

California Major Risk Medical Insurance Program

The California Major Risk Medical Insurance Program or MRMIP is a program designed to provide health insurance for individuals who cannot obtain health coverage on the open market because of their medical conditions. Those who qualify for the program will pay premiums and MRMIP will supplement those premiums to cover the cost of the program. The MRMIP program can be reached at 800-289-6574.

ELIGIBILITY

To be eligible for the program, an applicant must meet all of the following:¹

- Be a resident of the State of California
- Not be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. If an individual has COBRA or CalCOBRA, she may apply for deferred enrollment.
- Not be eligible for both Part A and Part B of Medicare (unless solely because of end-stage renal disease)
- Be unable to obtain adequate health coverage, as indicated by:
 - Denial of coverage within the last 12 months (this must be submitted with an application)
 - Involuntary termination of health insurance coverage in the last 12 months for reasons other than nonpayment of premium or fraud (this must be submitted with an application)
 - Offer of individual health insurance premium rate that is higher than the MRMIB subscriber rate for your first-choice participating health plan (this must be submitted with an application)

Even if an applicant is not currently eligible, she can apply for MRMIP if she anticipates becoming eligible.² For example, if an applicant is currently enrolled in COBRA or CalCOBRA coverage or her employer has informed her you that she will be involuntarily terminated from insurance coverage in the future, that applicant can apply for MRMIP before she is currently eligible. To apply for deferred enrollment, the applicant must indicate when she will become eligible and include documentation from a health insurance carrier, health plan, health maintenance organization or employer indicating when her coverage will end.³

If the MRMIP program has not reached maximum enrollment and an applicant otherwise qualifies, she will be enrolled in the program.⁴ If the program has reached its maximum enrollment, applicants' names will be placed on a waiting list in the order in which their completed applications are received.⁵

Medi-Cal beneficiaries can apply for the program, but will be responsible for monthly subscriber contributions (premiums), deductibles or co-payments, which can be up to \$4000 per year for a subscriber with enrolled dependents.⁶

While there is no application fee, applicants must submit their first month's subscriber contribution in order to obtain health care coverage.⁷ Brokers, insurance agents, and other qualified assistance providers will receive \$50 for helping applicants complete the MRMIP application.⁸

HOW THE PROGRAM WORKS

Subscribers may choose from any health plan participating in MRMIP. Health plans are permitted to require copayments and deductibles for benefits provided to a subscriber and enrolled dependents.⁹ Copayments, however, cannot exceed 25 % of the cost of the covered services or \$25 for plans not utilizing a deductible for benefits.¹⁰ Deductibles cannot exceed \$500 annually for a household.¹¹ The maximum out-of-pocket costs per calendar year for all MRMIP plans are \$2500 for individuals and \$4000 for an entire household covered by the MRMIP.¹² This maximum amount does not apply to services offered outside the subscriber's plan or services not covered by the MRMIP.¹³

The basic minimum scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Act.¹⁴ Those benefits include hospital inpatient care, medical and surgical services, family planning services, comprehensive maternity and perinatal care, emergency care, reconstructive surgery, prescription drugs, mental health benefits, medical rehabilitation, durable medical equipment, home health services, organ transplants of the cornea, human heart, heart-lung, liver, bone-marrow and kidney, and hospice services.¹⁵ The benefit limits are \$75,000 per calendar year and \$750,000 in a lifetime.¹⁶

Subscribers receive monthly notices requesting payment of the subscriber contribution. The contribution must be paid in advance and is due on the first day of every month.¹⁷ Subscribers can pay by check or money order or can have payments automatically deducted from their checking accounts.¹⁸ If payment is not received, a delinquency notice will be sent on the 10th day of the month.¹⁹ Subscribers are given a 31 day grace period. If payment is not received by the 32nd day, the subscriber's enrollment in MRMIP will be canceled.²⁰ The cancellation is retroactive to the last day of the month for which the subscriber's contribution was paid in full.²¹ If a subscriber is disenrolled for nonpayment, she may be reinstated only once in a rolling twelve month period.²²

PRE-EXISTING CONDITION EXCLUSION AND WAITING PERIODS

For subscribers enrolling in a fee-for-service plan, there is a pre-existing condition exclusion period of three months.²³ This means that no benefits or services relating to the pre-existing condition will be covered. However, subscribers are still required to pay their subscriber contribution during this period.²⁴ A pre-existing condition is any condition for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage by MRMIP.²⁵

For subscribers enrolling in a Health Maintenance Organization (HMO) participating plan, there is a three month post-enrollment waiting period.²⁶ The initial subscriber contribution submitted with the application is applied to the first month of service eligibility.

