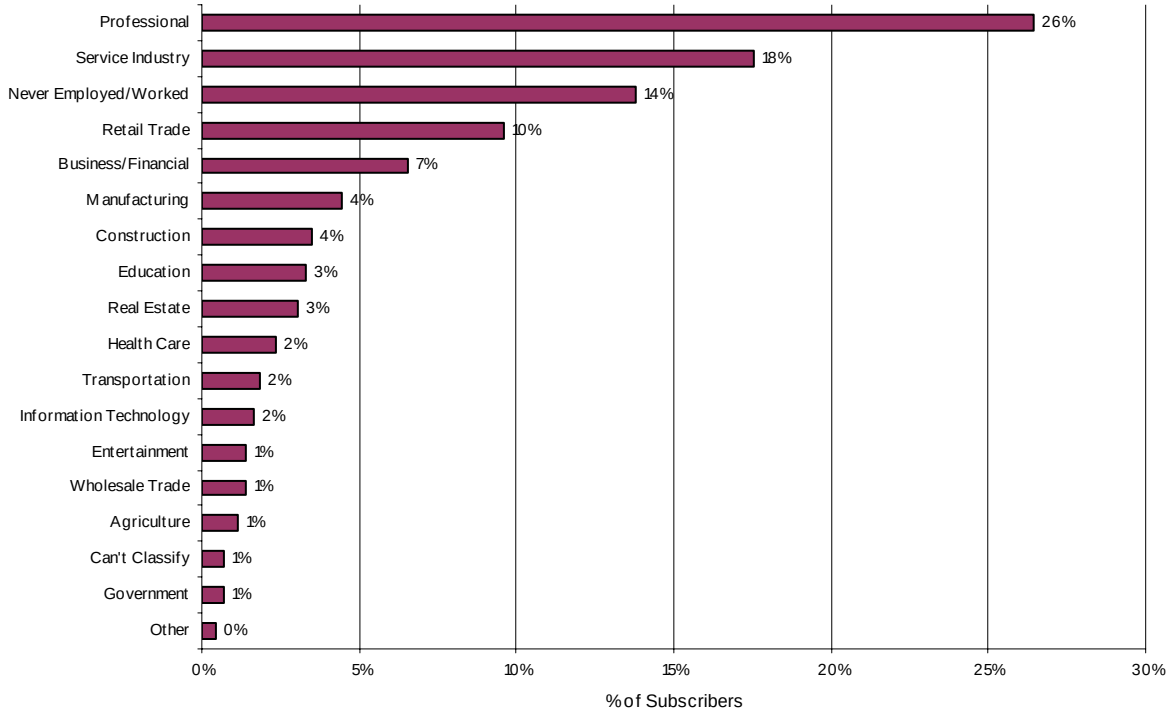
Source: MRMIP 2005 Independent Survey, (N=106)

Occupations

Most MRMIP subscribers report occupations as professional, in the service industry or in the retail trades. Fourteen percent of MRMIP subscribers report that they have never been employed. Occupation questions were not included in the GIP survey.

Chart VI-4

Occupational Categories of MRMIP Subscribers



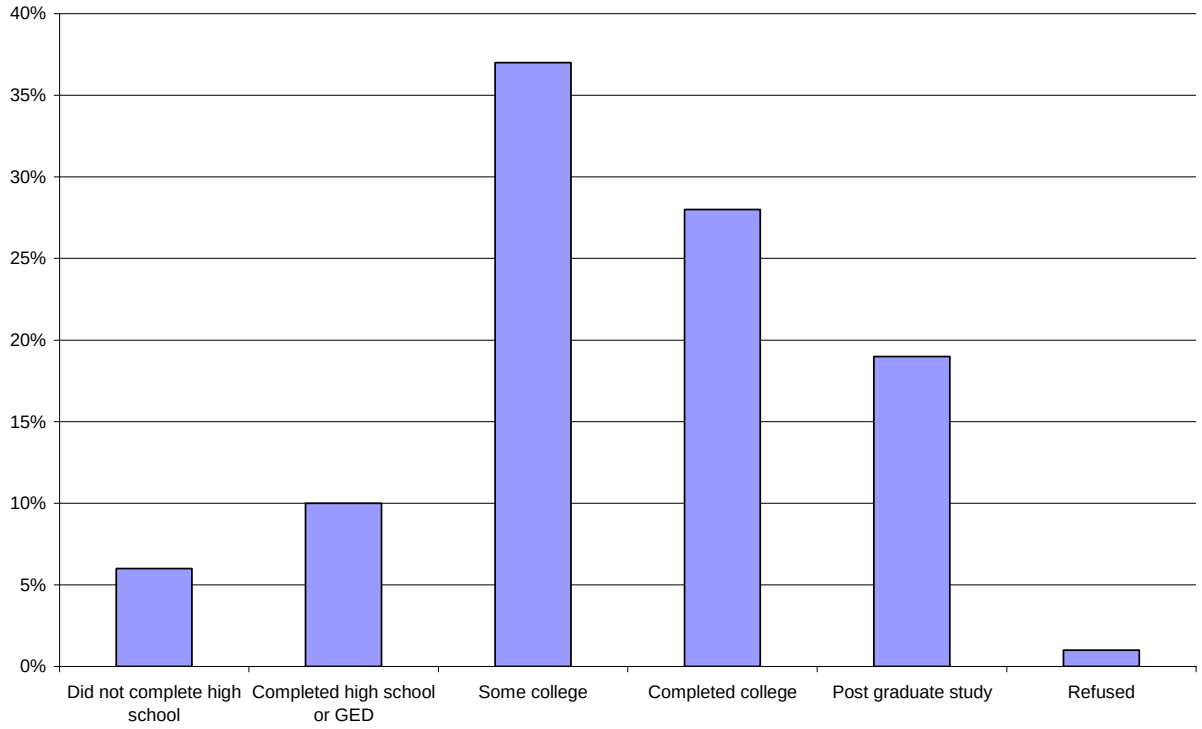
Source: MRMIP 2005 Independent Survey, (N=427)

EDUCATION

About eighty percent of MRMIP subscribers attended college. Education questions were not included in the GIP survey.

Chart VI-5

MRMIP Subscriber Education Level



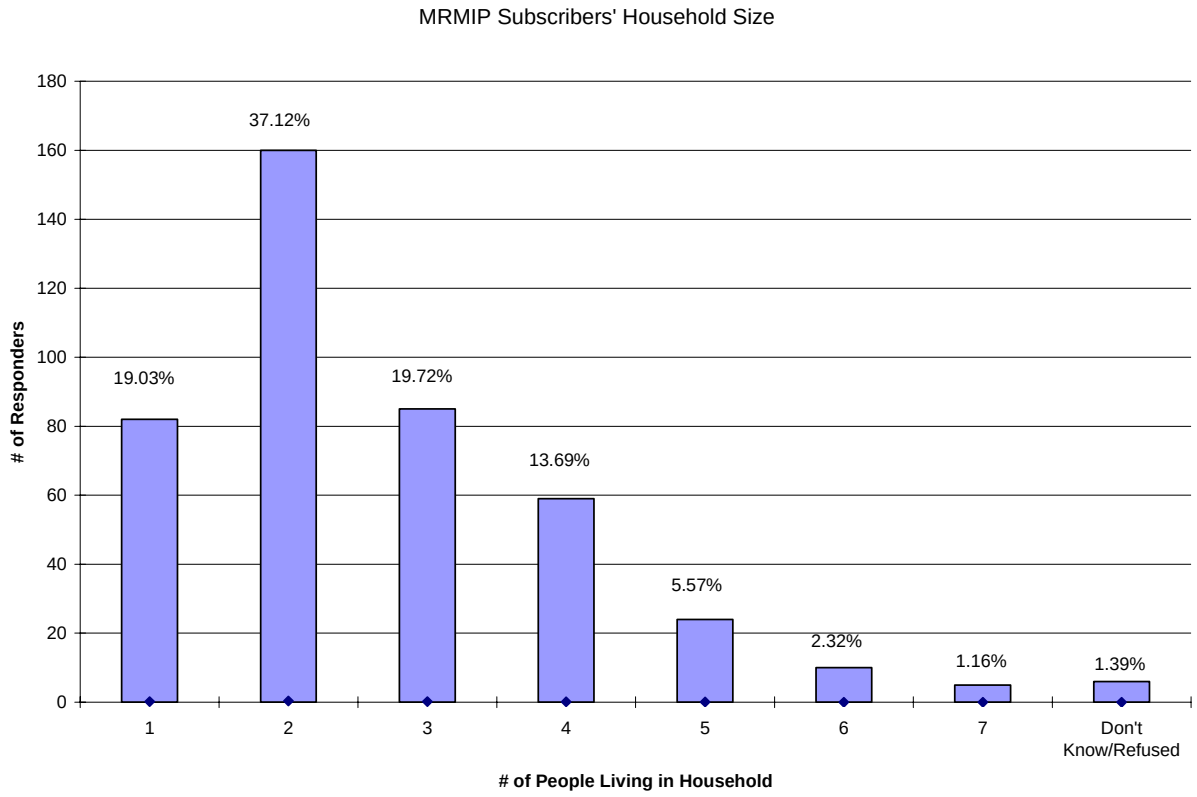
Source: 2005 MRMIP Independent Survey, (N=432)

HOUSEHOLD SIZE AND INCOME

MRMIP Household Size

Fifty-six percent of MRMIP subscribers have a family size of two or less.

Chart VI-6



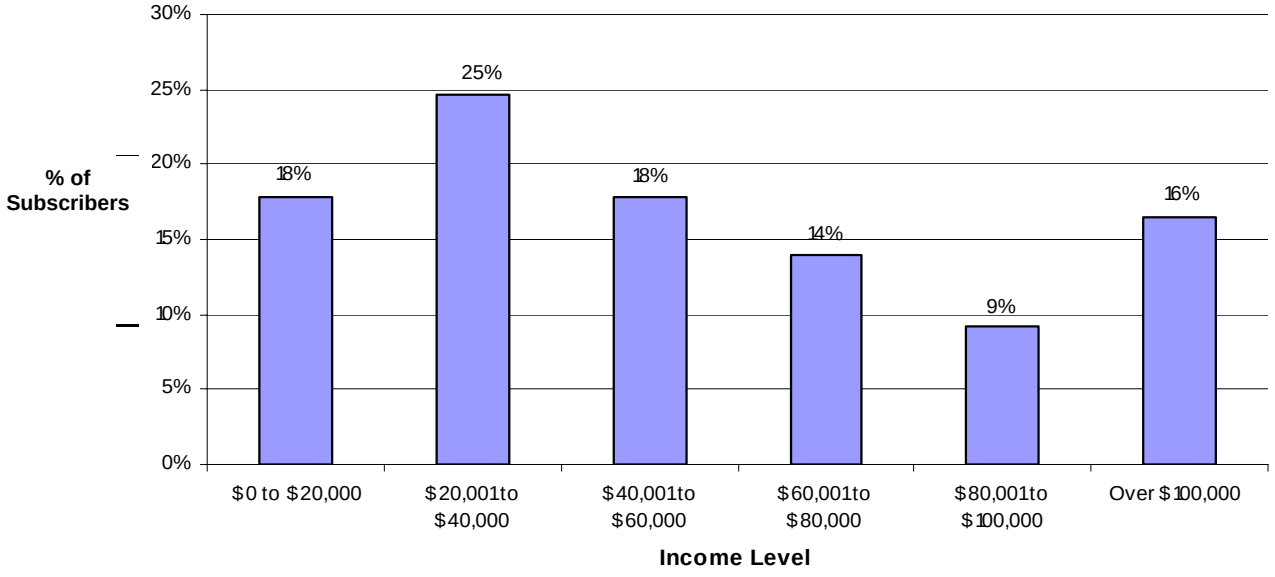
Source: 2005 MRMIP Independent Survey, (N=432)

MRMIP Household Income

Sixty percent of MRMIP subscribers surveyed have a 2005 household income below $60,000 a year.

Chart VI-7

MRMIP Subscribers' Household Income

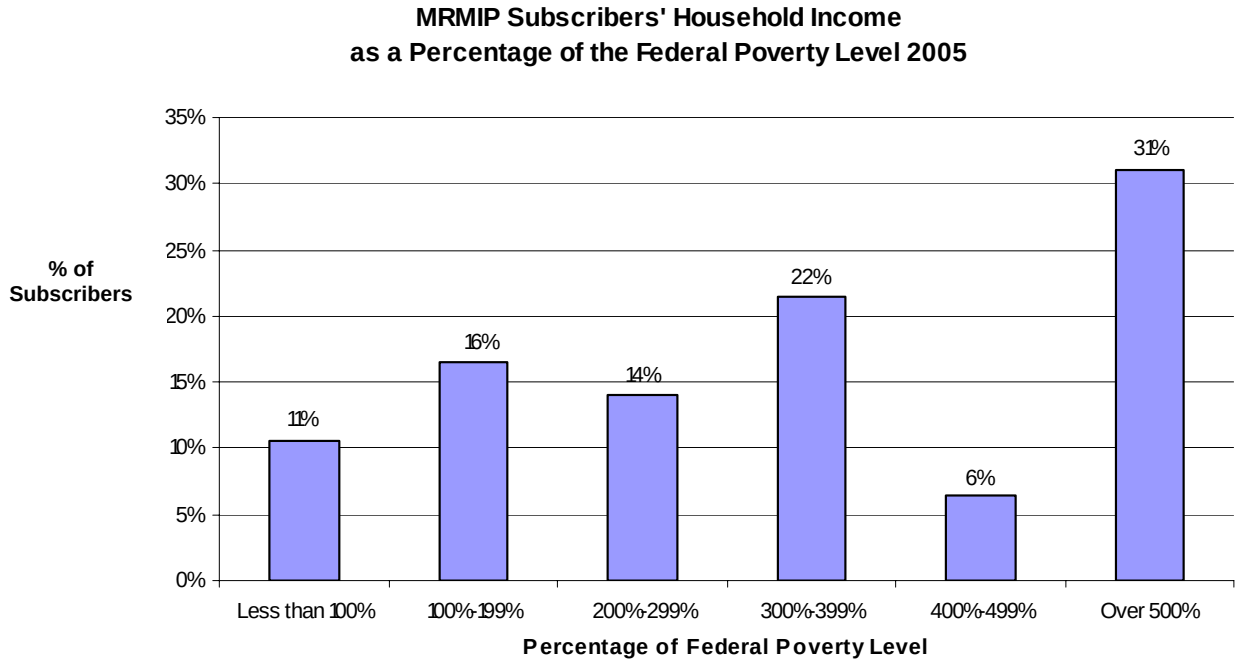


Source: 2005 MRMIP Independent Survey, (N=358)

Around four out of ten MRMIP subscribers live in households with incomes less than 300% of the Federal Poverty Level (FPL). One in three subscribers has incomes over 500% of the FPL. It is believed that there are fewer subscribers in MRMIP with low incomes because they may be eligible for share of cost Medi-Cal. Also, the premiums required for the program necessitate income levels higher than that present in other state subsidized health programs.

In 2005, the 300% FPL was $28,710 for an individual and $38,490 for a family of two.

Chart VI-8

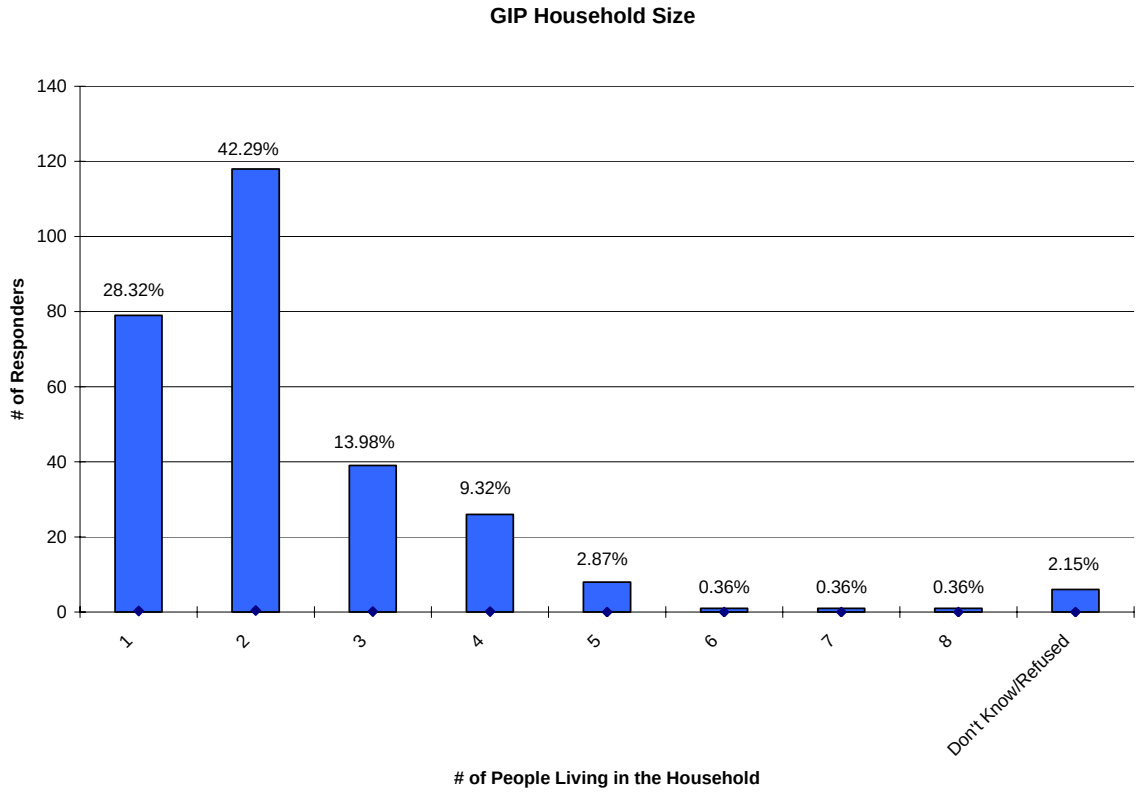


Source: 2005 MRMIP Independent Survey, (N=358)

GIP Household Size

Seventy percent of subscribers disenrolled due to the GIP eligibility time limit live in households of two or less.

Chart VI-9

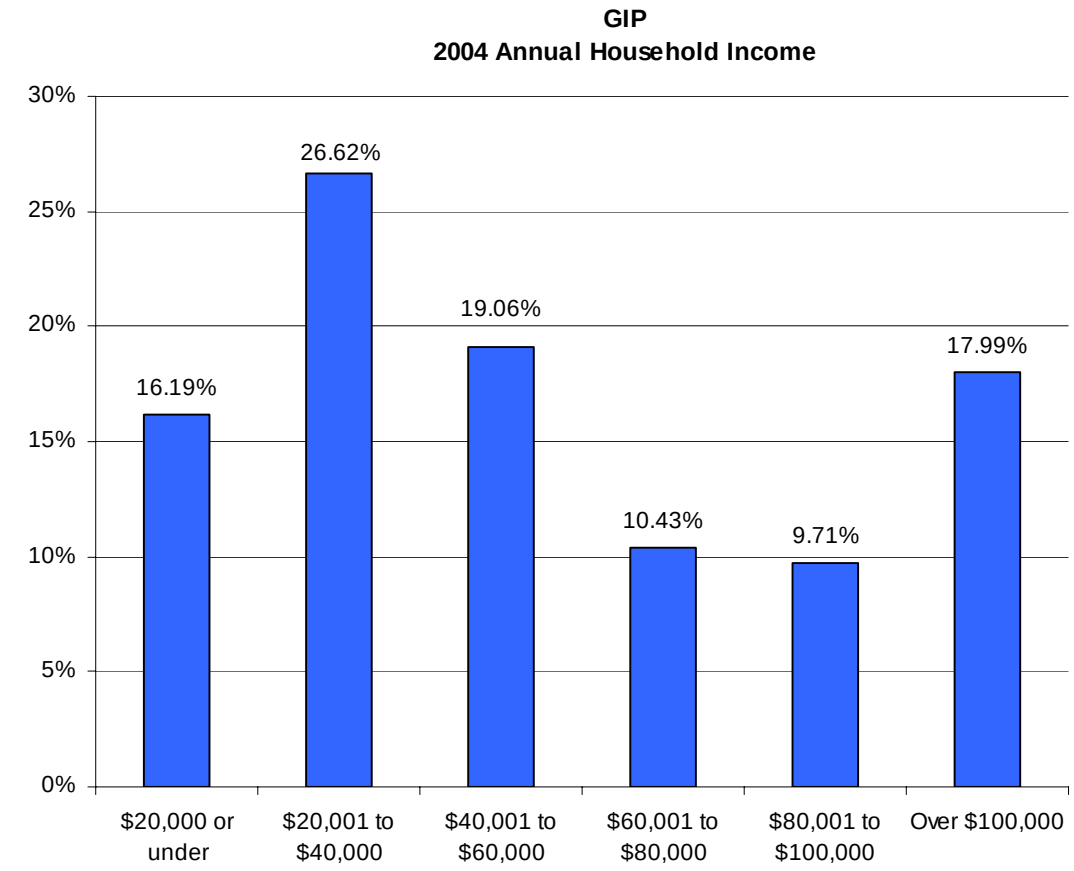


Source: 2005 GIP Survey: Total Population, (N=400)

GIP Household Income

Forty-three percent of subscribers disenrolled due to the GIP eligibility time limit had incomes below $60,000 a year.

