FINDING OF EMERGENCY

MAJOR RISK MEDICAL INSURANCE PROGRAM
ADOPTION OF REGUATIONS CONCERNING ELIGIBILITY
Section 2683.200

At its September 18, 2013, meeting, the Managed Risk Medical Insurance Board (MRMIB or Board) adopted an emergency regulation that will modify two eligibility provisions in the Major Risk Medical Insurance Program (MRMIP) in order to conform to requirements in the MRMIP statute that were affected by recent state Special Session legislation (AB X1-2, Chapter 1, Statutes of 2013 and SB X1-2, Chapter 2, Statutes of 2013) implementing the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148 as amended by P.L. 111-152).

At its September 18, 2013, meeting, the Managed Risk Medical Insurance Board (MRMIB) found that an emergency exists and that the immediate adoption of the enclosed regulations is necessary to avoid serious harm to the public peace, health, safety, or general welfare, and that this constitutes an emergency under Government Code sections 11342.545, 11346.1 and 11349.6.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

Insurance Code section 12700, et seq., established MRMIP in 1991. MRMIP is administered by MRMIB. The program provides access to health insurance for individuals who are denied health insurance coverage, or offered excessive premiums, because of a pre-existing medical condition. Section 2698.200 of Title 10 of the California Code of Regulations, implementing section 12725 of the Insurance Code, establishes MRMIP eligibility criteria.

On May 9, 2013, the Governor signed Special Session bills AB X1-2 (Chapter 1, Statutes of 2013) and SB X1-2 (Chapter 2, Statutes of 2013), mandating sweeping changes in the private health insurance market, effective January 1, 2014. AB X1-2 and SB X1-2 took effect September 29, 2013, the 91st day following the July 1, 2013 special session adjournment date. (California Constitution Article IV, section 8(c)(1).) AB X1-2 governs coverage sold by health insurers regulated by the Department of Insurance, while SB X1-2 governs coverage sold by health care service plans regulated by the Department of Managed Health Care.

The MRMIP eligibility standards eliminated through this rulemaking are (1) the individual's involuntary termination from private market coverage, and (2) an offer of private market coverage at a premium higher than the premium for individual's first choice MRMIP health plan. Because of changes in carrier protocols mandated by the Special Session bills, these two standards will no longer fulfill the MRMIP statute's eligibility criteria as of January 1, 2014.

Insurance Code section 12725, the portion of the MRMIP statute that spells out the criteria for MRMIP eligibility, states, in relevant part, as follows:

> (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program…

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers… [not relevant to current regulation package]

(2) Afford limited coverage…[not relevant to current regulation package]

(3) Afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates.

The MRMIP regulation implementing section 12725 requires that, to be eligible, an applicant be "unable to secure adequate private coverage." (10 CCR section 2698.200(b)(1)(D).) The regulation further states that an individual "shall be deemed unable to secure adequate private coverage" if the individual, within the previous 12 months:

1. Has been denied individual coverage; or

2. Has been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud; or

3. Has been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice of participating health plan.

As a result of AB X1-2 and SB X1-2, as they affect the private market, the second and third eligibility standards in the MRMIP regulations will no longer be authorized by the MRMIP statute beginning January 1, 2014. This is because those two standards will cease to describe an individual who is rejected for coverage or offered coverage significantly above standard average individual coverage rates, as required by Insurance Code section 12725. MRMIB is taking prompt and timely action to "sunset" these eligibility criteria January 1.[1]

[1] MRMIB has acted at the earliest appropriate time. The special session changes were signed into law May 9, 2013 and took effect September 29; by their terms, they apply to coverage beginning January 1, 2014.

Moreover, until the 2013-14 Budget Act and its accompanying Trailer Bill Legislation became law at the end of June 2013, it was not appropriate for MRMIB to adopt changes in the MRMIP program for 2014. The Governor's Proposed Budget for 2013-14 anticipated that MRMIP would cease to operate in 2014. (See "2013-14 Governor's Budget Summary," at pp. 62-63, stating, "The Managed Risk Medical Insurance Program . . . will phase-out with the implementation of the federal Affordable Care Act in 2014." Late in the budget process, it was decided that MRMIP would not indeed sunset January 1, 2014. The California Budget Act for 2013-14 (AB 110, Chapter 20, Statutes of 2013) and the Omnibus Health Trailer Bill that addressed MRMIB programs including MRMIP (AB 82, Chapter 23, Statutes of 2013) were signed into law June 27, 2013, without phasing out MRMIP. Once the Budget and associated Trailer Bill Legislation became law, MRMIB analyzed the effect of the January 1, 2014 market changes mandated by the special session legislation on MRMIP eligibility rules. Following this analysis in July, in compliance with the 10-day notice requirement of the Bagley-Keene Open Meeting Act (Government Code section 11125(a)), MRMIB placed the proposed regulations on the agenda of the next MRMIB public meeting (August 21, 2013) to solicit public input. At the following meeting (September 18, 2013), the MRMIB Board adopted the proposed regulations.