The pre-existing condition exclusion or the waiting period can be completely waived if:²⁷

- The subscriber was on the MRMIP waiting list for 180 days or more.
- The subscriber was covered under a program similar to MRMIP in another state within the last 12 months.
- The subscriber had a prior health insurance policy for at least three consecutive months, her MRMIP application was submitted within 180 days following termination of that policy, and termination was due to loss of employment or certain actions by the employer.
- The subscriber had a prior health insurance policy for at least three consecutive months, her MRMIP application was submitted within 63 days following termination of that policy, and termination was not due to loss of employment, non-payment of premiums, fraud, or certain actions by the employer.

If the subscriber had a prior health insurance policy for less than three consecutive months, but more than 30 days, they can receive a partial waiver of the exclusion or waiting period.²⁸

DEPENDENT COVERAGE

A subscriber's dependents can also be covered under MRMIP. Dependents include a subscriber's spouse, unmarried children under age 23 who are either natural children, adopted children, or stepchildren.²⁹ A dependent includes an unmarried child who is economically dependent on the subscriber.³⁰ An unmarried child over 23 may be covered if she cannot support herself because of a physical or mental disability that occurred before the age of 23.³¹ Documentation such as doctor's records must be submitted to show that the dependent child cannot work for a living because of a physical or mental disability that existed before the child reached the age of 23.

WAITING LIST

When MRMIP has reached a maximum enrollment, applicants and their dependents will be placed on a waiting list. They will be enrolled in order of the date of receipt of their application once spaces become available.³² If an applicant remains on the waiting list 180 days or more, her three month exclusion period will be completely waived.³³

TRANSFERS

Subscribers may transfer from one participating health plan to another in the following situations:³⁴

- The subscriber has moved to an area that is not served by her current health plan and another participating plan serves the subscriber's new area
- The subscriber requests a transfer because of a poor relationship with her current plan,

another participating plan serves the subscriber's area and the transfer is in the best interest of MRMIP, as determined by the executive director.

Requests for transfers must be sent to:

Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

By phone: (916) 324-4695
1-800-735-2929 (TTY)

DISENROLLMENT

A subscriber will be disenrolled from MRMIP when:³⁵

- The subscriber requests disenrollment in writing. It will be effective at the end of the month in which the request was received.
- The subscriber fails to make a subscriber payment by the required deadline. Disenrollment will be retroactive to the last day of the month for which payment was made in full.
- The subscriber fails to satisfy the residency requirement or becomes eligible for Medicare Part A or B unless solely because of end stage renal disease or fraud. Disenrollment is effective at the end of the month in which notice was received or as of the last paid date. If MRMIP discovers subscriber fraud, disenrollment is effective as of the last day of the month in which fraud is determined.

If a subscriber was disenrolled for nonpayment, they may be reinstated only once in a 12 month period.³⁶

DISPUTE RESOLUTION/APPEALS

If a subscriber is dissatisfied with actions taken by her health plan, she can resolve the dispute according to the plan's established policies and procedures.

Subscribers can also file an appeal with the Managed Risk Medical Insurance Board regarding:³⁷

- An action or failure to act by a participating health plan
- A determination by MRMIP of an applicant's eligibility
- Disenrollment of a subscriber by MRMIP
- Denial by MRMIP of a subscriber's request to transfer to another health plan
- A decision by MRMIP to grant a participating health plan's request to transfer of a subscriber

Some plans require their subscribers to participate in binding arbitration when disputes arise between the plan and the subscribers.³⁸ This means that the dispute will be reviewed by a neutral person and this person will make a decision that the parties must accept.

COORDINATION OF BENEFITS

MRMIP will coordinate coverage of benefits with other health insurance that subscribers have and will only pay for coverage after the subscriber's other insurance has paid. This does not include Medi-Cal or other state programs.³⁹

ENDNOTES

Information included in this fact sheet was obtained from the California Code of Regulations and the California Major Medical Risk Insurance Program guide on the MRMIB website, www.mrmib.ca.gov, on June 23, 2008.