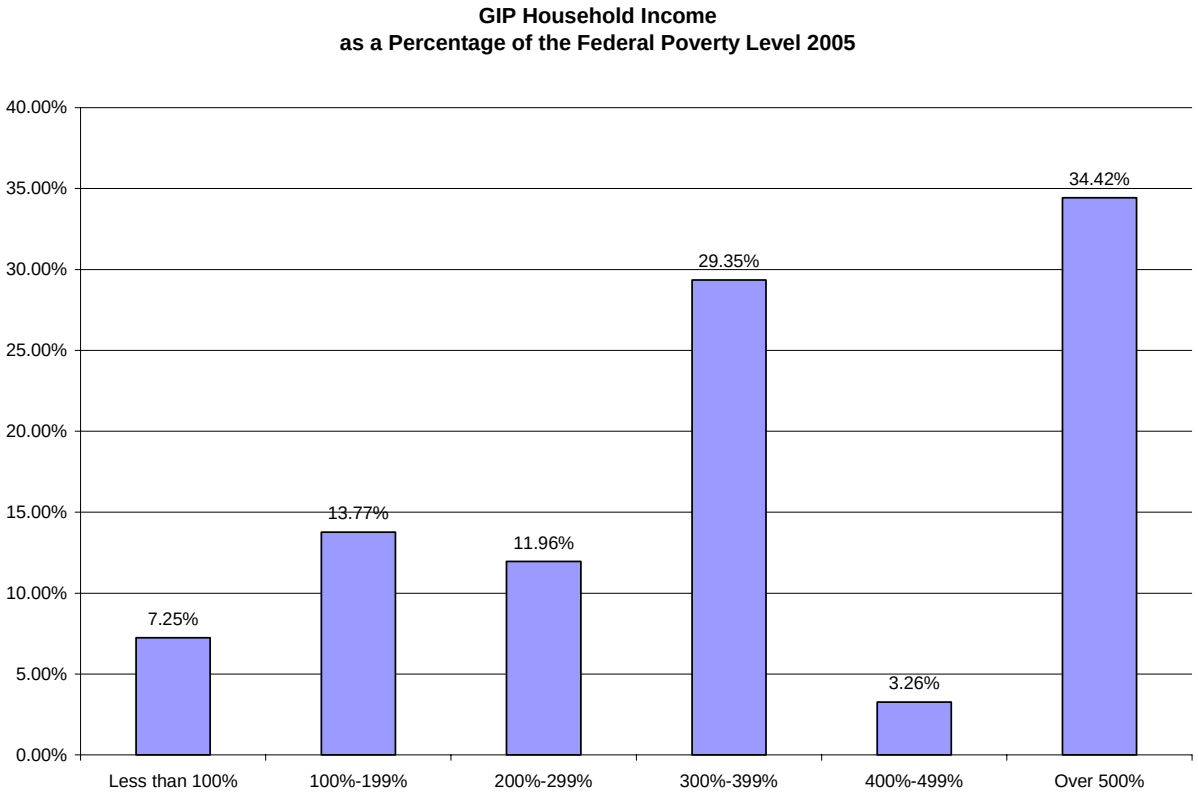
Chart VI-10



Source: 2005 GIP Survey: Total Population, (N=278)

One third of subscribers disenrolled due to the GIP eligibility time limit had incomes below 300% FPL, one third between 300% to 500%, and one third over 500% of the FPL. In 2004, the 300% FPL was $27,930 for an individual and $37,470 for a family of two.

Chart VI-11



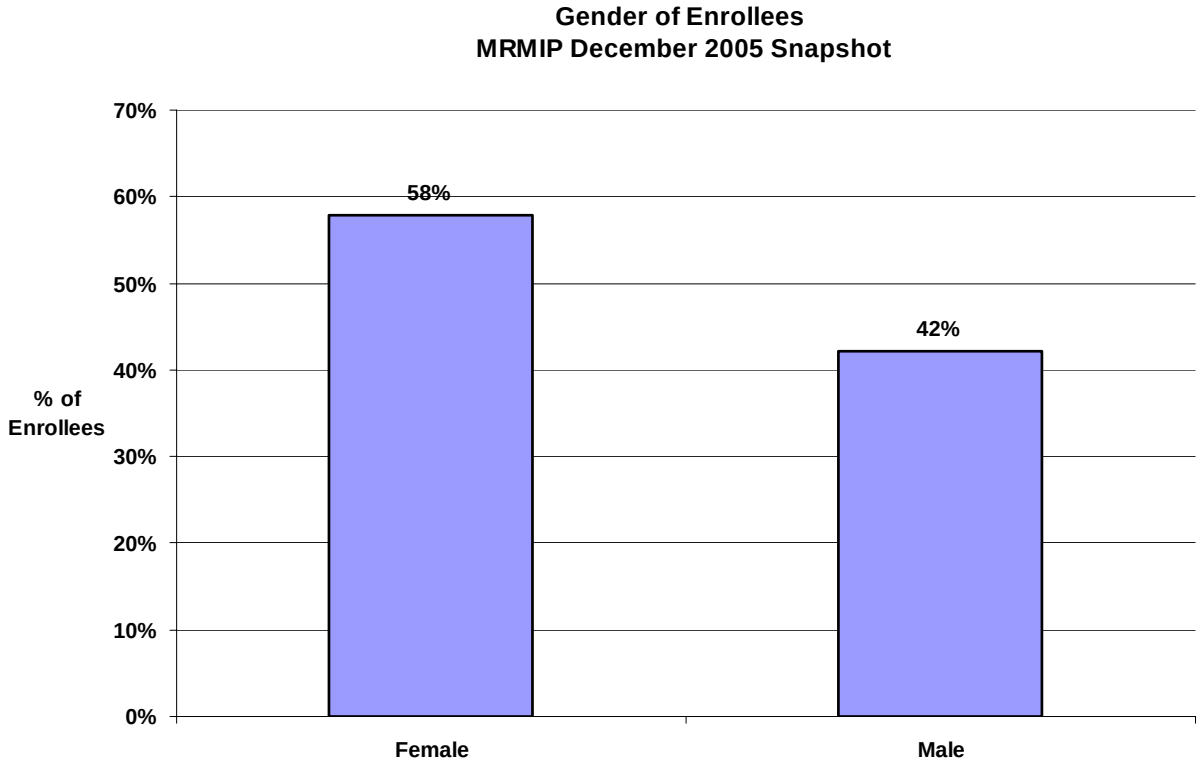
Source: 2005 GIP Survey: Total Population, (N=278)

GENDER

MRMIP

Close to 60% of MRMIP subscribers are women and close to one half are between the ages of 45 and 64. The percentage over 45 used to be considerably higher in MRMIP until those with 36 months coverage were disenrolled. Men are more likely to accept coverage in their own name, reflecting a longstanding pattern of women being more likely than men to be covered as dependents[5].

Chart VI-12



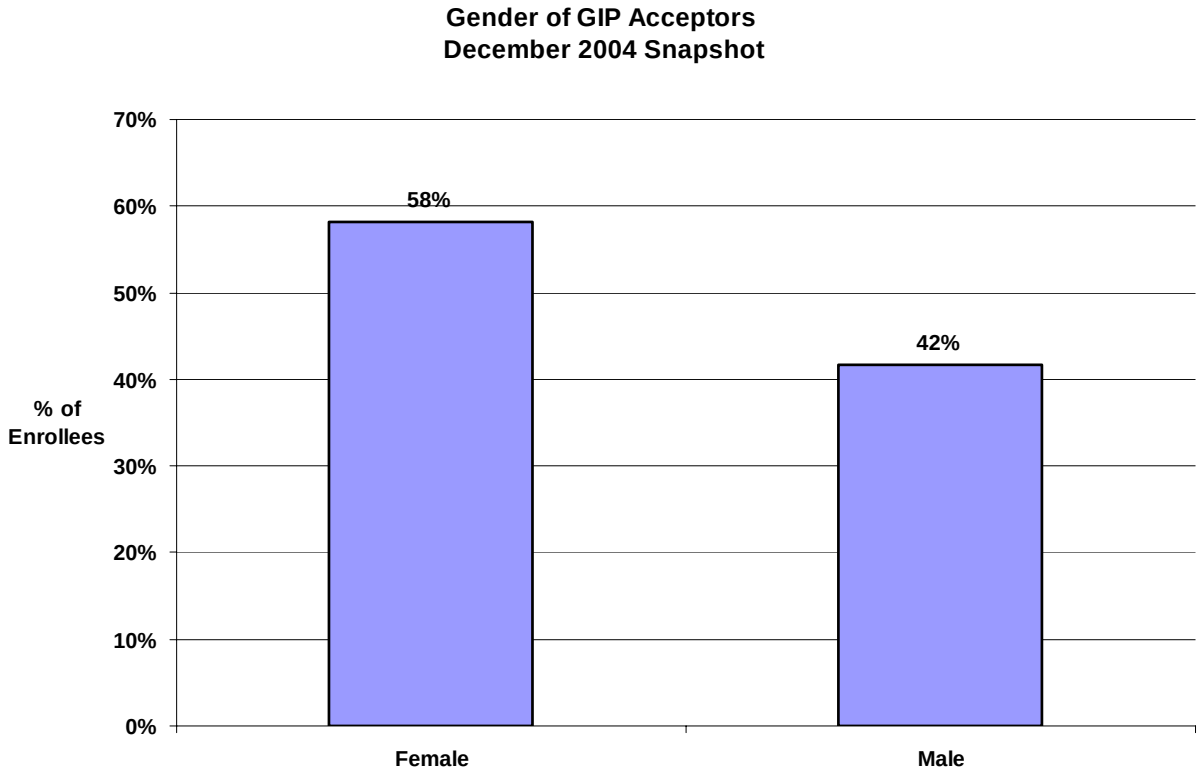
Source: MRMIP Enrollment Data, December 2005 Snapshot

[5] Brown, E.R.; Lavarreda, S.A; Rice, T; Kincheloe, J.R.; Gatchell, M.S.; The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2005; page 40.

GIP

There are no data presently available on the gender of all those disenrolled due to the GIP eligibility time limit. Like MRMIP, though, 58% of those purchasing GIP coverage ("acceptors") were female.

Chart VI-13



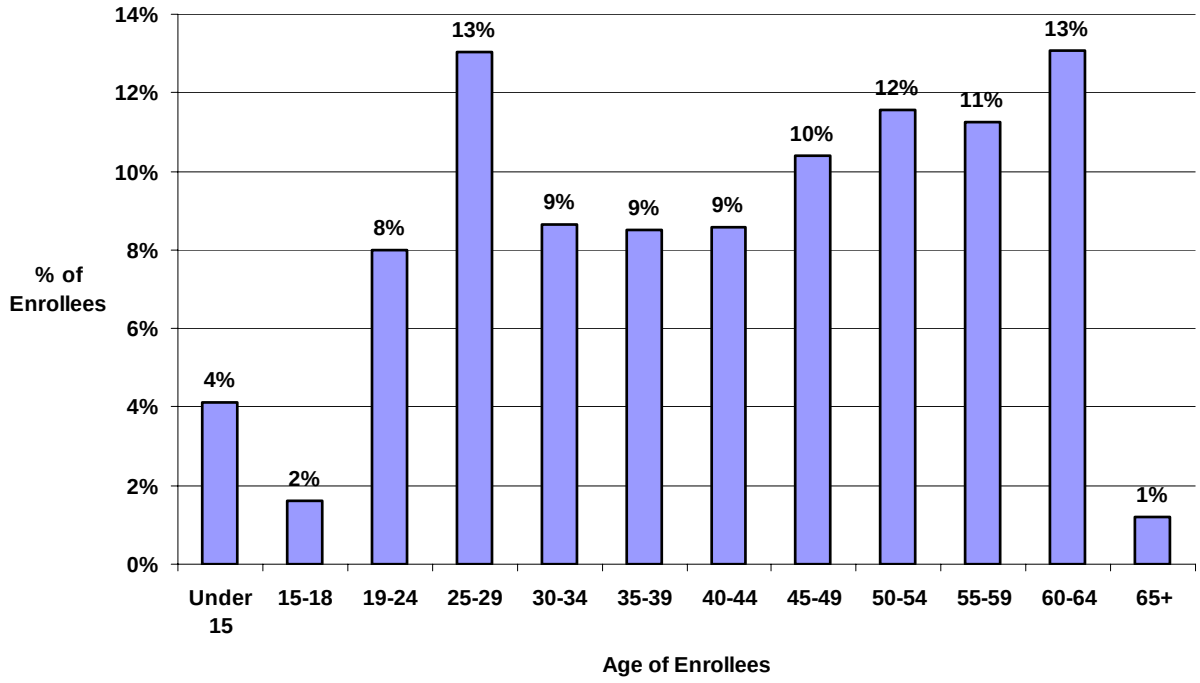
Source: GIP Enrollment Data, December 2004 Snapshot

AGE

MRMIP

As of December 2005, the average age for MRMIP subscribers age 18 and older was 43.

Chart VI-14
Enrollment by Age
MRMIP December 2005 Snapshot

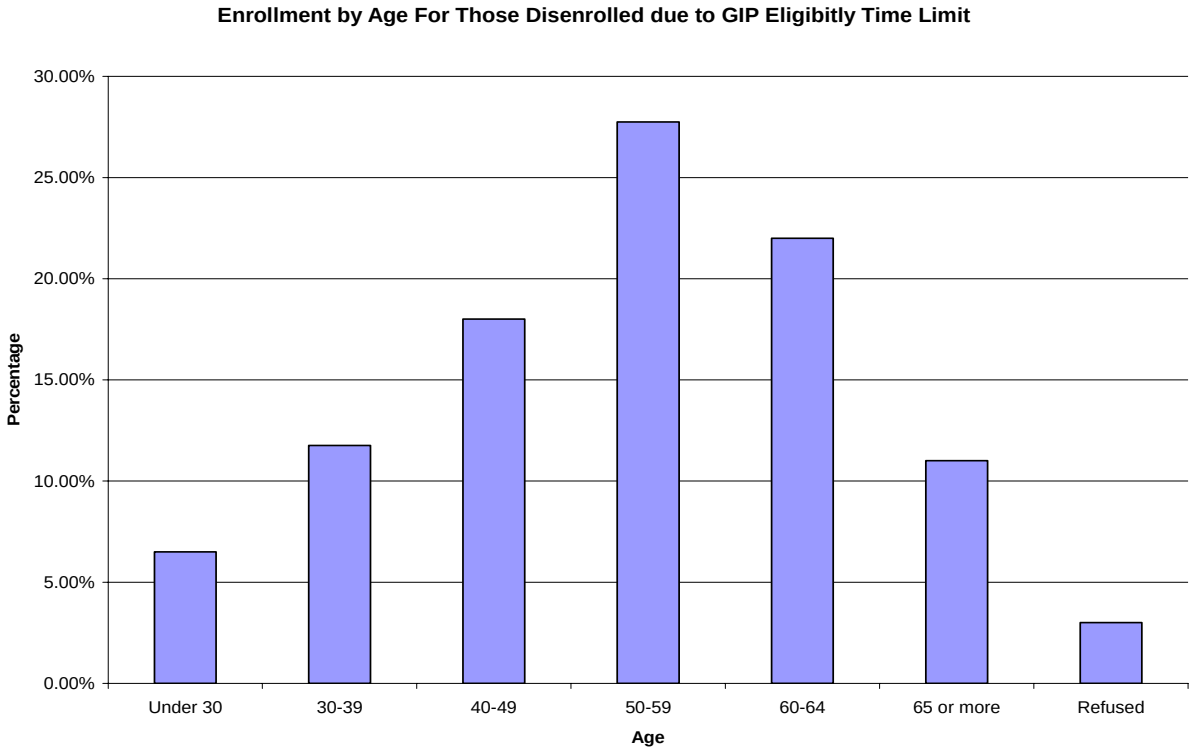


Source: MRMIP Enrollment Data, December 2005 Snapshot

GIP

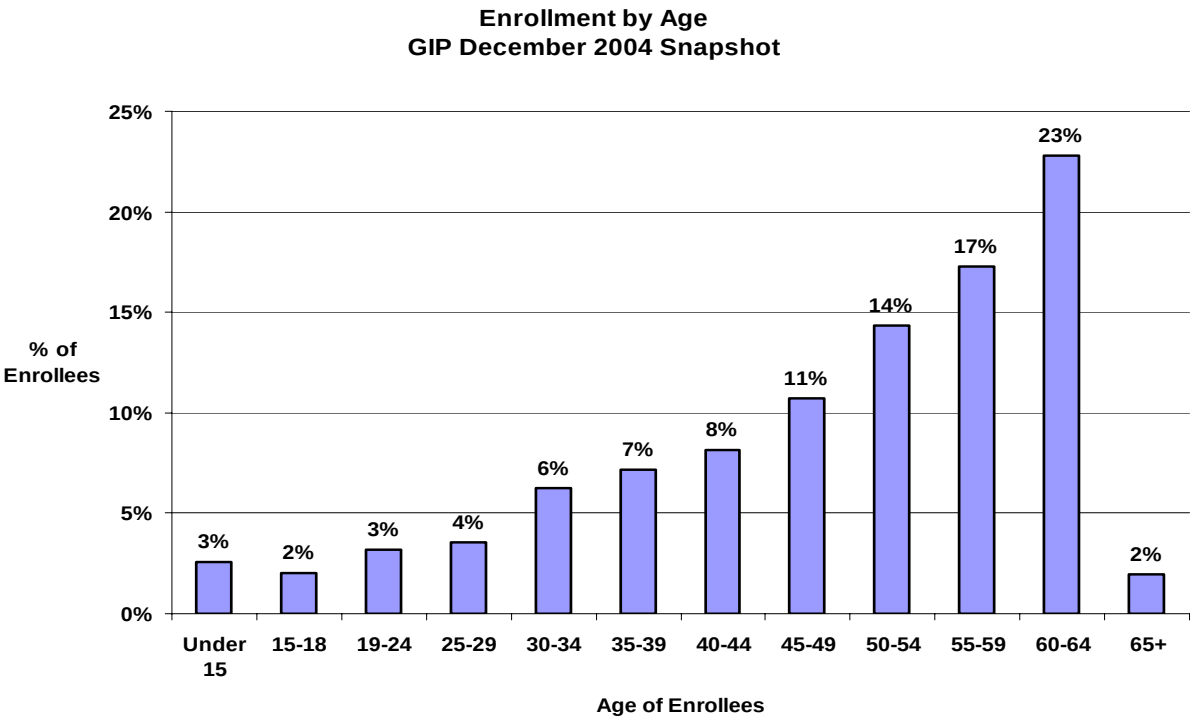
MRMIP subscribers who were disenrolled due to the GIP eligibility time limit were older than the present MRMIP population. Chart VI-15 shows the age distribution from the GIP survey data. Chart VI-16 shows those who purchased guaranteed issue products were significantly older than present MRMIP subscribers as provided by the GIP enrollment reports.