A specific discussion of the reasons that the second and third eligibility criteria will no longer authorized, beginning January 1, 2014, follows:

Involuntary Termination From Health Insurance Coverage

While the MRMIP statute (Insurance Code section 12725) does not specifically state that involuntary termination from coverage is a ground for eligibility, MRMIB, by regulation, determined that involuntary termination fell within the statutory rubric of inability "to secure adequate private health coverage." This was a valid interpretation of the MRMIP statute and will remain so until January 1, 2014. At that time, pursuant to the special session bills, all California residents will be able to purchase health coverage on a guaranteed issue basis, without regard to health condition. (Insurance Code section 10965.3(a),(g), added by section 19 of AB X1-1; Health & Safety Code section 1399.849(a),(g), added by section 18 of SB X1-2.)

With limited exceptions, AB X1-1 and SB X1-2 require that health insurers and health care service plans sell coverage only during statutorily-defined open enrollment periods. (Insurance Code section 10965.3(a),(c) and (d); Health & Safety Code section 1399.849(a),(c) and (d).) However, one of the exceptions, permitting an individual to purchase insurance outside the open enrollment periods, is loss of coverage for reasons that are not due to fault (e.g., fraud or failure to pay premiums). (Insurance Code section 10965.3(d), Health & Safety Code section 1399.849(d).)

Therefore, effective January 1, 2014, a person who suffers an involuntary loss of health coverage *will* be able to purchase coverage in the private market, on a guaranteed issue basis, and so can no longer be said to be "unable to secure adequate private health coverage." As such, MRMIB has concluded that, effective January 1, involuntary termination from health coverage will no longer be an authorized basis for MRMIP eligibility under the MRMIP statute and must be deleted from the regulations as a basis for eligibility.

Premium Offered Exceeds MRMIP Subscriber Rate

As stated above, the MRMIP statute also confers eligibility when MRMIB determines that the premium quoted "is significantly above standard average individual coverage rates." (Insurance Code section 12725(b)(3).) The "standard average individual coverage rate," or "standard average individual rate" (Insurance Code section 12737) is the rate charged for an individual who is not "rated up" based on individual factors such as health condition. Under the current regulation, an individual is eligible for MRMIP if quoted a premium higher than the premium for his or her first choice MRMIP plan. This regulation constituted MRMIB's determination, pursuant to the statute, that premiums higher than MRMIP premiums were "significantly above standard average individual coverage rates."[2]

Finally, as reflected in Doe *v.* Wilson et al (57 Cal.App.4th 296), adoption of an emergency regulation is appropriate where, as here, it is necessary to comply with a law that will take effect before the agency would have time to promulgate regulations in the regular, non-emergency manner.

[2] Until 2013, MRMIP premiums were statutorily required to be between 125 and 137.5 percent of standard average individual rates. (Insurance Code section 12737 as it existed before enactment of AB 1526, Chapter 855, Statutes of 2012.) Hence, a premium higher than the MRMIP premium rate was, inherently, well above the standard average individual rate. AB 1526 gave MRMIB the authority to subsidize premiums down to the standard individual rates in 2013; the 2013 Omnibus Health Trailer Bill extended

However, effective January 1, 2014, the special session bills discussed above require that carriers standardize health coverage premiums; in essence, carriers will not be permitted to quote rates that are "above standard average individual coverage rates." Specifically, carriers may vary premiums from a one product to another only for certain product-specific factors (Insurance Code section 10965.3(h)(3), Health & Safety Code section 1399.849(h)(3)) and may vary premiums from one individual to another only on the basis of age, geographic region and family size. (Insurance Code section 10965.9, added by section 19 of AB X1-2, Health & Safety Code section 1399.855, added by section 18 of SB X1-2.)

In other words, under the new laws, no one can be offered a rate that is higher than standard rates; by definition, all rates will be standard average individual rates. Therefore, MRMIB has concluded that, effective January 1, 2014, MRMIB will not have statutory authority to determine that a premium for health coverage sold by a licensed carrier is "above standard average individual coverage rates" and must amend its regulations to delete this basis for MRMIP eligibility.

AUTHORITY AND REFERENCE CITATIONS

Authority: Sections 12711 and 12712, Insurance Code.

Reference: Sections 12711 and 12725, Insurance Code.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Policy Statement: The objective of the proposed regulation amendment is to ensure that MRMIP eligibility regulations continue to comply with state law when the applicability of the MRMIP statute to specific provisions of the regulations changes January 1, 2014 as a result of special session legislation.

A summary of the proposed regulation's effect on existing law and regulations follows:

Section 2698.200(b)(1)(E). This new subparagraph provides that two current bases for MRMIP eligibility described in subparagraph (D) – specifically, involuntary termination from health insurance coverage for reasons other than nonpayment of premium or fraud, and the offer of an individual health insurance premium rate in excess of the rate for the individual's first choice of MRMIP health plan – shall not apply to MRMIP applications received on and after January 1, 2014.

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None

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this authority. (Section 25 of AB 82, Chapter 23, Statutes of 2013.) As a result, beginning in 2013, MRMIP premiums have been set at the standard individual rates. (Title 10 CCR section 2698.401(l) and ER-2-13, pending with the Office of Administrative Law.)

DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: None

Mandates on Local Agencies or School Districts: None

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None

Non-discretionary Costs or Savings Imposed on Local Agencies: None

Costs or Savings to Any State Agency: The proposed regulation deletes two of the three current bases for MRMIP eligibility effective January 1, 2014. The state fund may have savings since an unknown number of applicants will be ineligible for coverage. At this time, the amount of savings is unknown because the change in the MRMIP caseload cannot be predicted.

Costs or Savings in Federal Funding to the State: None.