

Senate Bill No. 661

CHAPTER 792

An act to amend Sections 12718 and 12737 of the Insurance Code, relating to health insurance.

[Approved by Governor September 22, 1996. Filed
with Secretary of State September 24, 1996.]

LEGISLATIVE COUNSEL'S DIGEST

SB 661, Maddy. Health insurance.

Existing law establishes the California Major Risk Medical Insurance Program. Under that program, health benefits are provided by the program or through participating health plans.

Existing law authorizes copayments and deductibles.

This bill would increase the maximum authorized copayments and would permit copayments of up to \$25 for plans not utilizing deductibles.

Existing law requires program contribution amounts to be established so that the average subscriber contribution is 125% of the standard average individual rates for comparable coverage.

This bill would require program contribution amounts to be established for each participating health plan, and would set forth the method of establishing subscriber contributions.

The people of the State of California do enact as follows:

SECTION 1. Section 12718 of the Insurance Code is amended to read:

12718. Benefits under this chapter or Chapter 5 (commencing with Section 12720) shall be subject to required subscriber copayments and deductibles as the board may authorize. Any authorized copayments shall not exceed 25 percent and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars (\$500). However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars (\$25). If the board contracts with participating health plans pursuant to Chapter 5 (commencing with Section 12720), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans. The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars (\$2,500) for an individual and four thousand dollars (\$4,000) for a family.

SEC. 2. Section 12737 of the Insurance Code is amended to read:

12737. (a) The board 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 board 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 program shall pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