Chart VI-15



Source: 2005 GIP Survey: Total Population, (N=400)

Chart VI-16



Source: GIP Enrollment Data, December 2004 Snapshot

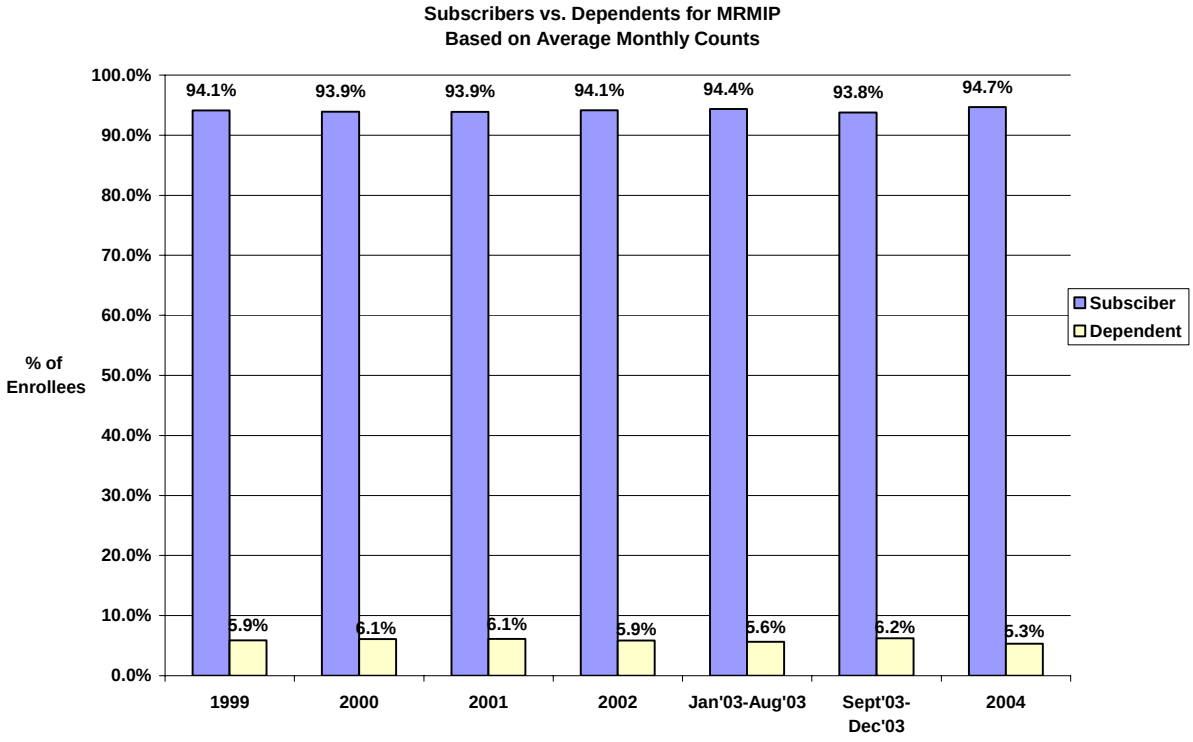
DEPENDENTS

Dependents currently comprise a very small percentage of enrollees in both MRMIP and in GIP. The small percentage of dependent enrollees reflects the high cost of premiums. The GIP data are for those who purchased GIP coverage ("acceptors").

Rates for dependents are based on the same risk assumptions used for subscribers. Dependents include: subscriber's spouse, registered domestic partner, and any unmarried child who is an adopted child, a stepchild, a recognized natural child under age 23, or a registered domestic partner's own separate child. A dependent also includes any unmarried child who is economically dependent upon the applicant. An unmarried child over 23 years old may be covered if that unmarried child is incapable of self-support because of physical or mental disability which occurred before the age of 23.

MRMIP

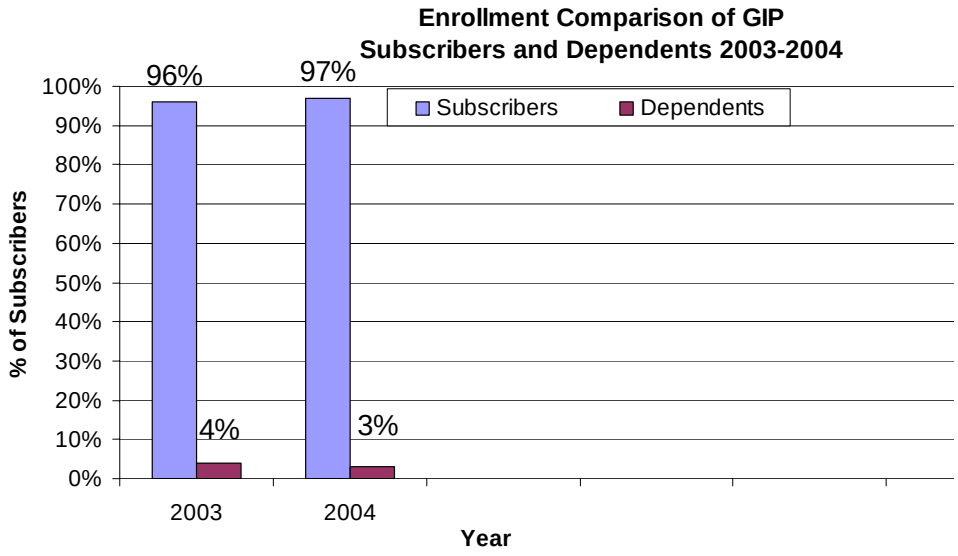
Chart VI-17



Source: MRMIP Historical Enrollment Data, 1999-2004; GIP Enrollment September 2003 - December 2004

GIP

Chart VI-18



Source: GIP 2004 Enrollment Data

Section VII

Benefits and Medical Costs

MRMIP BENEFITS

The MRMIP offers a comprehensive benefit package to subscribers. Subscribers have a maximum annual out-of-pocket expense of $2,500 per person or $4,000 per family, and have an annual benefit maximum of $75,000 or $750,000 per lifetime. The benefit package includes:

Chart VII-1

TYPE OF SERVICE	DESCRIPTION OF SERVICE
Physician Care	Outpatient and inpatient physician services.
Hospital Services	Semi-private room & board, medically necessary inpatient and outpatient services and supplies, and emergency hospital services as medically necessary.
Prescription Drugs	Medically necessary prescription drugs.
Diagnostic Test	Laboratory tests, x-rays and mammograms.
Durable Medical Equipment	As approved by the subscriber's health plan and required for care of an illness or injury.
Maternity Care	Prenatal care, inpatient delivery and complications of pregnancy.
Mental Health Services	As approved by the subscriber's health plan, up to 15 outpatient visits per calendar year and 10 inpatient days per calendar year.
Ambulance	Emergency transportation.
Speech/Physical/Occupational Therapy	As approved by the subscriber's health plan for short-term therapy for acute conditions.
Home Health Care/Hospice	As approved by the subscriber's plan.
Skilled Nursing services	As approved by the subscriber's plan.
Transplant Services	As approved by the subscriber's plan and includes corneal, human heart, heart-lung, liver, bone-marrow and kidney.

Source: Title 10, California Code of Regulations, Chapter 5.5, Article 3.

GIP BENEFITS

Benefits for guaranteed issue coverage are the same as they are for the MRMIP, except that the annual benefit maximum is $200,000 and individuals will begin a new lifetime benefit cap of $750,000.

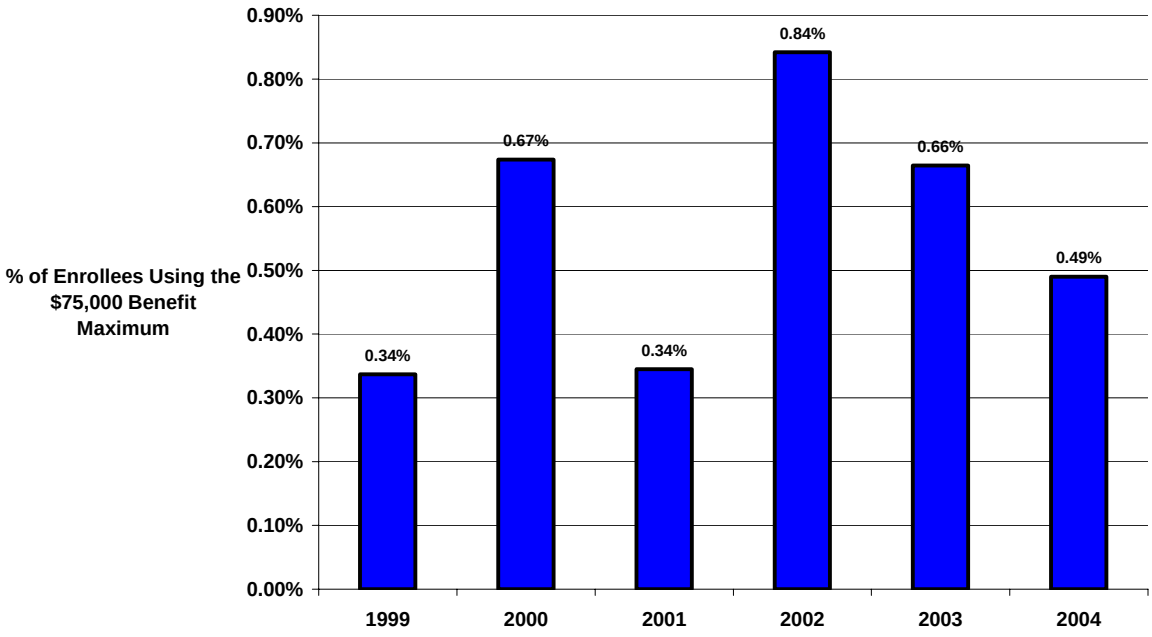
USE OF THE MAXIMUM ANNUAL BENEFIT

MRMIP Subscribers

Less than 1% of MRMIP subscribers reach the program's $75,000 maximum benefit each year. The percentage of MRMIP subscribers using the $75,000 annual maximum benefit has ranged from a low of 0.34% in 1999 and 2001 to a high of 0.84% in 2002. In 2004, only 0.49% of subscribers used the annual maximum benefit.

Chart VII-2

Percentage of MRMIP Enrollees Who Used the $75,000 Maximum Annual Benefits by Calendar Year

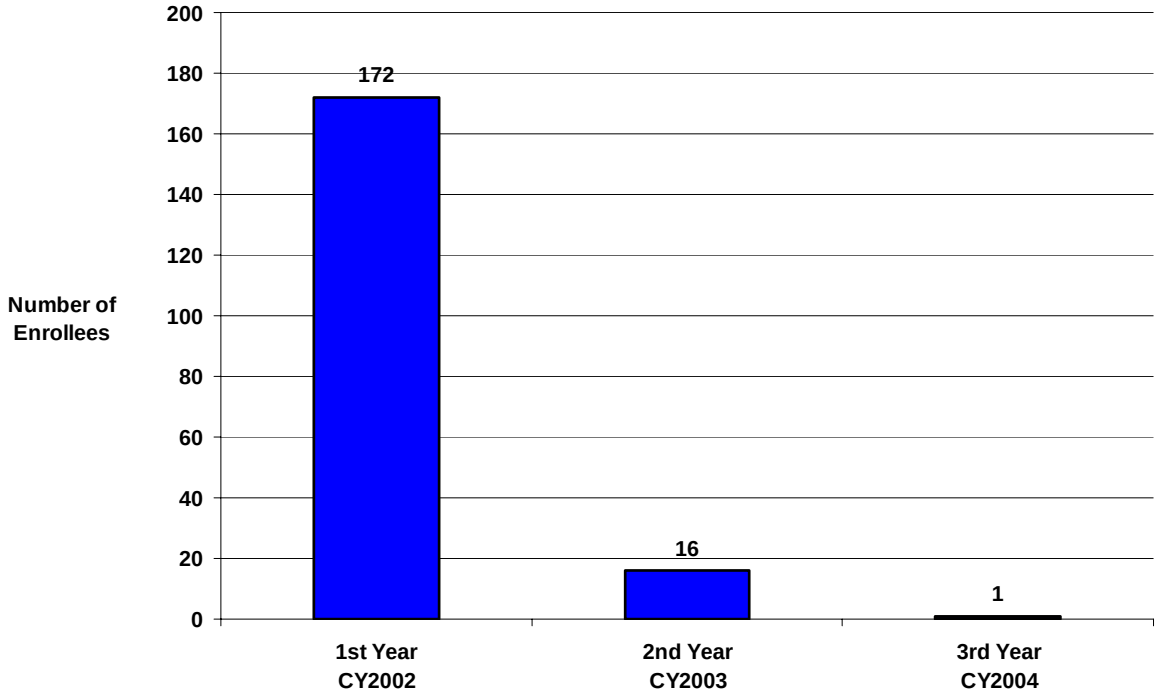


Source: MRMIP Medical Claims Data and Historical Enrollment Data, 1999-2004

An extremely small number of MRMIP subscribers reach the program's maximum annual benefit in multiple consecutive years.

Chart VII-3

Number of MRMIP Enrollees Who Used the $75,000 Maximum Annual Benefits in 2002 and Subsequently in 2003 and 2004



Source: MRMIP Medical Claims Data and Historical Enrollment Data, 1999-2004

GIP Subscribers

There is no comparable information for all plans on the use of the $200,000 maximum annual benefit by GIP subscribers because of the limited time that the GIP has been in effect. However, data from the Blue Cross of California PPO for September 1, 2003, through August 31, 2004, show that 0.4% of GIP subscribers (21 people) had costs over $200,000. These costs exceed $5 million.

HEALTH PLANS

MRMIP provides comprehensive health care coverage through four health plans. One Preferred Provider Organization (PPO) and three Health Maintenance Organizations (HMOs) participate in the program. The PPO plan offers subscribers a network of providers from which subscribers can seek care. The PPO plan also allows subscribers to seek services from providers outside the PPO network, but at a higher cost to the member. Subscribers enrolled in the PPO plan pay between 20% and 25% of the cost of medical services.

The HMO plans are organized health care delivery systems that provide health care services to plan subscribers in a geographic area. In an HMO, a member chooses a primary care provider (PCP) and uses network providers to receive care. These plans charge flat co-payments for many services rather than a percentage of costs.

MRMIP

Around half of MRMIP's subscribers are enrolled in the PPO. The table below shows the enrollment distribution across all participating plans.

Chart VII-4

Health Plan	Percentage of Enrollees	Number of Counties in Which Plan is Available
Blue Cross of California Preferred Provider Organization (PPO)	51.8%	Statewide
Kaiser Permanente	41%	28 Counties Partial Coverage in 18 Counties
Blue Shield of California HMO	6.0%	22 Counties Partial Coverage in 5 Counties
Contra Costa Health Plan	1.2%	1 County

Source: MRMIP Enrollment Data December 14, 2005

GIP

All plans in the individual market must offer guaranteed issue coverage to those disenrolled from MRMIP due to the 36 month eligibility limit. The plans offering this coverage are:

- Blue Cross of California PPO
- Blue Shield of California HMO
- Central Health
- Chinese Community Health Plan
- Fortis Insurance Company
- Health Net
- Kaiser Foundation Health Plan
- MEGA Life Insurance Company
- Mid-West National Life Insurance Company
- PacificCare Health and Life Insurance Company
- Universal Care
- Watts Health Foundation

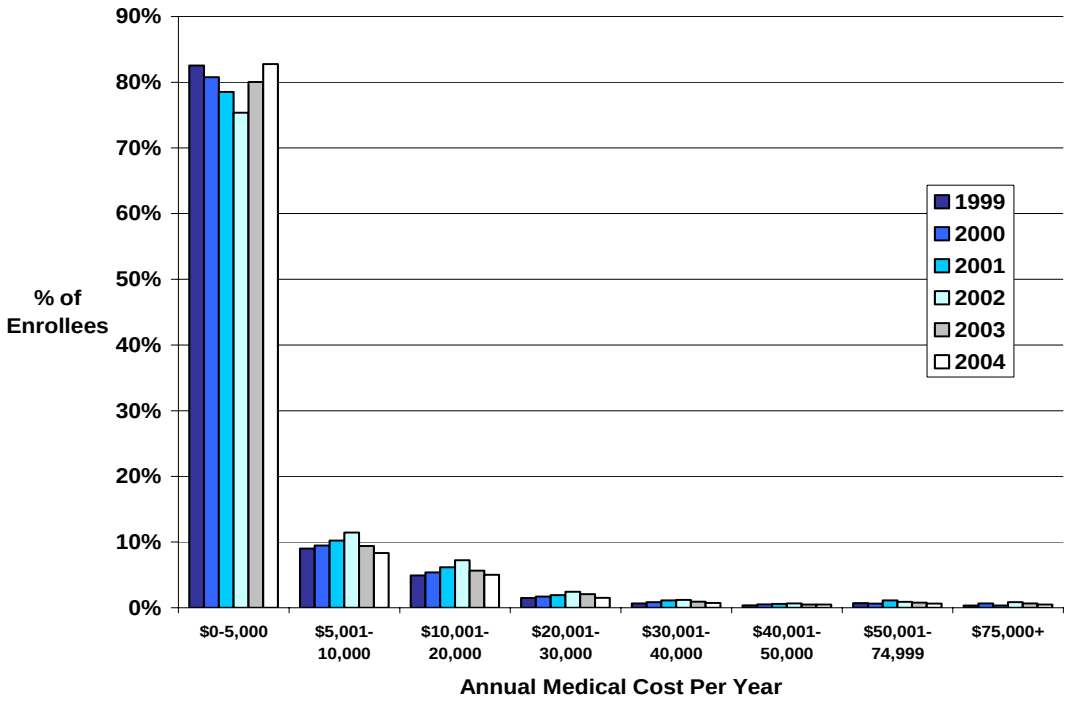
MEDICAL COSTS

MRMIP

Between 1999 and 2004, around eighty percent of MRMIP subscribers had medical costs of $5,000 or less per year. During 2004, nineteen percent of MRMIP enrollees made no medical claims, even though they have been determined to be uninsurable.

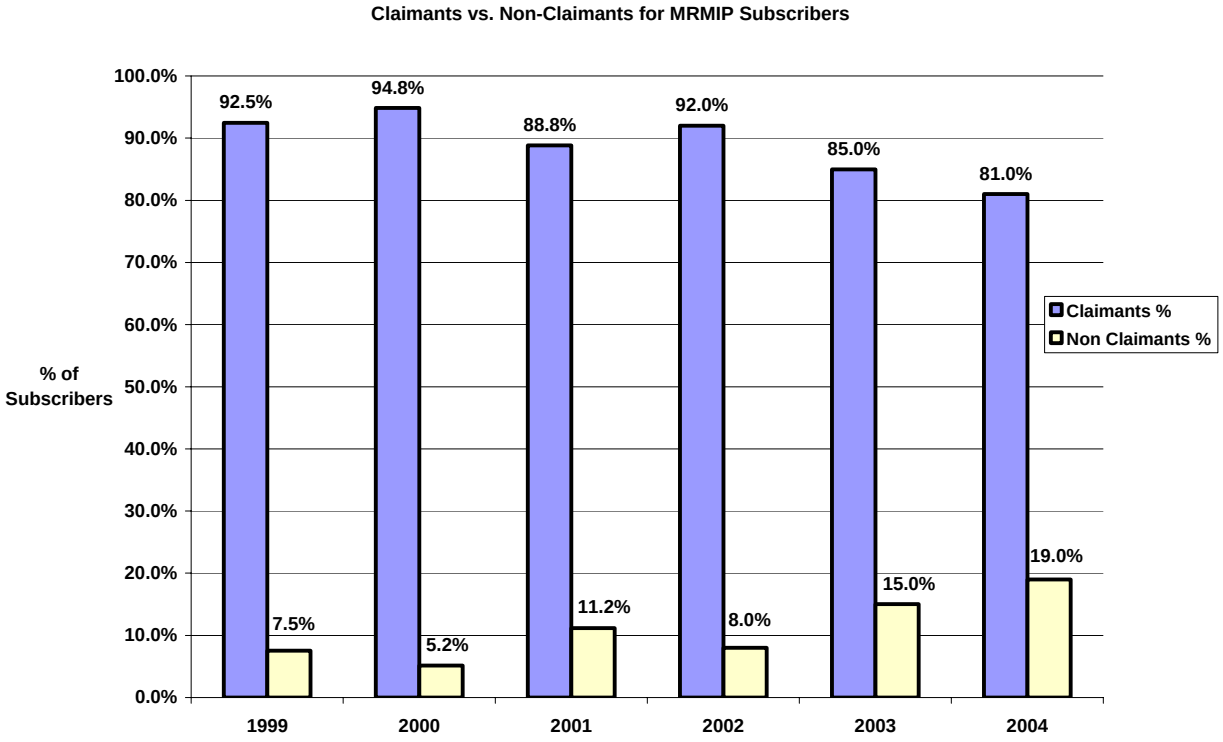
Chart VII-5

MRMIP Annual Medical Expenditure Range



Source: MRMIP Medical Claims Data and Historical Enrollment Data, 1999-2004

Chart VII-6

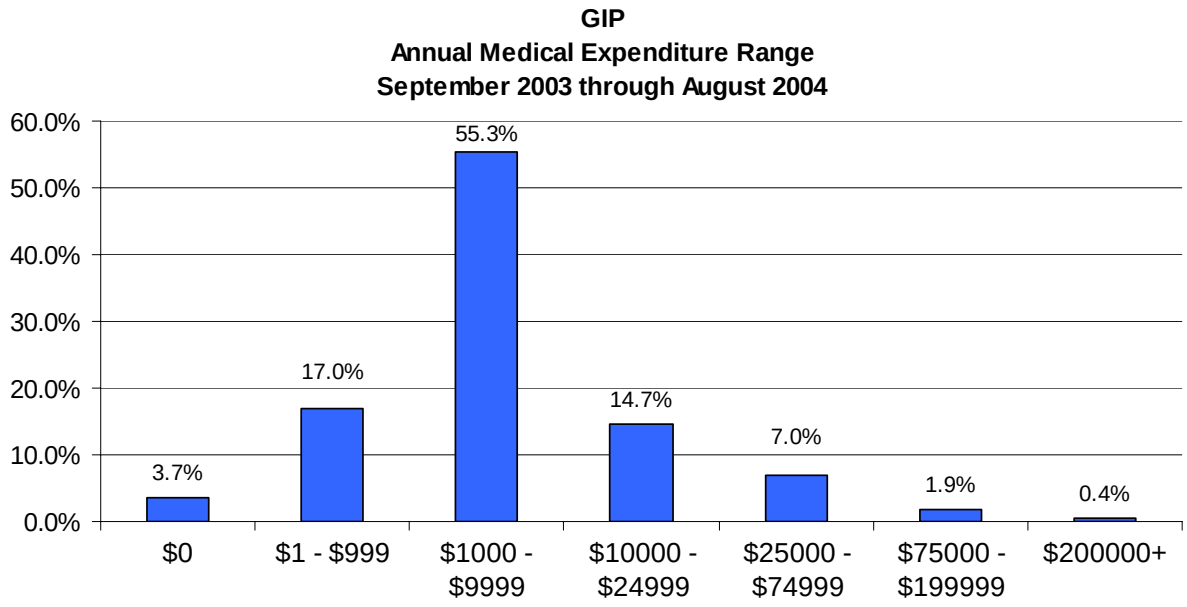


Source: MRMIP Medical Claims Data and Historical Enrollment Data, 1999-2004

GIP

During the time period of September 2003 through August 2004, three fourths of those purchasing guaranteed issue coverage through GIP had annual medical expenditures between $1,000 and $9,999. No data is presently available on the number of enrollees with no claims. (The $0 number below is percentage of claims with no cost).

