

Title 10. Investment

Chapter 5.5. Major Risk Medical Insurance Board Article 4. Risk Categories and Subscriber Contributions Section 2698.401

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2698.401. Determination of Subscriber Contribution.

- (a) (1) Each participating health plan shall provide an annual estimate of the standard average individual rate for the minimum benefits provided for in the contract with the participating health plan for each risk category specified in section 2698.400. Without applying risk categories to dependents or dependent subscribers, each participating health plan shall also provide an estimate of the standard average rate for covering a subscriber in each risk category and the subscriber's dependents as follows:
- (~~4~~ A) A subscriber and one dependent; and
 - (~~2~~ B) A subscriber and two or more dependents.
- (2) Notwithstanding paragraph (1) of this subsection, for plan years beginning on and after January 1, 2014, the Board shall calculate an annual estimate of the standard average individual rate for program benefits for each risk category specified in section 2698.400. Without applying risk categories to dependents or dependent subscribers, the Board shall also calculate an estimate of the standard average rate for covering a subscriber in each risk category and the subscriber's dependents as follows:
- (A) A subscriber and one dependent; and
 - (B) A subscriber and two or more dependents.
- (b) For plan years ending prior to January 1, 2014, for those participating health plans which have been offered through the program for two or more years, the Board shall calculate a loss ratio for each participating health plan for the prior calendar year. The loss ratio shall be calculated using 125 percent of the estimated rates provided by the participating plan as the denominator, and the sum of all medical costs for subscribers, dependent subscribers and dependents enrolled in the plan and all administration fees and risk payments to the plan as the numerator.

- (c) For plan years ending prior to January 1, 2014, for those participating health plans which have been offered through the program for two or more years, the Board shall calculate a percentage average subsidy amount per subscriber dollar contributed for each participating health plan for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.
- (d) ~~The~~ For plan years ending prior to January 1, 2014, the Board shall calculate the program loss ratio for the prior calendar year in the following manner:
- (1) Participating health plans with an average monthly number of enrollees of fewer than 1,000 in the prior calendar year shall be excluded from the calculation.
 - (2) If a participating health plan's loss ratio is less than 100 percent it shall be deemed to be 100 percent for purposes of the calculation.
 - (3) The weighted average of the participating health plans' loss ratios is the program loss ratio.
- (e) ~~The~~ For plan years ending prior to January 1, 2014, the Board shall calculate the program average subsidy for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.
- (f) For plan years ending prior to January 1, 2014, for each participating health plan with an average subsidy percentage amount higher than the program average subsidy percentage, that difference shall be called the excess subsidy.
- (g) ~~The~~ For plan years ending prior to January 1, 2014, the Board shall determine the subscriber contribution for each participating health plan that did not have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by 125 percent.
- (h) ~~The~~ For plan years ending prior to January 1, 2014, the Board shall determine the base subscriber contribution for each participating health plan that did have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by an additional 25 percent and then adding the excess subsidy amount. However, the actual subscriber contribution shall be subject to the following limitations:
- (1) No subscriber contribution will be more than 10 percent above 125 percent of the estimated rates provided by the participating plan. (See Title 10, section 2698.100(dd).)

- (2) If all participating health plans available in a county have an excess subsidy amount, the subscriber contribution for the plan with the lowest excess subsidy amount will not include the excess subsidy amount.
- (i) For plan years ending prior to January 1, 2014, Subscriber contribution for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the estimated rates provided by the participating plan for the first two benefit years the plan participates in the program. (See Title 10, section 2698.100(dd).)
- (j) Subscriber contributions shall be adjusted annually in accordance with this section.
- (k) Subscribers and dependent subscribers shall be informed by the program of the annually adjusted subscriber contribution at least one month prior to the effective date of the rate change.
- (l) ~~For~~ Commencing calendar year 2013, the Board shall further subsidize the subscriber contribution so that subscribers shall not pay more than 100% of the standard average individual rates for comparable coverage.

Note: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12713, 12736, 12737 and 12738, Insurance Code.



**TITLE 10, INVESTMENT, CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE BOARD
MAJOR RISK MEDICAL INSURANCE PROGRAM
AMEND SECTION 2698.401**

FINAL STATEMENT OF REASONS

LOCAL MANDATE DETERMINATION

The proposed regulations do not impose any mandate on local agencies or school districts.

SUMMARY AND RESPONSE TO COMMENTS RECEIVED DURING THE INITIAL NOTICE PERIOD

The originally proposed text was made available and open for comment for at least 45 days from January 31, 2014 to March 17, 2014. The Board did not receive any comments on the proposed text.

ALTERNATIVES THAT WOULD LESSEN ADVERSE ECONOMIC IMPACT ON SMALL BUSINESSES

No alternatives were proposed to the Board that would lessen any adverse economic impact on small business.

ALTERNATIVES DETERMINATION

The Managed Risk Medical Insurance Board has determined that no alternative would be more effective in carrying out the purpose for which the regulation is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The regulation adopted by the Board is the only regulatory provision identified by the Board that accomplishes the goal of subsidizing subscriber premiums to 100 percent of standard average individual rates for the Major Risk Medical Insurance Program. No other alternatives have been proposed or otherwise brought to the Board's attention.

UPDATED INFORMATIVE DIGEST

There have been no changes in applicable laws or to the effect of the proposed regulations from the laws and effects described in the Notice of Proposed Regulatory Action.

**MANAGED RISK MEDICAL INSURANCE BOARD
RESOLUTION**

The Board hereby approves the final adoption of regulation changes for the Major Risk Medical Insurance Program to continue the 2013 subscriber contribution subsidy and modify calculation of subscriber contributions, Regulation Package ER-2-13:

CERTIFICATION

I, John Ramey, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on April 23, 2014.

Dated this 24th day of April 2014.

John Ramey, Executive Director
Managed Risk Medical Insurance Board