¹ CAL. CODE REGS. tit. 10 § 2698.200 (2004). Between 2003-2007, MRMIP allowed subscribers to enroll in private insurance pilot program called Guaranteed Issue coverage (GIC) once they reached their 36-month coverage cap. Individuals who received a GIC certificate could join a private insurance plan with an annual benefit cap of \$200,000 and a lifetime cap of \$750,000. The state paid half of the costs of the individual's claims in excess of the premium. Once the pilot program ended, the 36-month coverage cap was lifted. Subscribers can stay in MRMIP as long as they are eligible or until they hit their lifetime benefit cap.

² CAL. CODE REGS. tit. 10 § 2698.201(d)(U) (2004).

³ *Id.*

⁴ CAL. CODE REGS. tit. 10 §§ 2698.202(c), (d) (2004).

⁵ CAL. CODE REGS. tit. 10 § 2698.202(e) (2004).

⁶ CAL. CODE REGS. tit. 10 § 2698.300(a)(3) (2004).

⁷ CAL. CODE REGS. tit. 10 § 2698.201(b)(2) (2004).

⁸ CAL. CODE REGS. tit. 10 § 2698.208 (2004).

⁹ CAL. CODE REGS. tit. 10 § 2698.300(a)(1) (2004).

¹⁰ *Id.*

¹¹ CAL. CODE REGS. tit. 10 § 2698.300(a)(2) (2004). (*Household consists of any subscriber and any enrolled dependents or of a dependent subscriber*)

¹² CAL. CODE REGS. tit. 10 § 2698.300(a)(3) (2004). (*\$2,500 is annual cap for subscriber or dependent subscriber, \$4,000 is annual cap for a household consisting of a subscriber plus enrolled dependents*).

¹³ CAL. CODE REGS. tit. 10 § 2698.300(b) (2004).

¹⁴ CAL. CODE REGS. tit. 10 § 2698.301(a) (2004).

¹⁵ *Id.*

¹⁶ CAL. CODE REGS. tit. 10 §§ 2698.302(b), (c) (2004). (*Includes benefits for the subscriber, the subscriber's enrolled dependents or dependent subscribers*).

¹⁷ CAL. CODE REGS. tit. 10 § 2698.403 (2004).

¹⁸ *Id.*

¹⁹ CAL. CODE REGS. tit. 10 § 2698.405 (2004). (*An exception is when the previous month's subscriber contribution arrives on the due date of the current month's payment. In this case, a final notice will be sent on the 15th day*).

²⁰ *Id.*

²¹ CAL. CODE REGS. tit. 10 § 2698.204(d) (2004).

²² CAL. CODE REGS. tit. 10 § 2698.407(a) (2004).

²³ CAL. CODE REGS. tit. 10 § 2698.303(b) (2004). (*Fee-for-service plans are either: 1) service benefit plans under which a carrier makes retrospective payments with contracted physicians or other health service providers; or 2) indemnity benefit plans under which a carrier agrees to pay retrospectively certain sums of money, not in excess of actual expenses incurred, for health services.*)

²⁴ *Id.* (*Health maintenance organizations are comprehensive group-practice, individual practice or network model prepayment plans that offer benefits on a prepaid basis with professional services provided by physicians or other health service providers.*)

²⁵ CAL. CODE REGS. tit. 10 § 2698.100(w) (2004).

²⁶ CAL. CODE REGS. tit. 10 § 2698.303(a) (2004).

²⁷ CAL. CODE REGS. tit. 10 § 2698.303(c) (2004). (*The pre-existing condition exclusion or the waiting period can be waived if the employer stopped offering or sponsoring health coverage, or because the employer stopped making contributions towards health coverage*)

²⁸ CAL. CODE REGS. tit. 10 § 2698.303(d) (2004).

²⁹ CAL. CODE REGS. tit. 10 § 2698.100(f) (2004).

³⁰ *Id.*

³¹ *Id.*

³² CAL. CODE REGS. tit. 10 § 2698.202(e) (2004).

³³ CAL. CODE REGS. tit. 10 § 2698.303(c)(5) (2004).

³⁴ CAL. CODE REGS. tit. 10 § 2698.207 (2004).

³⁵ CAL. CODE REGS. tit. 10 § 2698.204 (2004).

³⁶ CAL. CODE REGS. tit. 10 § 2698.407(a) (2004).

³⁷ CAL. CODE REGS. tit. 10 § 2698.500(b) (2004).

³⁸ CAL. CODE REGS. tit. 10 § 2698.501 (2004).

³⁹ CAL INS. CODE §12717 (1989).