Chart VII-7

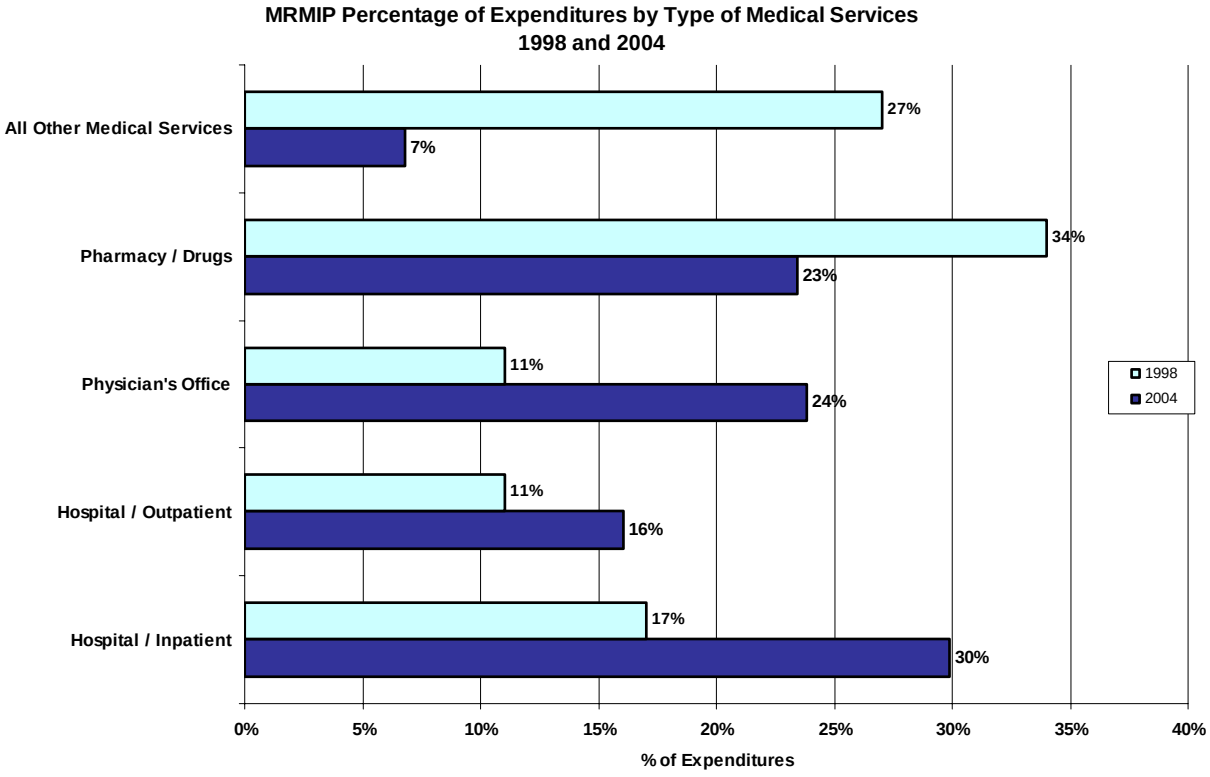


Source: 2005 Medical Claims Data from Blue Cross

BENEFIT EXPENDITURES BY TYPE OF SERVICE RECEIVED

The highest program health expenditures for MRMIP in 2004 were for hospital/inpatient services (thirty percent) followed by physician office services (twenty-four percent) and prescription drugs (twenty-three percent) respectively. This appears to be different from 1998 (the year discussed in the last fact book) when the highest program health care expenditures were for prescription drugs (thirty-four percent) followed by the category of "all other medical services" (twenty-seven percent). However, the change likely results from a change in how pharmacy/drugs were categorized.

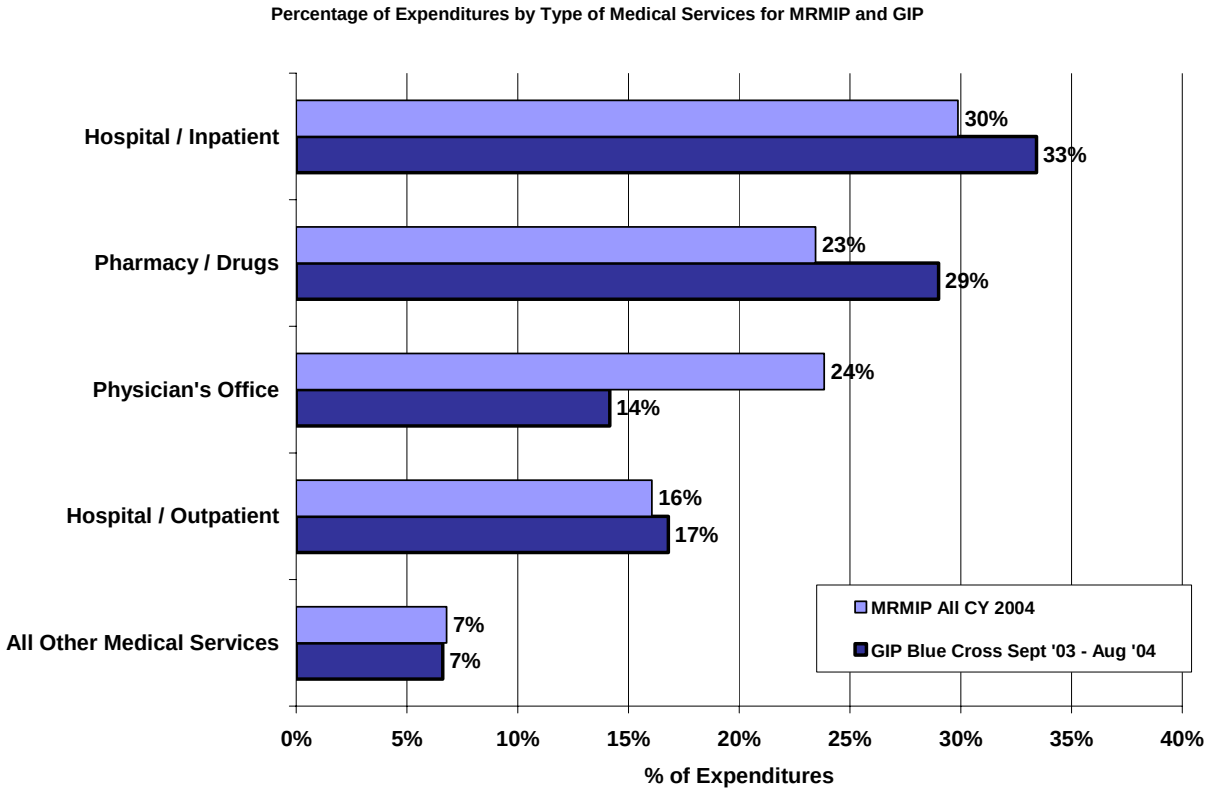
Chart VII-8



Source: MRMIP Medical Claims Data

The highest program health expenditures for persons enrolled in guaranteed coverage through GIP in 2003-2004 were also for hospital/inpatient services (thirty-three percent) followed by prescription drugs (twenty-nine percent) and hospital/outpatient services (seventeen percent). Chart VII-9 shows health expenditures for MRMIP (2004) and GIP (2003-2004).

Chart VII-9



Source: MRMIP and GIP Medical Claims Data from Blue Cross

Section VIII

Medical Conditions

MEDICAL CONDITIONS

MRMIP

MRMIP subscribers have a wide variety of medical conditions. Chart VIII-1 below indicates the percentage of MRMIP subscribers with medical claims for the following 16 broad categories of illness. For 2003 and 2004, there was a fairly significant decline in these percentages between 2003 (the year that GIP was implemented) and 2004. Of note is that the highest level percentage decrease in medical conditions between 2003 and 2004 were in medical conditions that would be indicative of the older GIP population being disenrolled from MRMIP. Examples of these medical conditions and their corresponding decreases are shown below:

- Disease of the Musculoskeletal System (examples include arthritis, rheumatism) ↓ 6.6%
- Nutritional and Metabolic Diseases (examples include thyroditis, diabetes) ↓ 7.4%
- Diseases of the Circulatory System (heart disease) (examples include hypertension, myocardial infarction, aneurysm, varicose veins) ↓ 7.6%
- Diseases of the Nervous System (examples include bacterial meningitis, Alzheimer's disease) ↓ 6.7%

Chart VIII-1

Percentage of MRMIP Subscribers with Selected Medical Conditions

Disease Category	2003	2004
Disease of the Musculoskeletal System (examples include arthritis, rheumatism)	25.9%	19.3%
Diseases of Genitourinary System (examples include renal failure, infection of kidney, cystitis)	20.3%	16.9%
Nutritional and Metabolic Diseases (examples include thyroditis, diabetes)	26.6%	19.2%
Diseases of the Circulatory System (heart disease) (examples include hypertension, myocardial infarction, aneurysm, varicose veins)	23.0%	15.4%
Diseases of the Respiratory System (examples include pneumonia, influenza)	20.8%	16.5%
Diseases of the Nervous System (examples include bacterial meningitis, Alzheimer's)	23.9%	17.2%
Diseases of the Skin and Subcutaneous Tissue (examples include abscess, dermatitis)	16.3%	12.5%
Injury and Poisoning (examples include bone fractures, sprains)	15.5%	11.9%
Cancers and Neoplasms	13.0%	10.2%
Diseases of the Digestive System (examples include duodenal ulcers, gastritis, cirrhosis, of liver, diverticulitis)	13.8%	10.4%
Mental Disorders (examples include dementia, psychosis, depression)	13.1%	11.6%
Infectious and Parasitic Diseases (examples include AIDS, Tuberculosis)	9.7%	7.6%
Diseases of the Blood (examples include anemia, coagulation defects)	4.2%	3.2%
Pregnancy, childbirth and complications thereof	1.5%	2.2%
Certain Conditions Originating In the Perinatal Period	0.5%	0.6%
Congenital Anomalies	2.6%	1.7%

Source: MRMIP Medical Claims Data, 2003 and 2004. Note: Subscribers could have more than one condition.

A significantly lower percentage of subscribers with these conditions had medical claims cost exceeding $500.

Chart VIII-2

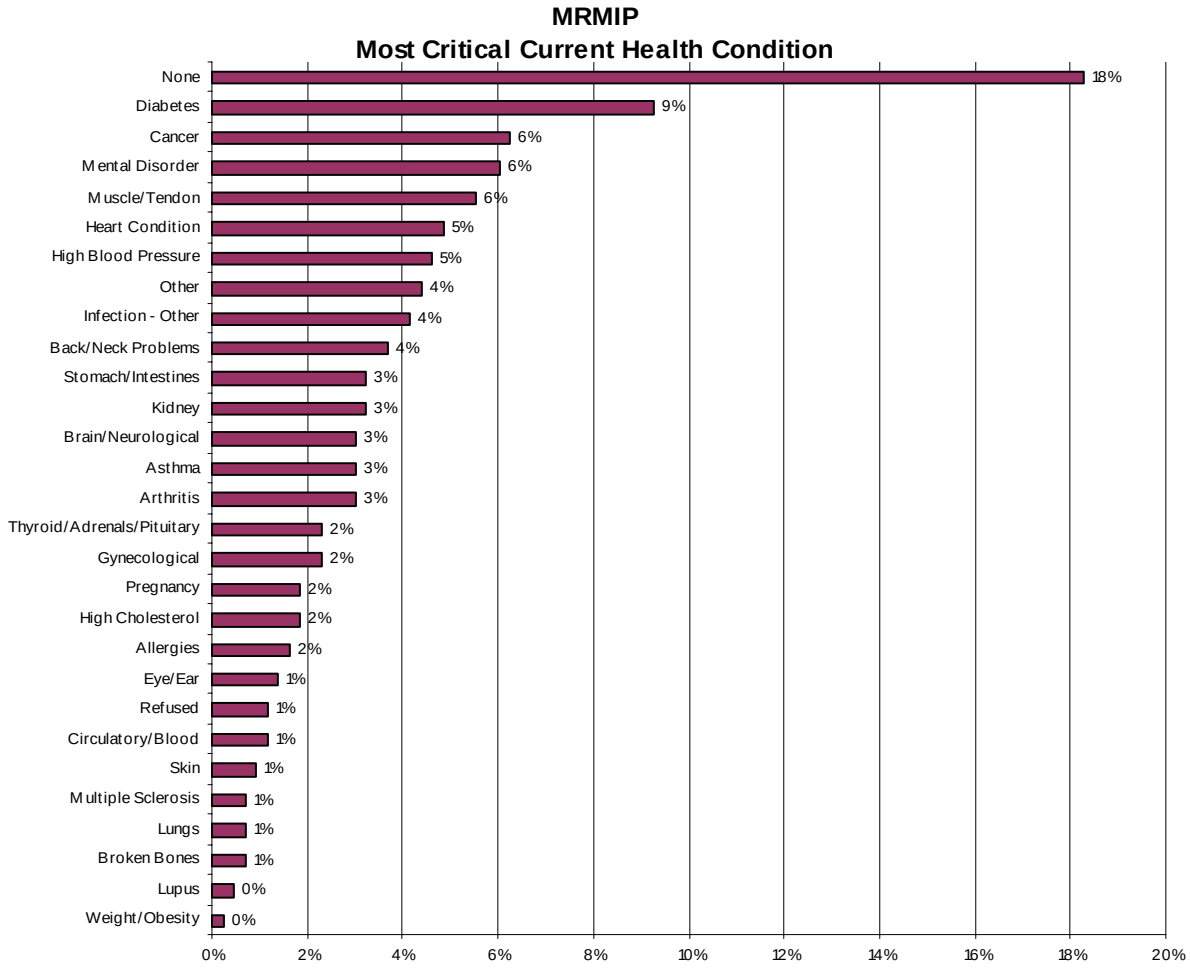
Percentage of MRMIP Subscribers with Selected Medical Conditions and Claims Costs Exceeding $500

Disease Category	2003	2004
Disease of the Musculoskeletal System (examples include arthritis, rheumatism)	8.4%	6.7%
Diseases of Genitourinary System (examples include renal failure, infection of kidney, cystitis)	4.0%	4.4%
Nutritional and Metabolic Diseases (examples include thyroditis, diabetes)	4.8%	3.7%
Diseases of the Circulatory System (heart disease) (examples include hypertension, myocardial infarction, aneurysm, varicose veins)	5.8%	4.2%
Diseases of the Respiratory System (examples include pneumonia, influenza)	3.0%	2.3%
Diseases of the Nervous System (examples include bacterial meningitis, Alzheimer's disease)	4.9%	3.2%
Diseases of the Skin and Subcutaneous Tissue (examples include abscess, dermatitis)	1.6%	1.3%
Injury and Poisoning (examples include bone fractures, sprains)	4.9%	4.4%
Cancers and Neoplasms	4.6%	4.5%
Diseases of the Digestive System (examples include duodenal ulcers, gastritis, cirrhosis, of liver, diverticulitis)	4.6%	4.0%
Mental Disorders (examples include dementia, psychosis, depression)	5.1%	4.5%
Infectious and Parasitic Diseases (examples include AIDS, Tuberculosis)	1.8%	1.3%
Diseases of the Blood (examples include anemia, coagulation defects)	1.0%	0.9%
Pregnancy, childbirth and complications thereof	0.6%	1.8%
Certain Conditions Originating In the Perinatal Period	0.1%	0.2%
Congenital Anomalies	0.7%	0.6%

Source: MRMIP Medical Claims Data, 2003 and 2004. Note: Subscribers could have more than one condition.

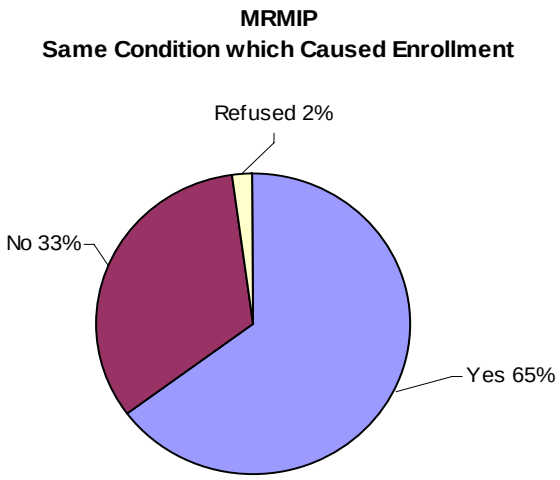
Surveyed MRMIP subscribers were asked to report on their current health condition, and whether that was the same condition causing their enrollment in MRMIP. Sixty-five percent indicated that their current health condition was the same condition that caused enrollment in MRMIP, while thirty-three percent stated their current health condition was different than the condition that caused them to enroll in MRMIP.

Chart VIII-3



Source: 2005 MRMIP Independent Survey, (N=432)

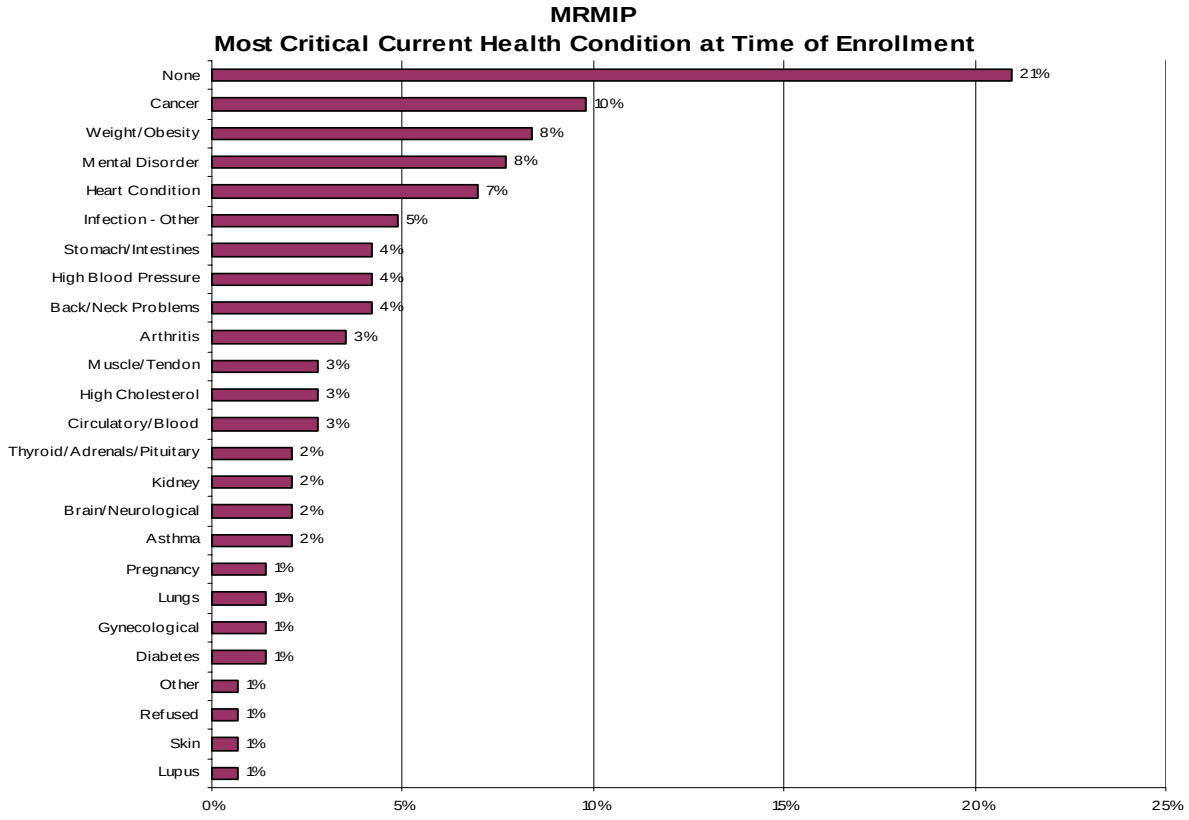
Chart VIII-4



Source: 2005 MRMIP Independent Survey, (N=432)

Subscribers who indicated that their current condition was different than their condition at the time of enrollment in MRMIP were asked to identify the condition at time of enrollment.

