WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3.3. Health Care Coverage Assistance [15800 - 15895] *(Part 3.3 added by Stats. 2013, Ch. 23, Sec. 68.)*

CHAPTER 4. California Major Risk Medical Insurance Program [15870 - 15895] *(Chapter 4 added by Stats. 2014, Ch. 31, Sec. 90.)*

ARTICLE 6. Plan Rates and Compensation from the Fund [15890 - 15891.5] *(Article 6 added by Stats. 2014, Ch. 31, Sec. 90.)*

15890. Upon enrollment as a subscriber in the program, the subscriber shall be responsible for payment of the subscriber contribution. Termination of coverage by a participating health plan for nonpayment of the subscriber contribution shall be governed by the same laws and regulations by which the participating health plan is regulated as to all its subscribers and enrollees.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15890.5. Each health plan contracting with the department pursuant to Article 4 (commencing with Section 15881) shall submit annually to the department rates which it estimates are sufficient to cover the cost of providing major risk medical coverage to its subscribers. The rates shall be submitted on the basis of categories of risk which shall be established by the department.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15891. (a) The department shall establish program contribution amounts for each category of risk for each participating health plan. The program contribution amounts shall be based on the average amount of subsidy funds required for the program as a whole. To determine the average amount of subsidy funds required, the department shall calculate a loss ratio, including all medical costs, administration fees, and risk payments, for the program in the prior calendar year. The loss ratio shall be calculated using 125 percent of the standard average individual rates for comparable coverage as the denominator, and all medical costs, administration fees, and risk payments as the numerator. The average amount of subsidy funds required is calculated by subtracting 100 percent from the program loss ratio. For purposes of calculating the program loss ratio, no participating health plan's loss ratio shall be less than 100 percent and participating health plans with fewer than 1,000 program members shall be excluded from the calculation.

Subscriber contributions shall be established to encourage members to select those health plans requiring subsidy funds at or below the program average subsidy. Subscriber contribution amounts shall be established so that no subscriber receives a subsidy greater than the program average subsidy, except that:

(1) In all areas of the state, at least one plan shall be available to program participants at an average subscriber contribution of 125 percent of the standard average individual rates for comparable coverage.

(2) No subscriber contribution shall be increased by more than 10 percent above 125 percent of the standard average individual rates for comparable coverage.

(3) Subscriber contributions for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the standard average individual rates for comparable coverage for the first two benefit years the plan participates in the program.

(b) The department shall pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

(c) Commencing January 1, 2013, in addition to the amount of subsidy funds required pursuant to subdivision (a), the department may further subsidize subscriber contributions so that the amount paid by each subscriber is below 125 percent of the standard average individual risk rate for comparable coverage but no less than 100 percent of the standard average individual risk rate for comparable coverage. For purposes of calculating premiums for the following products, any reference to, or use of, subscriber

contributions, premiums, average premiums, or amounts paid by subscribers in the program shall be construed to mean subscriber contributions as described in subdivision (a) without application of the additional subsidies permitted by this subdivision:

(1) Standard benefit plans pursuant to Section 10127.16 of the Insurance Code and Section 1373.622 of the Health and Safety Code.

(2) Health benefit plans and health care service plan contracts for federally eligible defined individuals pursuant to Sections 10901.3 and 10901.9 of the Insurance Code and Sections 1399.805 and 1399.811 of the Health and Safety Code.

(3) Conversion coverage pursuant to Section 12682.1 of the Insurance Code and Section 1373.6 of the Health and Safety Code.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)

15891.5. A participating health plan may charge subscriber contributions under this article that do not exceed the difference between its plan rate for the category of risk and the program contribution amount for the category of risk.

(Added by Stats. 2014, Ch. 31, Sec. 90. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15872.5.)