Chart VIII-5



Source: 2005 MRMIP Independent Survey, (N=144)

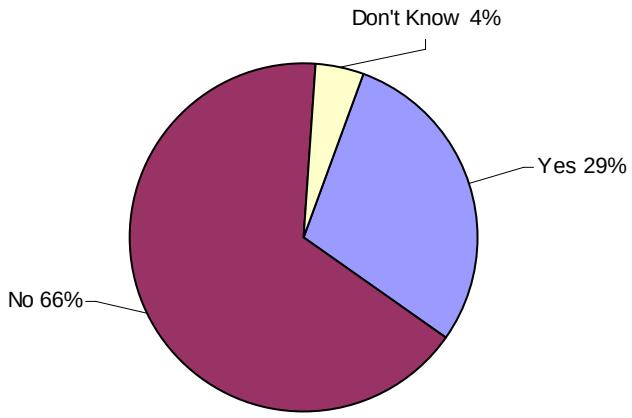
Of note:

- Twenty-one percent of these subscribers felt that they did not have a medical condition at time of enrollment.
- Obesity appears as a significant critical condition at time of enrollment (8%) but not as a critical current condition (1%).
- However, diabetes is identified as the most critical current condition (9%), but was a minor one at enrollment (1%).
- Cancer was not identified as a significant current condition (2%), but was the highest identified condition at the time of enrollment (10%).

Twenty-nine percent of MRMIP subscribers anticipate needing medical services in the next six months for any of their other medical conditions.

Chart VIII-6

MRMIP
Need Medical Services for Other Conditions in the Next 6 Months

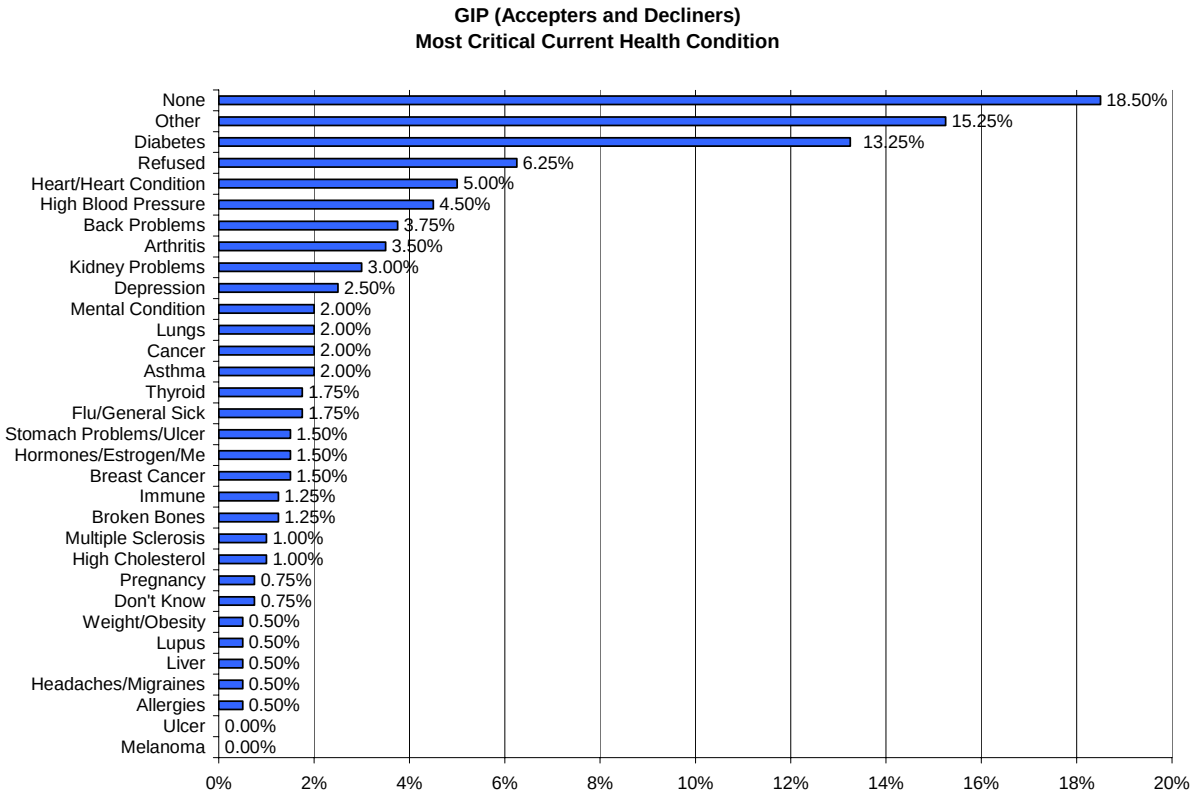


Source: 2005 MRMIP Independent Survey, (N=432)

GIP

Those people disenrolled from MRMIP due to the 36 month eligibility time limit were also asked to report on their medical conditions. The chart below details what subscribers reported as their current critical health condition.

Chart VIII-7

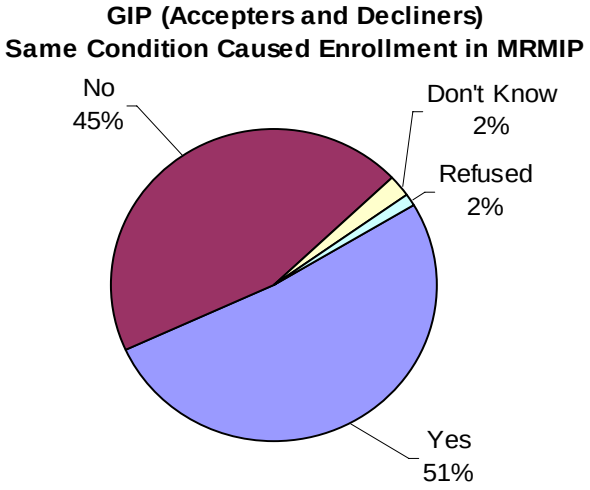


Source: GIP Survey, (N=400)

Like MRMIP subscribers, the largest percentage reported no current medical condition. And like MRMIP, the most frequent identified current condition was diabetes.

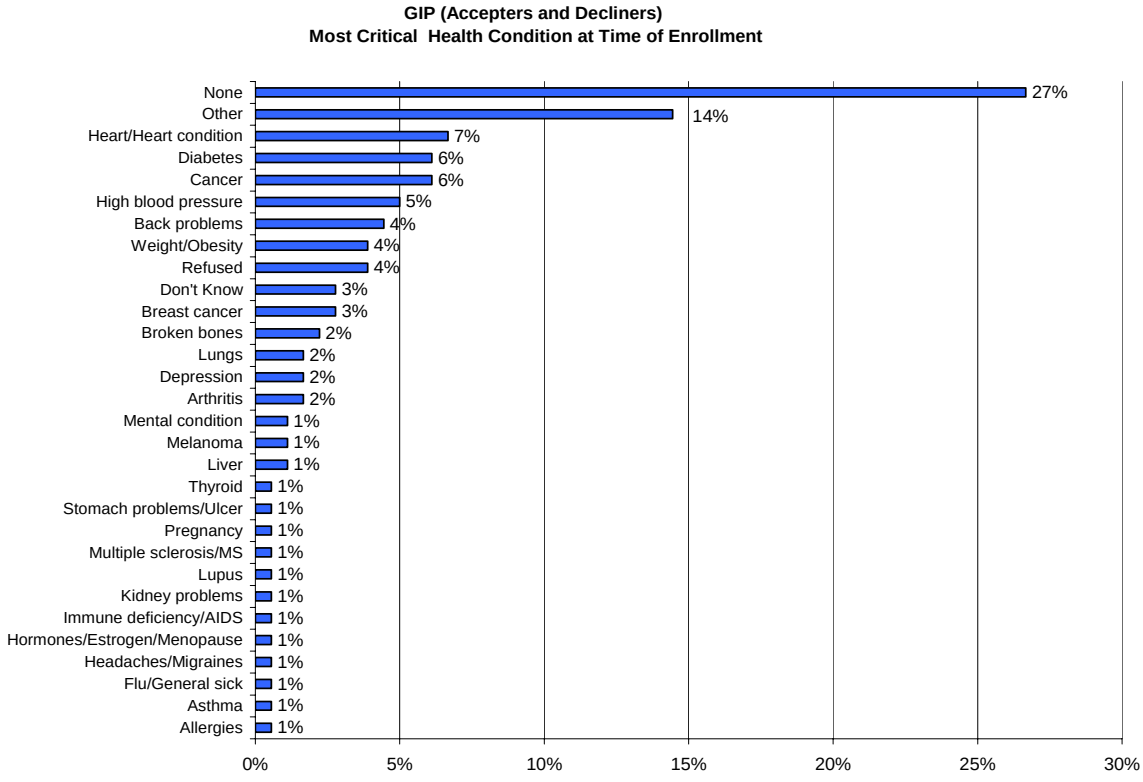
Fifty-one percent of those disenrolled to GIP who reported on their current health condition in the survey percent indicated that their current health condition was the same condition that caused enrollment in MRMIP, while forty-five percent stated their current health condition was different than the condition that caused them to enroll in MRMIP.

Chart VIII-8



Source: 2005 GIP Independent Survey, (N=400)

Chart VIII-9



Source: 2005 GIP Independent Survey, (N=180)

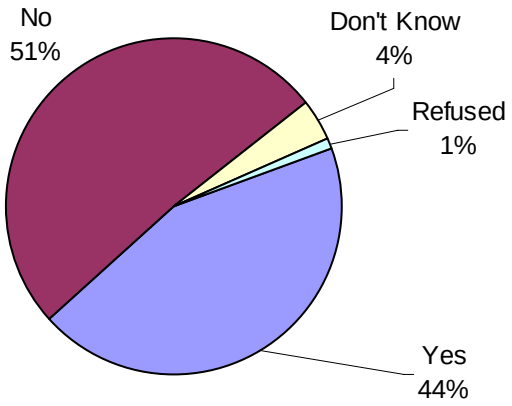
Information from Chart VIII-9:

- Twenty-seven percent indicated that they had no critical health condition at time of enrollment.
- Diabetes was identified by 6% of GIP respondents as a critical condition at enrollment, but by 13% as a current condition (the highest specified condition).

Forty-four percent of people in the pilot anticipated needing medical services in the next six months for any of their other medical conditions.

Chart VIII-10

GIP (Accepters and Decliner)
Need Medical Services for Other Conditions in the Next 6 Months



Source: 2005 GIP Independent Survey, (N=400)

Subscriber Assessment of Health Status

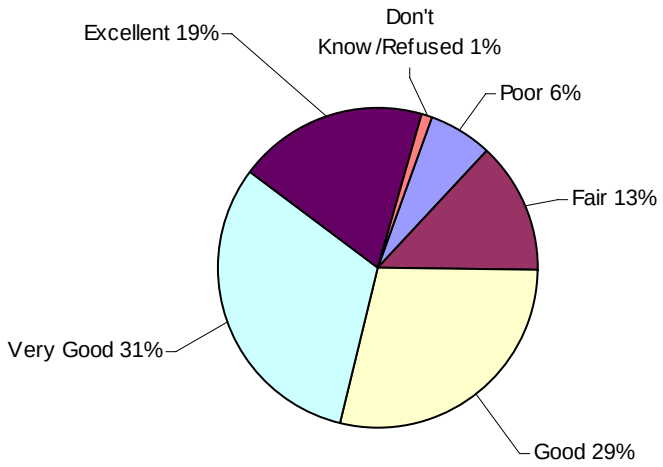
Both MRMIP subscribers and those disenrolled to the GIP were asked to assess their health status.

MRMIP

Fifty percent of MRMIP subscribers assess their health status as very good or excellent. In fact, those assessments do correlate to medical claims paid during CY 2004.

Chart VIII-11

MRMIP Current Health Status



Source: 2005 MRMIP Independent Survey, (N=432)

Chart VIII-12

MRMIP
Costs per Month by Health Status

Health Status	Claims Per Member Per Month
Excellent	$185.27
Very Good	$250.99
Good	$482.77
Fair	$645.87
Poor	$855.01
Refused/Don't Know	$791.05

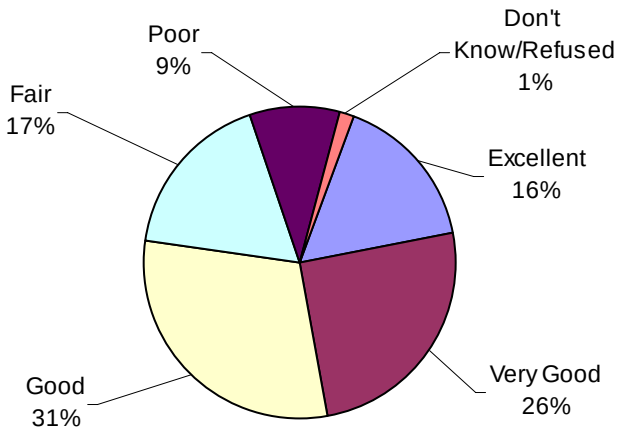
Source: 2005 MRMIP Independent Survey, (N=432)

GIP

Fewer GIP subscribers (42%) assess their health status as very good or excellent. Their assessments also correlate to their costs. However, the cost per member per month is significantly higher in GIP than MRMIP.

Chart VIII-13

GIP (Accepters and Decliners)
Current Health Status



Source: 2005 GIP Independent Survey, (N=400)

Chart VIII-14

GIP
Costs per Month by Health Status

Health Status	Claims Per Member Per Month
Excellent	$283.22
Very Good	$606.05
Good	$854.46
Fair	$971.91
Poor	$1,326.60
Refused/Don't Know	$704.68

Source: GIP Independent Survey, (N=400)

Section IX

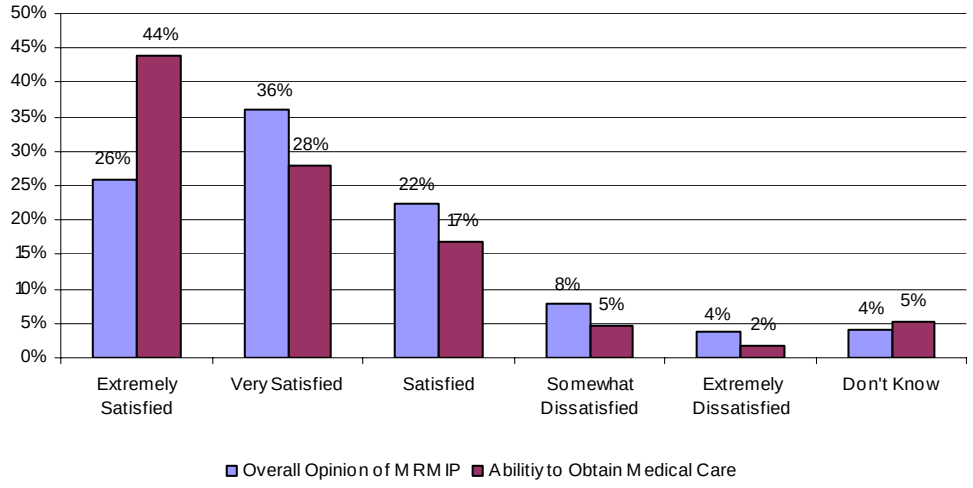
MRMIP Subscriber Satisfaction

MRMIP SUBSCRIBER SATISFACTION

As show in Chart IX-1, eighty-four percent of MRMIP subscribers indicated that they were satisfied with the program. Eighty-nine percent of subscribers were satisfied with their ability to obtain medical care through the program.

Chart IX-1

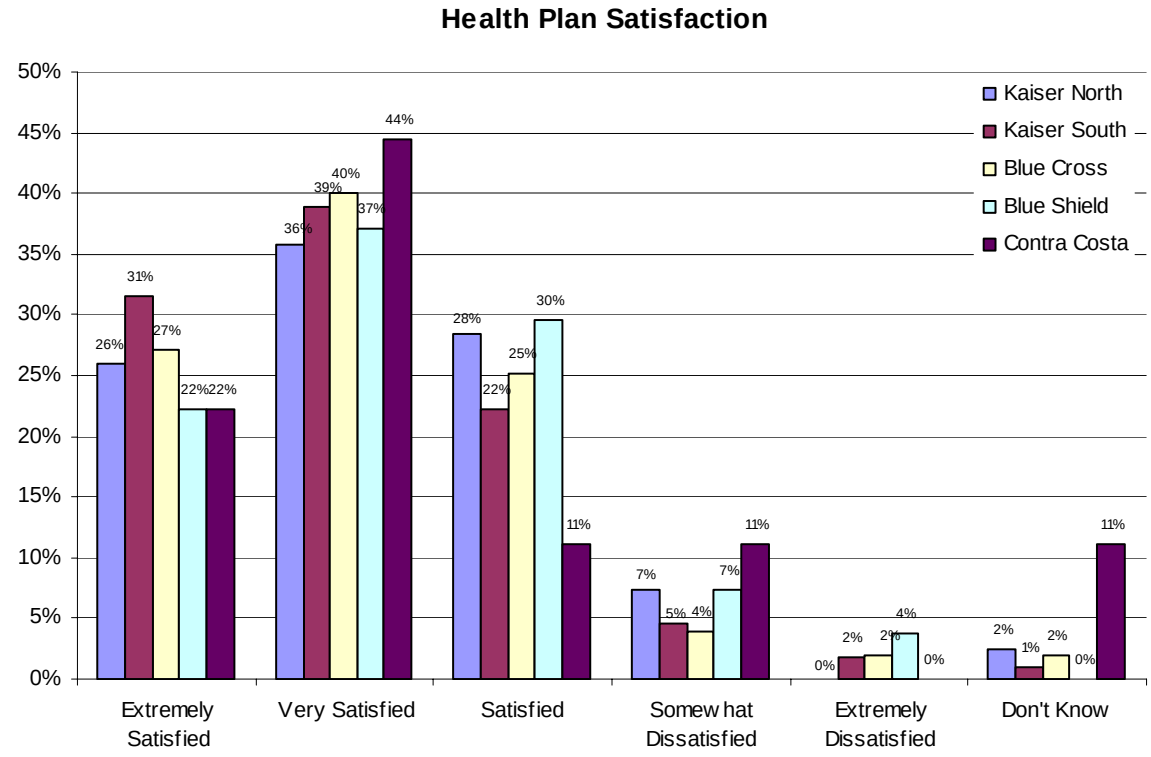
Levels of Subscriber Satisfaction with their Health Plans



Source: 2005 MRMIP Independent Survey, (N=432)

Chart IX-2 shows MRMIP subscriber satisfaction with particular plans ranged from a high of ninety-two percent for Kaiser South and Blue Cross to seventy-seven percent for Contra Costa. Overall measures of satisfaction – health plan staff are helpful and courteous, and health benefits provided are beneficial – as shown in Chart IX-3.

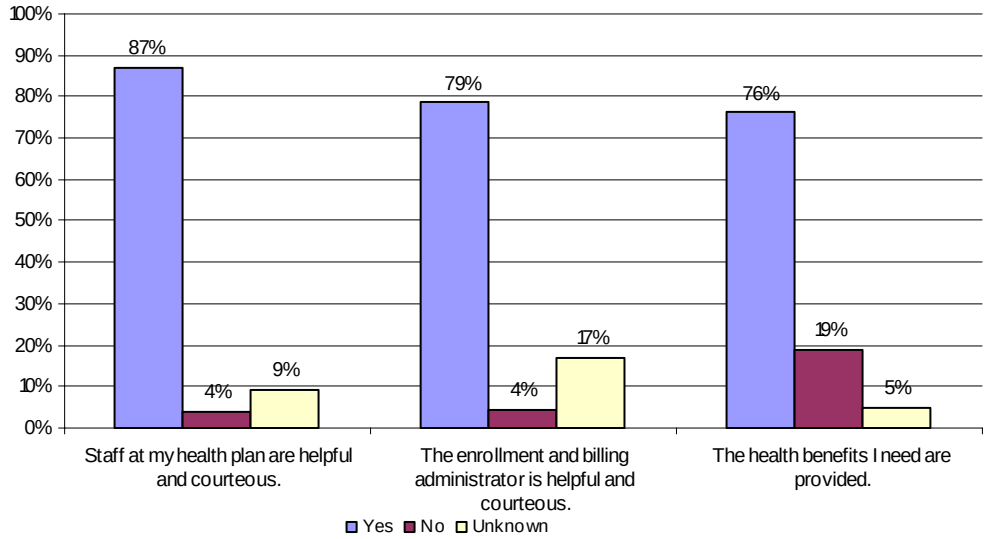
Chart IX-2



Source: 2005 MRMIP Independent Survey, (N=432)

Chart IX-3

Subscriber Overall Satisfaction with the Program 2005



Source: 2005 MRMIP Independent Survey, (N=414)

Section X

Comparison of Acceptors and Decliners of GIP

Guaranteed Issue Pilot Program: Perspectives from the November 2005 Survey

Supported by a grant from the California HealthCare Foundation (CHCF), based in Oakland, California.

SUMMARY

In September 2003, a total of 9,140 persons—over half of those enrolled—left the Major Risk Medical Insurance Program (MRMIP), a state-subsidized program for medically high risk persons. These individuals were the first (and largest) group of MRMIP subscribers whose eligibility is terminated each month as a result of a statutory 36-month time limit on program participation. To replace their MRMIP health coverage, they were offered guaranteed-issue health coverage through private plans, subsidized in part by the state and private plans. However, one out of four former subscribers did not take up the guaranteed coverage. Furthermore, some who initially enrolled in post-MRMIP coverage subsequently dropped that coverage. Since MRMIP is designed to provide access to health insurance for individuals unable to obtain affordable coverage through commercial markets, typically because they have failed medical underwriting tests, questions arose regarding how these individuals were meeting their health care needs after leaving MRMIP.

This paper presents findings from a survey of 400 former MRMIP subscribers who lost eligibility in September 2003 due to the 36-month time limit. They were surveyed in November 2005, slightly more than two years after leaving MRMIP. While for the most part the findings are not surprising, they are significant in that they provide data on what has been speculative up to now on the choices and behavior of this group. Some differences can be seen between those who enrolled in the Guaranteed Issue Pilot (herein referred to as “GIP acceptors”) and those who did not (referred to as “GIP decliners”). For example, maintaining health coverage was more important for acceptors, while affordability of monthly premiums was a major concern for decliners. The survey findings are intended to help inform the policy discussion on whether or not to continue, modify, or terminate the pilot program that established the 36-month time limit and made other changes to MRMIP.

SETTING THE STAGE: AB 1401

Program History

MRMIP provides subsidized health insurance coverage to Californians who are unable to obtain coverage in the private individual insurance market. MRMIP subscribers are typically considered high risk due to pre-existing medical conditions that require intensive treatment and specialized and frequent care. The subscribers pay monthly premiums for coverage from private health plans

and insurers under contract with the Managed Risk Medical Insurance Board (MRMIB), which administers the program. Subscriber premiums cover over half of the total costs of the program, with the remainder covered by state funds (Proposition 99). Plan participation in MRMIP is voluntary; four plans currently participate in the program.

Because funding for the program is statutorily fixed at $40 million annually, MRMIB has established enrollment caps to ensure that costs do not exceed the annual appropriation. The Board evaluates the cap every six months in conjunction with caseload and cost projections for the next 12 months developed by its actuaries, PricewaterhouseCoopers (PwC). From its inception in January 1991 until September 2003, the program typically operated at maximum capacity and maintained a waiting list of potential subscribers. May 1999 marked a turning point in the program, when enrollment levels were reduced for the first time—from 21,900 to 21,124—due to an increase in program benefit levels and rising health care costs. Cost pressures in the context of a fixed appropriation continued for the next few years.

The program received some fiscal relief in 1999 and again in 2000. In 1999, the California Healthcare Foundation provided a $2 million grant that enabled MRMIP to maintain 448 enrollment slots that otherwise would have been cut. In 2000, a one-time $5 million legislative budget augmentation for FY 2000-01 temporarily prevented further cutbacks in the MRMIP enrollment cap. However, in lieu of another augmentation the following year, then-Governor Gray Davis directed MRMIB to work with the Legislature and the insurance industry to find market-based solutions for extending coverage to this high-risk population. The result was Assembly Bill 1401 (Thomson; Chapter 794/Statutes of 2002).

AB 1401 and Its Outcomes

Among other provisions, AB 1401 established a pilot program with a time limit on participation in MRMIP. Effective September 1, 2003 through September 1, 2007, subscribers are limited to 36 consecutive months of enrollment in MRMIP, after which they are eligible for post-MRMIP guaranteed-issue coverage. Every health plan and insurer that sells individual health policies in the private market is required by AB 1401 to also offer a guaranteed-issue product to these former MRMIP subscribers. The guaranteed-issue product must be identical to one offered in MRMIP (except for a higher annual benefit limit of $200,000 instead of $75,000), and subscribers pay a premium that is 10% higher than the comparable MRMIP premium. They must apply for guaranteed-issue coverage no later than 63 days after being disenrolled from MRMIP.

In September 2003, the first group of time-expired individuals, numbering 9,140 persons out of approximately 15,500 subscribers, was disenrolled due to the 36 month time limit. Many of these had received program benefits for longer than 36 months. The number of disenrollments in subsequent months has been

considerably lower, ranging from single digits to several hundred per month. As Chart X-1 on the next page shows, in the 22 months since the inception of the time limit, another 2,370 persons joined the first group, for a cumulative total of 11,510 persons disenrolled as of June 2005 due to the time limit.

One of the main objectives of AB 1401 appears to have been accomplished—namely, to accommodate more people in MRMIP and post-MRMIP with the same level of state funding. As of December 1, 2005, MRMIP enrollment stood at 8,949 persons. The cap at that time was 9,014, but based on the semiannual PwC estimate, MRMIB was able to increase it the next month to 10,227. As of January 1, 2006, enrollment was 9,230 (with no waiting list). Enrollment in post-MRMIP guaranteed-issue coverage as of June 2005 was 6,701. Altogether, approximately 15,000 to 16,000 persons a month could have been served in the two programs. The capacity issue is covered further in the discussion of the evaluation by the Legislative Analyst's Office.

Prior to the survey, scant data existed on how time-expired MRMIP subscribers fared following disenrollment. Additionally, policymakers had no information on the experience of those who did take guaranteed coverage. Approximately three-fourths of the initial group of 9,140 individuals went on to enroll in a guaranteed issue plan. Very little was known about the remaining one-fourth who did not take up this option, particularly their reason for declining coverage and what alternative health coverage they might have obtained. Because they were enrolled in MRMIP for at least 36 months, and because MRMIP has premium levels that range from 125% to 137.5% of the premium charged for individuals who pass underwriting tests, they would have been expected to have a high need for continuing health care. Furthermore, some acceptors who initially enrolled in a guaranteed-issue plan have not maintained that coverage. As shown in Chart X-1, the percentage of persons eligible to enroll in a GIP plan has been declining. As of June 2005, only 58% of all GIP eligible persons were enrolled in a guaranteed issue plan. This take-up rate reflects the combined impact of initial enrollment by acceptors and subsequent discontinuation by some of them.

The reasons for failure to enroll or continue in a GIP product could be expected to parallel those given by subscribers who drop out of MRMIP. MRMIB conducts an annual survey of subscribers who disenroll from MRMIP in January for reasons other than the 36-month time limit. In both 2003 and 2004, the majority of the respondents stated they could no longer afford the monthly premiums (51.1% and 45.6%, respectively), followed closely by those who became eligible for Medicare, obtained coverage through an employer, or otherwise obtained other health coverage (44.4% and 46.3%, respectively). However, in the 2005 survey, only 22.9% cited affordability as a reason for terminating MRMIP coverage, while 64.6% said they had obtained other health coverage. The reasons for this change in affordability as a cause of MRMIP termination are unknown at this time. The disenrollment survey results may not be fully

representative of the experience of all individuals who voluntarily disenroll from MRMIP. All subscribers who disenroll in January are contacted, but only one-third to one-fourth of disenrolled persons chooses to complete the survey. With premiums for the post-MRMIP product priced at 10% above the comparable MRMIP premium, affordability was expected to be a major factor in the GIP take-up rate. Absent specific data, however, these reasons were, at best, educated guesses.

Chart X-1

MAJOR RISK MEDICAL INSURANCE PROGRAM – AB 1401 GUARANTEED ISSUE PILOT ENROLLMENT, CLAIMS, AND PREMIUM STATISTICS

ALL PLANS	Month	# of GIP Enrollments	Cumulative # Disenrollments	% of GIP Eligibles Enrolled	Claims Reported Including IBNR	Subscriber Premiums Reported	Medical Loss Ratio (MLR)
	3-Sep	6,809	9,140	74.50%	$4,561,512.18	$4,526,223.64	101%
	3-Oct	7,466	9,371	79.67%	5,441,579.85	4,523,877.91	120%
	3-Nov	7,553	9,391	80.43%	4,869,951.92	4,079,479.83	119%
	3-Dec	7,452	9,391	79.35%	5,125,547.94	4,279,668.92	120%
	4-Jan	7,071	9,392	75.29%	6,028,950.71	4,105,246.87	147%
	4-Feb	6,920	9,392	73.68%	5,345,957.34	4,136,177.96	129%
	4-Mar	6,931	9,545	72.61%	6,787,228.83	4,278,170.92	159%
	4-Apr	6,875	9,634	71.36%	5,682,011.82	4,065,488.43	140%
	4-May	6,741	9,634	69.97%	5,627,137.73	3,875,922.92	145%
	4-Jun	6,633	9,635	68.84%	5,858,650.81	3,972,198.68	147%
	4-Jul	6,428	9,635	66.72%	5,875,910.08	3,673,200.22	160%
	4-Aug	6,317	9,635	65.56%	6,540,148.43	3,847,369.59	170%
	4-Sep	6,224	9,640	64.56%	6,100,524.81	3,597,309.76	170%
	4-Oct	6,126	9,641	63.54%	5,169,205.26	3,576,885.64	145%
	4-Nov	6,036	9,645	62.58%	5,835,479.69	3,590,667.48	163%
	4-Dec	6,199	9,972	62.16%	5,993,212.17	3,772,938.47	159%
	5-Jan	6,440	10,537	61.12%	5,802,671.30	3,971,777.42	146%
	5-Feb	6,542	10,816	60.48%	5,235,377.86	4,090,391.43	128%
	5-Mar	6,623	11,054	59.91%	6,434,316.28	4,208,003.59	153%
	5-Apr	6,751	11,340	59.53%	6,392,338.97	4,209,275.07	152%
	5-May	6,797	11,505	59.08%	6,255,022.07	4,277,891.17	146%
	5-Jun	6,701	11,510	58.22%	6,537,849.13	4,225,158.89	155%
				67.27%	$127,500,585.18	$88,883,324.81	143%

Source: Interim Reports filed with MRMIB by participating plans. Data as of January 2006.

Legislative Analyst's Office Report

AB 1401 directed the Legislative Analyst's Office (LAO) to assess the effectiveness of the measure in providing health coverage for the hard-to-insure population. In December 2005, the LAO issued their report and stated the following findings:[6]

- MRMIP enrollment dropped significantly following the implementation of AB 1401, largely due to the 36-month time limit on participation in the program.

- After the implementation of the AB 1401 pilot, MRMIP enrollees were, on average, younger individuals with lower medical costs.

- Post-MRMIP subscribers were, on average, more costly than individuals enrolled in MRMIP.

- The impact of AB 1401 on conversion, continuation, and Health Insurance Portability and Accountability Act coverage is not yet clear and may not be apparent until sometime after December 2006.

- Some anecdotal information suggests that post-MRMIP coverage has become unaffordable for some graduates, but the extent of this problem is unclear because definitive data on this matter are not available.

- Assembly Bill 1401 has increased MRMIP's capacity to help hard-to-insure individual's access health insurance coverage using the same level of state resources. However, a significant number of individuals are opting against this coverage for reasons that are unknown at this time.

According to the report, not only did AB 1401 increase the overall capacity to serve both MRMIP and post-MRMIP individuals, it also reduced the waiting time to access MRMIP services. The LAO estimated the increase in capacity to be 15% in December 2004.

However, as the LAO notes, it is unknown whether or not the initial gain in capacity will be sustained beyond the study period. With a statutory due date of fall 2005 for their evaluation, the LAO was limited to approximately one year of data on time-expired persons. Furthermore, the LAO relied on available data sources, most of which were designed for program administration rather than specifically for the evaluation. This resulted in significant data gaps that constrained the LAO's ability to assess whether costs and benefits for MRMIP enrollees and acceptors should be changed. The LAO states, for example, that it is unknown whether decliners turned down guaranteed-issue coverage because they found coverage elsewhere or because it was unaffordable. Accordingly, the report recommends seeking additional information on

[6] Legislative Analyst's Office, Assessing Recent State Efforts: Health Care for the Hard-to-Insure", Sacramento, California, December 2005, Figure 3, p. 10. The report is available at www.lao.ca.gov or by calling (916) 445-4656.

"(1) the reasons some individuals have opted against post-MRMIP coverage and (2) how these individuals are currently receiving coverage for their health care costs," and notes that the MRMIB survey may address some of the information gaps.[7]

SURVEY OBJECTIVES

In spring 2005, recognizing the need to obtain data on health care decisions and experiences of time-expired individuals after leaving MRMIP, MRMIB began planning to survey a sample of this group. Since the data reported regularly to MRMIB by health insurers are limited to GIP acceptors, MRMIB staff felt a survey of both groups—acceptors and decliners—was necessary to provide a complete picture of health coverage outcomes. Survey results would also help shape the policy discussion relating to whether the AB 1401 pilot project should be retained, modified, or ended on September 1, 2007. The California HealthCare Foundation agreed to support this project with the threefold objectives of supplementing and complementing the LAO evaluation, contributing to the policy discussion on the AB 1401 pilot program, and increasing the understanding of California's high risk population.

MRMIB and PwC developed two questionnaires, one for acceptors and another for decliners. External reviewers and legislative staff commented on both questionnaires before they were finalized. Questions generally fell into one of three categories:

- Identical or similar questions asked of both groups, such as health status and need for health care in the 12 months after leaving MRMIP, current health status and coverage, anticipated need for health coverage in the future, and opinions on consumer information provided to help make post-MRMIP enrollment decisions. Demographic information on a respondent's age, family size, and household income was also solicited.

- Questions tailored to acceptors, such as factors influencing their decision to enroll in and maintain or drop guaranteed-issue coverage, factors that were important in their choice of health plan, and whether or not health coverage was provided by the same health plan as under MRMIP.

- Questions tailored to decliners, such as factors influencing their decision not to enroll in a guaranteed plan, whether they had explored and/or secured other health coverage after leaving MRMIP, and how they handled their post-MRMIP health care.

A random sample was selected from the first group of time-expired subscribers that had left MRMIP in September 2003. The sample was stratified to reflect a 70%-30% proportion of acceptors and decliners. The questionnaire was further refined and tested, and in November 2005, Corey, Canapary & Galanis Research completed a telephone survey of 400 former subscribers (280 acceptors and 120 decliners). PwC analyzed the survey findings on which this report is based.

[7] LAO, p. 17.

SURVEY FINDINGS

Before discussing respondents' reasons for their health coverage choices, a brief profile of the 400 respondents will help provide context for survey findings.

Demographic Factors

GIP acceptor and decliner survey respondents were similar in terms of age and household size. As reported by the LAO, this group of former MRMIP subscribers tends to be older than current subscribers still in the program. Chart X-2 shows that approximately half of the respondents in both samples were between the ages of 50 and 64 years, with one-fourth of acceptors and one-third of decliners between 50-59 years old. Most respondents lived in a household with one other person (42% and 43%, respectively, for acceptors and decliners) or by themselves (28% and 23%, respectively).

The most striking difference between the two groups was in annual household income. As shown in Charts X-3 and X-4, a higher percentage of decliners fell in the lowest income bracket. Specifically, Chart X-3 shows that 13% of acceptors and 23% of decliners had incomes of $20,000 or below, while 29% and 20%, respectively, fall into the $20,000 to $40,000 bracket. Differences between the two groups in other income brackets were not as great and ranged from 1 to 4 percentage points. This income differential for the lowest income respondents has a direct bearing on a graduate's perception of affordability of post-MRMIP coverage and, as discussed below, is consistent with reasons given by decliners for not enrolling in a guaranteed-issue plan. Chart X-4 shows income differences between acceptors and decliners using Federal Poverty Levels instead of income brackets.

Chart X-2

Age of Survey Respondents
Guaranteed Issue Pilot Acceptors and Decliners

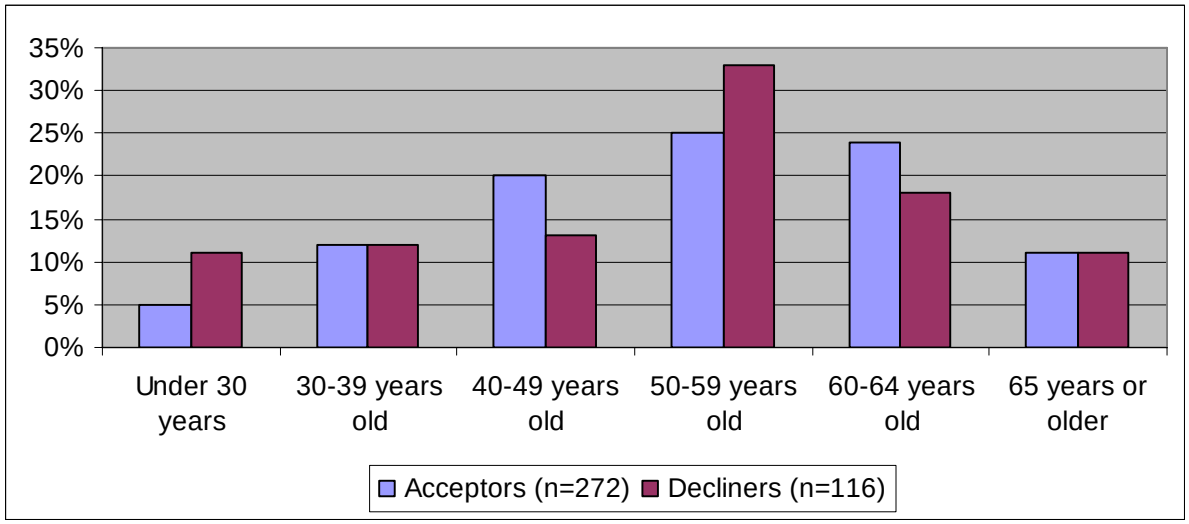


Chart X-3

Annual Household Income of Survey Respondents
Guaranteed Issue Pilot Acceptors and Decliners

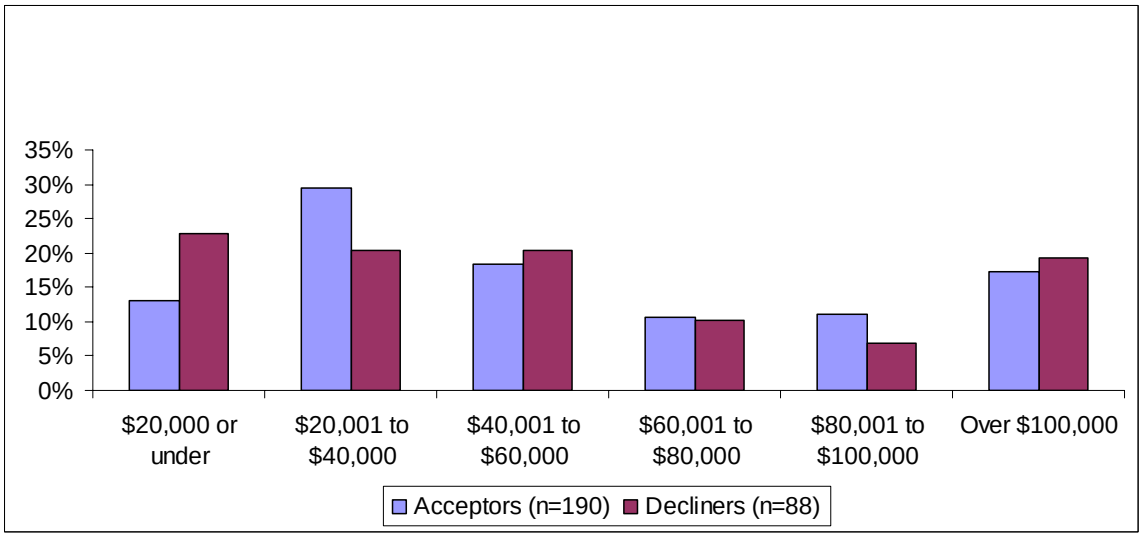
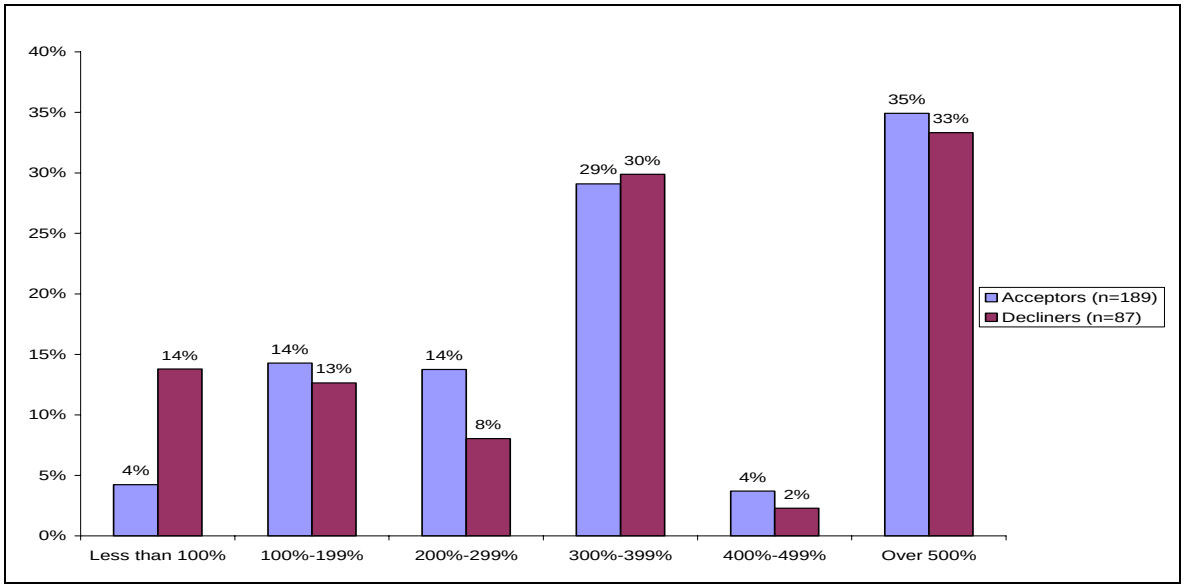


Chart X-4

Annual Household Income of Survey Respondents as a Percentage of 2005 Federal Poverty Level



Health Status

Several survey questions pertained to a respondent's health status at the time he/she was in MRMIP and at the time of the survey. While over half of both groups felt they were in good to excellent health at the time of the survey, 38% of acceptors—as opposed to 46% of decliners—rated their current health as very good or excellent. At the other end, 31% of acceptors and 23% of decliners felt they were in fair or poor health. Put another way, more GIP acceptors felt they were in poorer health than GIP decliners, who tended to give themselves higher ratings. This result is consistent with what would be expected of an informed decision maker: a person who perceives a need for health care would be more likely to purchase coverage.

Chart X-5

Self-Assessment of Current Health Status

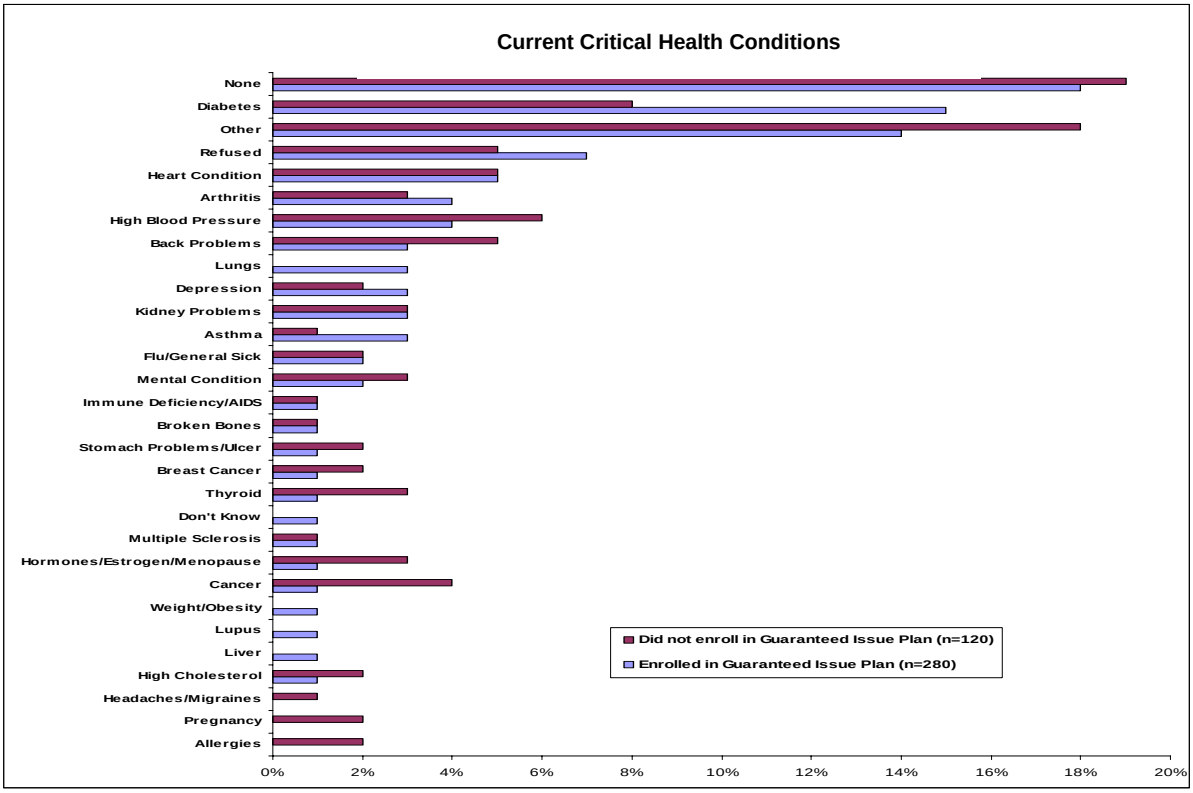
	Acceptors (n=280)		Decliners (n=120)	
	#	%	#	%
Excellent	43	15%	21	18%
Very good	63	23%	34	28%
Good	85	30%	37	31%
Fair	52	19%	19	16%
Poor	33	12%	8	7%
Don't Know/Refused to Answer	4	2%	1	1%

When asked to describe their most critical current health condition for which they would be most likely to seek health care, roughly half of both groups of respondents indicated that their current critical condition is different from the one that caused them to enroll in MRMIP (54% for acceptors, 46% for decliners). Current conditions mentioned most frequently included arthritis, asthma, back problems, diabetes, high blood pressure, kidney problems, and mental conditions. Original health conditions at the time of MRMIP enrollment were more limited in number (arthritis and asthma were not mentioned as frequently, for example) and included such conditions as obesity and cancer. Charts X-6 and X-7 (below) provide more detail on the health conditions reported by respondents.

At the time of the survey, 18% of acceptors and 19% of decliners reported having no critical health condition. Furthermore, 28% of acceptors and 25% of decliners stated they had no critical health condition at the time they enrolled in MRMIP but felt the need to have coverage.[8]

Two-thirds of both groups anticipated needing health care services in the next six months for their primary medical condition.

Chart X-6

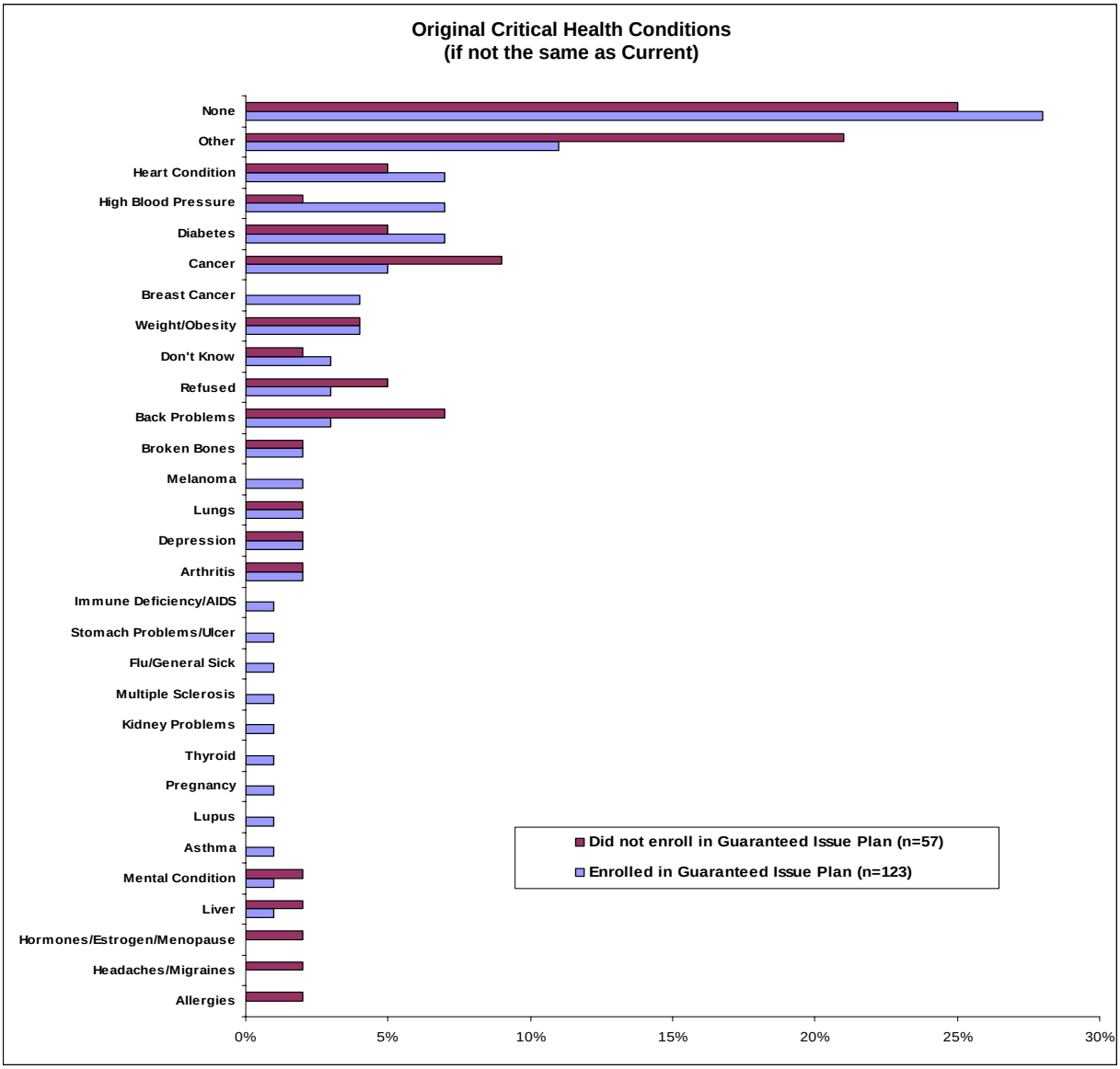


[8] To be eligible for MRMIP, an individual must fail an underwriting test given by one health plan, be offered a premium for a comparable product that is more expensive than the MRMIP premium, or be offered a product with significant coverage limitations. Consequently, while individuals could not identify a specific health condition that resulted in their enrollment in MRMIP, it is likely that such a condition existed, or that something in the applicant's health history raised a concern about the possibility of higher health costs.

Data used for Chart X-6
Current Critical Health Conditions as Reported by Survey Respondents

	ACCEPTORS		DECLINERS	
Health Condition	**#**	**%**	**#**	**%**
N =	*280*	*100%*	*120*	*100%*
None	51	18%	23	19%
Diabetes	43	15%	10	8%
Other	39	14%	22	18%
Refused	19	7%	6	5%
Heart Condition	14	5%	6	5%
High Blood Pressure	11	4%	7	6%
Arthritis	11	4%	3	3%
Back Problems	9	3%	6	5%
Kidney Problems	8	3%	4	3%
Depression	8	3%	2	2%
Lungs	8	3%	0	0%
Asthma	7	3%	1	1%
Mental Condition	5	2%	3	3%
Flu/General Sick	5	2%	2	2%
Thyroid	4	1%	3	3%
Breast Cancer	4	1%	2	2%
Stomach Problems/Ulcer	4	1%	2	2%
Broken Bones	4	1%	1	1%
Immune Deficiency/AIDS	4	1%	1	1%
Cancer	3	1%	5	4%
Hormones/Estrogen/Menopause	3	1%	3	3%
Multiple Sclerosis	3	1%	1	1%
Don't Know	3	1%	0	0%
High Cholesterol	2	1%	2	2%
Liver	2	1%	0	0%
Lupus	2	1%	0	0%
Weight/Obesity	2	1%	0	0%
Pregnancy	1	0%	2	2%
Headaches/Migraines	1	0%	1	1%
Allergies	0	0%	2	2%

Chart X-7


Original Critical Health Conditions
(if not the same as Current)
None
Other
Heart Condition
High Blood Pressure
Diabetes
Cancer
Breast Cancer
Weight/Obesity
Don't Know
Refused
Back Problems
Broken Bones
Melanoma
Lungs
Depression
Arthritis
Immune Deficiency/AIDS
Stomach Problems/Ulcer
Flu/General Sick
Multiple Sclerosis
Kidney Problems
Thyroid
Pregnancy
Lupus
Asthma
Mental Condition
Liver
Hormones/Estrogen/Menopause
Headaches/Migraines
Allergies
0%
5%
10%
15%
20%
25%
30%
Did not enroll in Guaranteed Issue Plan (n=57)
Enrolled in Guaranteed Issue Plan (n=123)

Data used for Chart X-7
Original Critical Health Condition Reported by Survey Respondents
(if different from current condition)

	ACCEPTORS		DECLINERS	
Health Condition	**#**	**%**	**#**	**%**
N =	*123*	*100%*	*57*	*100%*
None	34	28%	14	25%
Other	14	11%	12	21%
Heart Condition	9	7%	3	5%
Diabetes	8	7%	3	5%
High Blood Pressure	8	7%	1	2%
Cancer	6	5%	5	9%
Weight/Obesity	5	4%	2	4%
Breast Cancer	5	4%	0	0%
Back Problems	4	3%	4	7%
Refused	4	3%	3	5%
Don't Know	4	3%	1	2%
Broken Bones	3	2%	1	2%
Arthritis	2	2%	1	2%
Depression	2	2%	1	2%
Lungs	2	2%	1	2%
Melanoma	2	2%	0	0%
Liver	1	1%	1	2%
Mental Condition	1	1%	1	2%
Asthma	1	1%	0	0%
Lupus	1	1%	0	0%
Pregnancy	1	1%	0	0%
Thyroid	1	1%	0	0%
Kidney Problems	1	1%	0	0%
Multiple Sclerosis	1	1%	0	0%
Flu/General Sick	1	1%	0	0%
Stomach Problems/Ulcer	1	1%	0	0%
Immune Deficiency/AIDS	1	1%	0	0%
Allergies	0	0%	1	2%
Headaches/Migraines	0	0%	1	2%
Hormones/Estrogen/Menopause	0	0%	1	2%

Decliners' Utilization of Health Care Services Following Disenrollment

Decliners were asked whether they had been treated by a health care professional or had a prescription filled in the 12 months after leaving MRMIP. The vast majority (86%) reported being treated by a health care professional one or more times during that time period. A similar number (84%) reported obtaining prescription drugs, with 46% doing so as frequently as one or more times a month. Further, 17% of the time, the treatment or drugs were for a new medical problem that emerged after leaving MRMIP.

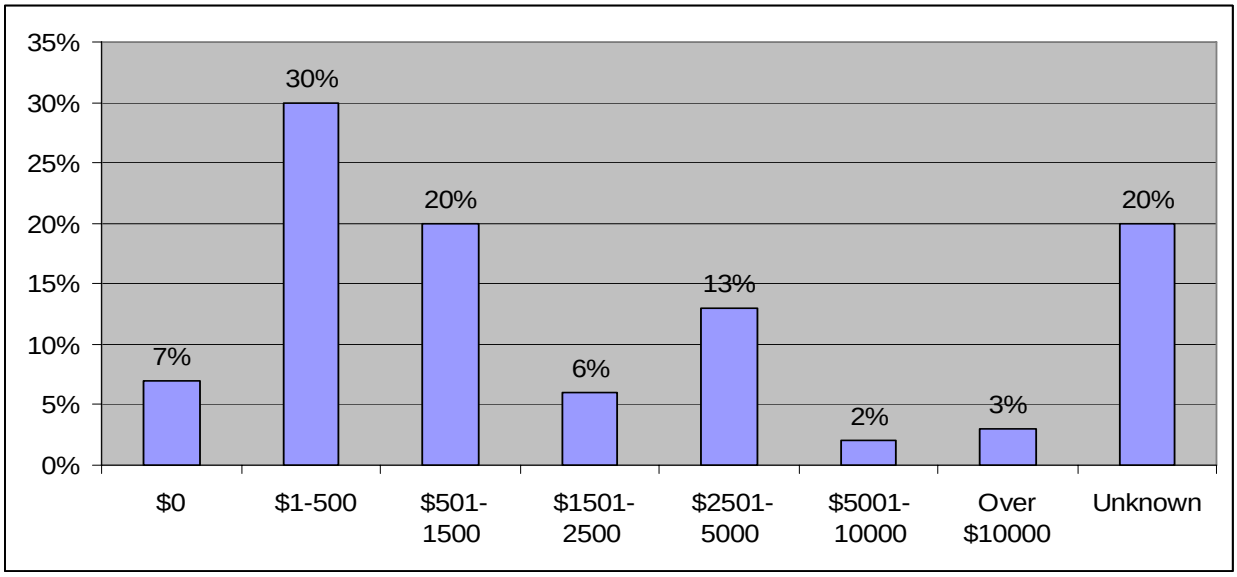
Treatment was typically provided by the same health care providers used by a respondent before MRMIP health coverage was terminated. Few reported using county hospitals and free clinics, and 25% reported using hospital emergency rooms. Among those who did not use health care services during the 12 month period, one-third reported they did not have a need for services during that time. However, 17% of decliners reported that they went without health care because they could not afford it. In response to a parallel question, 15% of acceptors reported forgoing treatment for financial reasons.

Similar questions were posed to the acceptors who subsequently dropped their guaranteed issue coverage, but the number of respondents is too small to make any comparisons with decliners or to draw any other conclusions.

Decliners were further asked whether they had received specified medical services in the 12 months after leaving MRMIP. The purpose of these questions was to see if an uninsured respondent had received costly services (e.g., overnight hospital stays, chemotherapy, and prescription drugs costing more than $500 monthly) and to gauge the reliability of answers to questions on the cost of care received. By and large, most decliners had not received these types of services. When asked the approximate cost personally paid by a respondent for health care in that 12-month period, 7% reported no costs, and 50% reported costs between $1 and $1,500. Another 19% reported costs between $1,501 and $5,000, and 5% reported costs over $5,001. One-fifth of respondents either did not know their costs or refused to answer. Chart X-8 shows these responses.

Chart X-8

Decliners' Self-reported Costs for Health Care in 12 Months after MRMIP



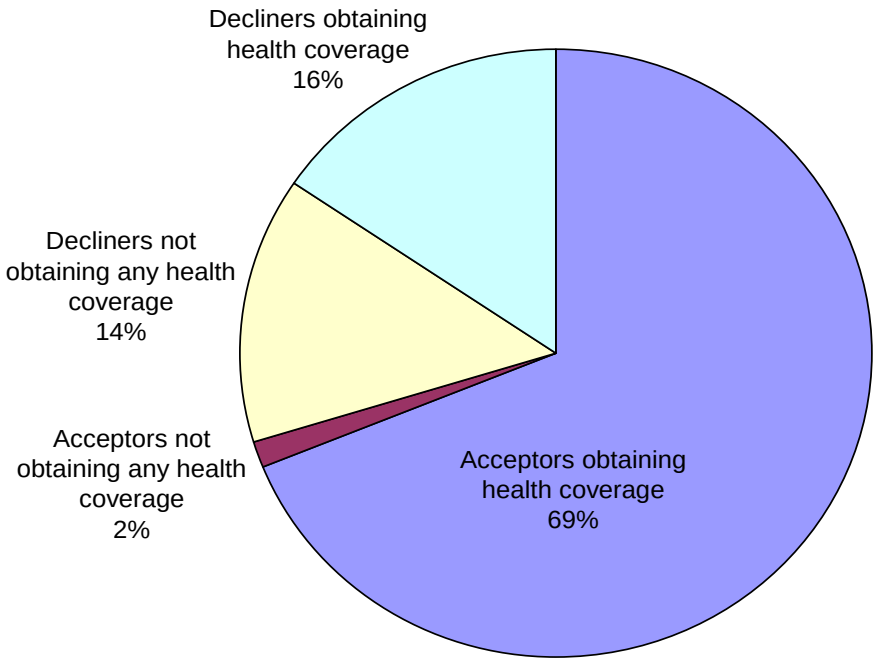
Factors Influencing Health Coverage Decisions

As stated earlier, about three-fourths of the September 2003 time-expired persons chose to enroll in a guaranteed-issue plan when they left MRMIP. Some subsequently dropped that coverage. In June 2005, the most recent time period for which data are available, the overall GIP take-up rate was 58%. Premiums paid by acceptors for guaranteed issue coverage are statutorily set at 10% above comparable MRMIP premiums.

In the first 12 months after leaving MRMIP, the majority of survey respondents obtained some form of health coverage. Chart X-9 shows that 85% of those surveyed (comprised of 69% acceptors and 16% decliners) had some form of health coverage, while 16% had no coverage (2% acceptors and 14% decliners).

Chart X-9

Survey Respondents' Health Coverage for the First 12 Months after MRMIP
(n=279 Acceptors; 118 Decliners)



To help MRMIP subscribers who are scheduled to be disenrolled from the program due to the time limit, MRMIB sends several mailings containing information on post-MRMIP coverage options and the process for continuing GIP coverage. Information on plan choices is also posted on websites maintained by the Departments of Managed Health Care and Insurance. The majority of survey respondents felt the information received from the state was sufficient to make a decision about health coverage, with only 8% of acceptors and 13% of decliners rating the information not helpful. Four out of five respondents knew where to call or write if they had questions.

Acceptors were asked whether they had considered other options for health coverage before choosing a guaranteed issue plan. About two-thirds (68%) had not. Respondents were then asked to rate the importance of the following reasons in their decision to continue coverage (the percentage saying a reason was "very important" is indicated):

- "I believe it is important to have health insurance, even though I don't use it every month." (80%)
- "I believe that if I don't maintain coverage now I will be unable to obtain it again in the future when I need it." (72%)

- “I anticipate needing health care services in the foreseeable future.” (68%)
- “I needed the coverage to help pay for my immediate medical expenses.” (61%)

Four out of five acceptors continued coverage in the same health plan they had while in MRMIP. In choosing a plan, 59% of acceptors felt their health status was a very important factor. Keeping the same health care providers while in MRMIP similarly was very important to 56% of acceptors, while monthly premiums and benefits provided were very important to about half the acceptor group.

While acceptors were concerned about maintaining health coverage and health status, decliners tended to place greater importance on financial factors in making their decision to decline the guaranteed-issue coverage. Affordability of monthly premiums was the only reason that was cited by over half of decliners. Given that more decliners fell in the lowest income bracket, the emphasis on affordability is not surprising.

In order of importance, decliners’ reasons for deciding against coverage were:

- Couldn’t afford monthly premiums (53%)
- Obtained other health coverage through job or spouse (41%)
- Bought a plan with different levels of co-payments or deductibles (32%)
- Didn’t feel the insurance was worth the price because need for health care services was less than before (25%)
- Enrolled in Medicare or Medi-Cal (18%)
- Bought a plan that covered only major medical expenses but not routine health visits and care (12%)

When asked to rate the importance of several factors in making their decision to decline coverage, decliners rated monthly premiums (68%), health status (46%), keeping the same providers (38%), and benefits provided (34%), in that order, as very important.

After deciding against the guaranteed-issue coverage, 65% of decliners explored purchasing other health coverage in the 12 months after leaving MRMIP. Of these, 79% (or 52% of all decliners surveyed) actually obtained coverage. Unlike acceptors, however, coverage was typically from a different plan than was used under MRMIP. Two-thirds of the decliners who obtained coverage reported their premiums were lower than what they paid for MRMIP, and 39% reported lower co-payments. Over half had to pay a deductible for their new coverage, which provided the same benefits, services and access to providers as MRMIP for 77% of this subgroup. It should be noted that MRMIP subscribers do not pay any deductible. The fact that some decliners were willing to pay for deductibles in their new coverage, despite their generally lower income, could reflect their self-perceived higher health status, relative to acceptors.

At the time of the survey (two years after respondents had left MRMIP), 96% of acceptors and 85% of decliners reported having some form of health coverage. Nearly all intended to maintain that coverage. To help understand what might cause them to

drop coverage, the survey provided a list of factors and asked respondents to identify the two most important factors that would influence their decision to pay for health coverage in the future.

Charts X-10 and Charts X-11 and X-12 summarize responses for the two groups. As with the initial decision to enroll in guaranteed-issue coverage, acceptors and decliners differed in the importance they assigned to the various factors. Chart X -10 shows that, although affordability was important to both groups, it was weighted more heavily by decliners (61% of decliners compared to 42% of acceptors for cost of premiums, and 28% versus 14% for co-payments and deductibles). Conversely, covered benefits and services were relatively more important to acceptors (42%) than decliners (32%). A self-perceived need for health care, as indicated previously in the discussion on health status, is more influential for acceptors (40%) than decliners (28%).

Chart X-10

Major Factors Influencing Future Health Coverage Decisions
Guaranteed Issue Pilot Acceptors and Decliners

Factor	Acceptors		Decliners	
	#	%	#	%
Cost of premiums	118	42%	73	61%
Cost of co-payments and deductibles	40	14%	34	28%
Covered benefits & services	117	42%	38	32%
Availability of doctors	93	33%	29	24%
Location of offices and other facilities	13	5%	4	3%
Individual's need for health care	113	40%	34	28%
Don't know or refused to answer	14	5%	7	6%

Charts X-11 and X-12 delineate the importance of these factors by income level of acceptors and decliners, respectively. The findings are consistent with respect to the emphasis placed on affordability factors (premiums paid and co-payments and deductibles) by lower income respondents in both groups.

Chart X-11

Major Factors Influencing Acceptors' Future Health Coverage Decisions By Income Level
(n=266)

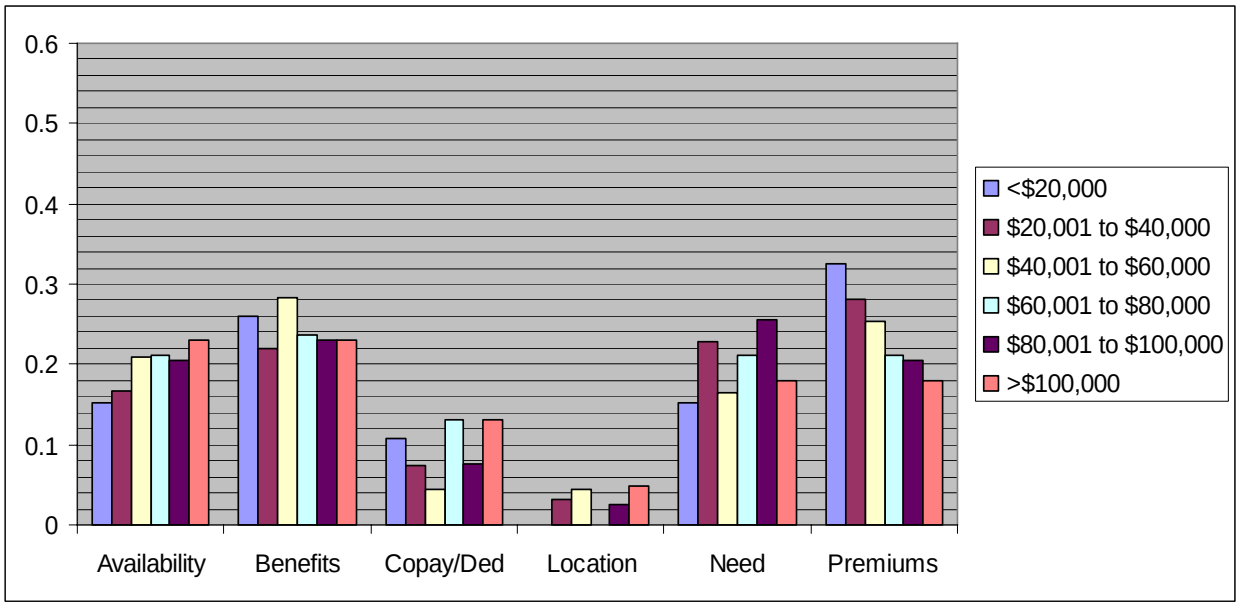
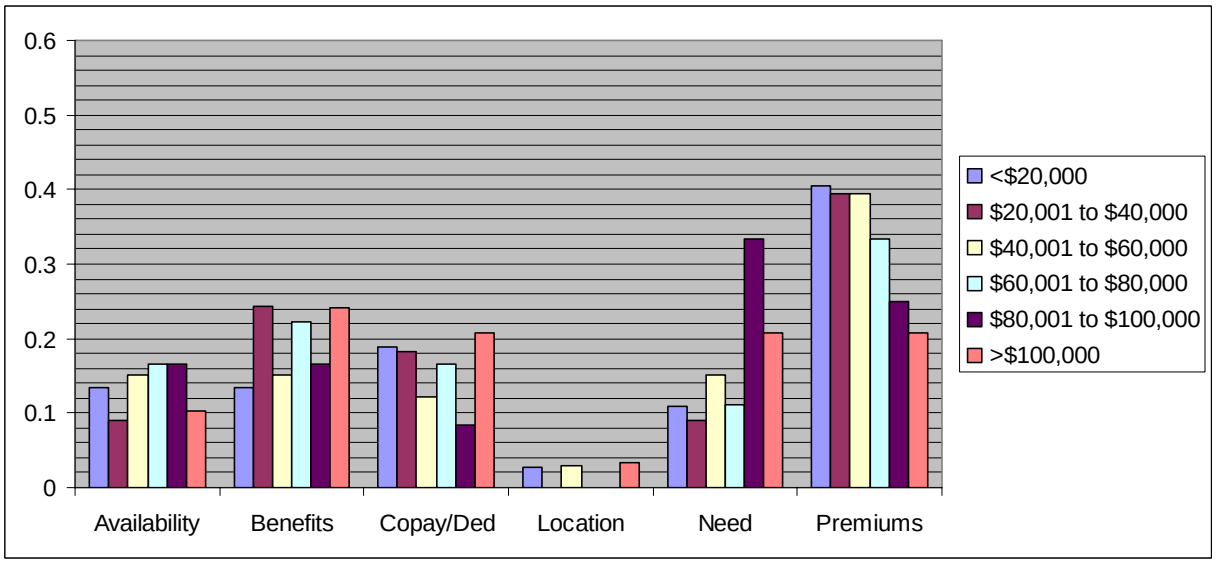


Chart X-12

Major Factors Influencing Decliners' Future Health Coverage Decisions By Income Level
(n=113)



MRMIP CLAIMS ANALYSIS

To supplement the survey findings, PwC analyzed claims data for GIP acceptors in the two years prior to their leaving MRMIP and for their first year of enrollment in a guaranteed issue plan to see how the costs of care changed. Unaudited claims data provided by the carrier with the majority of enrollees showed that the average expenditure per member per month (PMPM) made by that carrier increased each year over the three-year period, as follows:

- 22% increase between the next-to-last and final years of MRMIP coverage (i.e., between the 2001-02 and 2002-03 periods); and

- 18% increase between the final year of MRMIP coverage and the first year of guaranteed issue coverage (i.e., between 2002-03 and 2003-04).

A separate analysis of claims data for all MRMIP carriers who offered a GIP plan showed cost differences between persons who were disenrolled from MRMIP on September 1, 2003 due to the 36-month time limit and those who remained. For the two-year period September 1, 2001 through August 31, 2003, PwC calculated that the MRMIP average expenditure PMPM for time-expired persons who left the program in September 2003 was $642, which is 22.1% higher than the $526 average expenditure PMPM for persons remaining enrolled in MRMIP. The higher average expenditure for time-expired persons is very likely due to their higher average age, compared to other MRMIP subscribers, and may also be due to other factors. The September 2003 cohort included a large number of individuals who had been enrolled for more than 36 months in MRMIP.

PwC took the analysis a step further by linking claims data to the medical condition of claimants, using the International Classification of Diseases, 9th revision (ICD9) to categorize claims into disease categories. This was done separately for acceptors and decliners. Claim costs were those reported for the period September 2002 through August 2003, or one year before disenrollment from MRMIP. Charts X-13 and X-14 show the results of this analysis. Chart X-13 shows which disease categories accounted for the highest number of claims exceeding $500. Both acceptors and decliners had the most claims for diseases of the musculoskeletal system and connective tissue, followed by circulatory system diseases. More importantly, the table shows that GIP acceptors generally had a higher incidence of claims over $500.

A high number of claims, however, may not necessarily translate into high average cost of care, since treatment costs for disease categories can vary widely. PwC therefore calculated the average annual cost for each major cost disease category, again differentiating between acceptors and decliners. As Chart X-14 shows, although musculoskeletal system diseases accounted for the highest number of claims, their average cost of $6,750 for acceptors ranked only 9th out of the 16 disease categories shown. Instead, the highest average cost for acceptors was for circulatory system diseases, which also ranked second highest in incidence of claims. PwC does caution

against broad generalizations, since some of the disease categories involve a very small number of persons.

Chart X-13

Disease Categories Accounting for Claims Over $500 in Final Year of MRMIP Enrollment
GIP Acceptors and Decliners Disenrolled in September 2003

Disease Category	% GIP Acceptors with Claims (n=3,667)	% GIP Decliners with Claims (n=632)
Diseases of the Musculoskeletal System and Connective Tissue	13.3%	9.1%
Diseases of the Circulatory System	9.9%	6.5%
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders	8.6%	5.6%
Diseases of the Nervous System and Sense Organs	8.2%	5.8%
Mental Disorders	7.8%	5.1%
Diseases of the Digestive System	7.8%	5.9%
Injury and Poisoning	7.7%	6.3%
Neoplasms	7.5%	5.0%
Diseases of the Genitourinary System	5.8%	4.9%
Diseases of the Respiratory System	4.5%	3.2%
Infections and Parasitic Diseases	3.6%	2.0%
Diseases of the Skin and Subcutaneous Tissue	2.7%	2.0%
Diseases of Blood and Blood Forming Organs	1.8%	0.9%
Congenital Anomalies	1.4%	1.1%
Complications of Pregnancy, Childbirth and the Puerperium	0.6%	0.6%
Certain Conditions Originating In the Perinatal Period	0.1%	0.0%

Note: Individuals may be counted in more than one disease category. Claim costs must total at least $500 in order to be counted within a disease category. Non-specific disease categories, such as *Signs, Symptoms, and Ill-defined Conditions*, were excluded.

Analysis based on claims incurred September 2002 through August 2003.

Chart X-14

Highest Cost Disease Categories in Final Year of MRMIP Enrollment
GIP Acceptors and Decliners Disenrolled in September 2003

Major Cost Disease Category	GIP Acceptors (n=3,667)		GIP Decliners (n=632)	
	Number of Persons	Average Annual Cost Within Disease Category	Number of Persons	Average Annual Cost Within Disease Category
Certain Conditions Originating In the Perinatal Period	3	$5,263	0	$ -
Complications of Pregnancy, Childbirth and the Puerperium	32	$7,022	10	$5,046
Congenital Anomalies	54	$9,697	15	$5,551
Diseases of Blood and Blood Forming Organs	40	$9,621	4	$24,333
Diseases of the Circulatory System	424	$10,594	65	$6,377
Diseases of the Digestive System	319	$7,084	62	$7,678
Diseases of the Genitourinary System	237	$6,689	56	$7,337
Diseases of the Musculoskeletal System and Connective Tissue	552	$6,750	96	$4,198
Diseases of the Nervous System and Sense Organs	347	$5,191	68	$5,899
Diseases of the Respiratory System	157	$9,157	25	$5,904
Diseases of the Skin and Subcutaneous Tissue	75	$4,487	10	$1,375
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders	320	$5,571	46	$8,461
Infections and Parasitic Diseases	159	$4,145	23	$1,995
Injury and Poisoning	278	$9,256	51	$8,095
Mental Disorders	345	$3,434	54	$3,372
Neoplasms	325	$8,544	47	$10,413

POLICY IMPLICATIONS

The survey clearly accomplished two of its three objectives. It provided a wealth of data on how GIP acceptors and decliners fared after leaving MRMIP and the factors that influenced their health coverage choices, thereby adding to policy makers' understanding of this medically high risk population. The survey confirmed that affordability remains a concern for both groups. Additionally, the survey filled in many of the data gaps identified by the LAO. The results help explain some of the enrollment and disenrollment patterns observed among acceptors and decliners, particularly when viewed in terms of their health and financial status. Acceptors tended to have higher incomes and perceived their health status to be lower than did decliners.

With regard to the third objective of adding to the policy discussions on the future of GIP, the survey findings point out the complexities involved in making policy changes. We now know why time-expired former MRMIP subscribers did what they did, and this information will be extremely helpful as policymakers assess whether or not to continue the GIP approach. For example, the LAO and others have suggested possibly

modifying GIP program benefit levels, co-payments, and/or deductibles. However, the survey identified different values among these former MRMIP subscribers that might be in conflict if changes are proposed. This could involve tradeoffs between acceptors, who value having the safety net of health coverage, and decliners, who place more weight on affordability. Underlying these attitudes are differences in self-perception of health status and the likelihood of needing health care in the future, as well as differences in income levels.

The preliminary claims analysis by PwC points to other areas worth exploring. Obtaining and analyzing complete claims data on acceptors could help identify which disease categories are responsible for the majority of program expenditures and trends that could be monitored for their cost and programmatic impact. Additionally, cost comparisons in average expenditure PMPM before and after leaving MRMIP should be monitored to see if first-year results continue. Data glitches and omissions will take time to remedy but may well be worth the effort. These data need to be viewed in the context of the changing health conditions of many acceptors and decliners, many of whom subsequently developed health conditions that were different from those that caused them to enroll in MRMIP.

The first year of cost data for acceptors, although only for the largest GIP plan, indicate that acceptors could command a relatively large share of the fixed $40 million appropriation for MRMIP and GIP. This would leave fewer dollars to serve current MRMIP subscribers. As discussed in a previous chapter on MRMIP funding, it may be prudent to examine new program design and funding options for both MRMIP and GIP before funding problems are exacerbated, with a resulting detrimental impact on California's uninsured population.

Other factors beyond those associated with the survey will also be important in assessing the value of GIP, include being able to provide coverage to all who are unable to get individual market coverage and wish to purchase it, as well as having a structure that does not provide a disincentive for carriers to participate in MRMIP.

Sources of Data and Information

There are several sources of data and information that were used to compile this report. Information was obtained from MRMIB contractors and internal program reports, as well as other sources.

The MRMIB contractors providing information for this report include:

- Blue Cross of California, the MRMIP enrollment contractor
- PricewaterhouseCoopers LLP Inc. (managed the independent surveys of MRMIP and GIP subscribers through a subcontractor) *****
- Participating health plans

Internal program reports for the MRMIP and the GIP:

- Enrollment Data
- Claims Data
- Premium Data
- Medical Claims Data

Other sources of information used in this report include:

- Brown, E.R.; Lavarreda, S.A; Rice, T; Kincheloe, J.R.; Gatchell, M.S.; The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2005.
- Communicating for Agriculture. The Comprehensive Health Insurance for High-Risk Individuals, Nineteenth Edition, 2005.
- DeNavas-Walt,C.; Lee, C.; and Proctor, B.; Income, Poverty, and Health Insurance Coverage in the United States: 2004; August, 2005: U.S. Census Bureau
- Frakt, A.; Pizer: S.; and Wrobel, M.; High Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects: Winter 2004-2005, Health Care Financing Review; Volume 26, Number 2.
- Iseri, J.; Health Care For Medically High Risk Persons November 2005 Survey of Guaranteed Issue Pilot Acceptors and Decliners
- Hunt, S.: Individual Health Insurance Options for California; September 2000 (Report presented to the Managed Risk Medical Insurance Board by PricewaterhouseCoopers, the Board's contract actuary.)
- 2005 Independent Surveys:

  *****In November 2005, a total of 400 GIP subscribers were surveyed to solicit their views on the GIP and to obtain more detailed demographic information on subscribers. In addition, a total of 432 MRMIP subscribers were surveyed in December 2005 to solicit their views on the MRMIP and to obtain more detailed demographic information on subscribers.

  Both surveys were conducted via phone calls to the subscribers' homes in the evenings and weekends. Individuals included in the survey were randomly selected from a current list of subscribers. The sample was stratified by health care delivery system type to provide representative data on subscribers enrolled in Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs).

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To request copies of this report, or for questions about the MRMIP please call the Managed Risk Medical Insurance Board at (916) 324-4695, or view the Managed Risk Medical Insurance Board website at: www.mrmib.ca.gov.