MRMIP Frequently Asked Questions (FAQs)

What is the Major Risk Medical Insurance Program (MRMIP)?

The Major Risk Medical Insurance Program (MRMIP) is a state program that offers health coverage to individuals who live in California. The MRMIP was created to provide health insurance to Californians who are unable to obtain coverage in the individual insurance market. Services are delivered through licensed health insurance plans. MRMIP subscribers participate in the payment for the cost of their coverage by paying monthly premiums, an annual deductible, and copayments. MRMIP is funded annually by tobacco tax funds.

What is the Minimum Essential Coverage (MEC) mandate?

Beginning in 2014, the Affordable Care Act included a mandate for most individuals to have health insurance or potentially pay a tax penalty for noncompliance. Individuals with insurance needed to ensure their current insurance met Minimum Essential Coverage (MEC) requirements and they are required to maintain MEC for themselves and their dependents. Some State high risk pools such as MRMIP that did not meet MEC but they were granted a one year extension and their members would not be subject to tax penalties for the 2014 tax year.

Does the MRMIP meet the MEC mandate? What changes, if any, will MRMIP meeting the MEC Mandate have on the subscribers - such as rates and benefits?

Yes, MRMIP meets the MEC designation. In February 2015, the federal government granted permanent MEC designation for any State high-risk pool in existence as of November 26, 2014. MRMIP subscribers will not need to obtain additional health coverage and will not be subject to tax penalties for non-compliance since MRMIP has been granted permanent MEC designation. The MRMIP benefit and rate structure will not change due to the MEC designation.

Are you eligible for MRMIP?

You may qualify for MRMIP if:

- You are a resident of California.
- You are **not** eligible for Medicare Part A and Part B (except for end-stage renal disease) or for COBRA or Cal-COBRA benefits.
- You have been denied individual health coverage within the last 12 months

Who Can Apply for MRMIP?

The following individuals can apply for MRMIP:

- Any person 18 years of age **or** older.
- Parents (natural or adoptive) or step-parents applying for children living in their home.
- Legal guardians, foster parents, or caretaker relatives applying for a child living in their home.
- An emancipated minor. This is a person who is under 18 years old who **does not** live with their parent, legal guardian, stepparent, or caretaker relative. Emancipated minors must apply for themselves.

What is a MRMIP pre-existing condition exclusion period?

MRMIP subscribers enrolled in a Preferred Provider Organization (PPO) have to **wait 3 months after** their start date of coverage to begin receiving health care benefits related to their "pre-existing condition". "A pre-existing condition" is any medical condition that a doctor or other licensed health practitioner diagnosed, cared for, recommended treatment for, or treated for a period of time before obtaining new health coverage. The MRMIP PPO plan is Anthem Blue Cross.

During the first 3 months, **no benefits or services related to a pre-existing condition are covered.** However, other types of benefits and services may be covered during this period. Subscribers are required to pay monthly premiums during the pre-existing condition exclusion.

What is a MRMIP post-enrollment waiting period?

MRMIP subscribers enrolled in a Health Maintenance Organization (HMO) have to **wait 3 months before** they begin receiving any health care benefits (including any pre-existing condition treatment). **No benefits or services are provided to subscribers during the post-enrollment period and no premiums are paid for this period.** MRMIP will inform subscribers when the post-enrollment period begins and ends. The premium payment included with the application will be applied towards your first month of MRMIP coverage, after the post-enrollment waiting period ends.

The MRMIP HMO plan is Kaiser Permanente (Northern & Southern California).

I previously had other health coverage or was on the MRMIP waiting list. Can I waive all (or part) of the MRMIP pre-existing condition exclusion or post enrollment waiting period?

Yes, you can waive all (or part) of the exclusion/waiting period if **one** of the following occurs:

- You have been on the MRMIP waiting list for 180 days or longer. The exclusion/waiting period will be completely waived; **or**
- You previously had health coverage (including Medicare and Medi-Cal) and you apply for the MRMIP **within 63 days** from the date your insurance ended; **or**
- You previously had health coverage and it ended because of **one** of the following:
    - Loss of employment; **or**
    - Employer stopped offering health coverage; **or**
    - Employer stopped making contributions towards the health coverage.
- You must apply for MRMIP **within 180 days** from the date your health coverage ended.
- You received health coverage from a similar high-risk program in another state within the last 12 months. The MRMIP exclusion/waiting period will be completely waived.

Please note: Dependents age 18 years or younger qualify for a full MRMIP pre-existing condition or post enrollment waiting period waiver.

What is a waiting list? Does MRMIP have a waiting list?

The MRMIP has an enrollment cap which limits the number of individuals that can be enrolled. At times, the MRMIP may have a waiting list due to limited funding. When MRMIP reaches its maximum enrollment capacity, individuals who qualify for MRMIP will be placed on a waiting list until enrollment slots become available. Placement on the waiting list will be based on the date a complete application is received.

Any time spent on the waiting list **does not** count towards the 3-month pre-existing condition exclusion **or** post enrollment waiting period. However, if the individual has been on the waiting list for 180 days or longer, the 3-month pre-existing condition exclusion **or** post enrollment waiting period will be completely waived.

For more information about the MRMIP waiting list, please call 1-800-289-6574, Monday - Friday from 8:30 a.m. - 5:00 p.m. The call is toll free!

I am eligible for Medicare both Part A and Part B because of end-stage renal disease. What type of document do I send with my application?

In addition to the other required documents shown in the MRMIP Application and Handbook, which contains a checklist, you must also send a letter issued by Medicare. The Medicare letter must state that you are eligible for Part A and Part B because of end-stage renal disease.

Does MRMIP offer dependent coverage?

MRMIP allows subscribers with pre-existing conditions to enroll dependents into MRMIP on the same application. Dependents include spouse, registered domestic partner, children under the age of 23, adopted child, stepchild, natural child, or child of a domestic partner. However, dependents must meet all the same eligibility requirements except for demonstrating that they have a pre-existing condition. In addition, dependents without pre-existing conditions generally can purchase health coverage in the individual market at much lower rates. Some subscribers with dependents may benefit from differences in premiums or cost sharing in MRMIP, and from the option to enroll a newborn or newly adopted child.

Do I have to provide my Social Security Number when applying for MRMIP?

No, you do not have to provide your Social Security Number. Giving us your Social Security Number is optional.

I am currently enrolled in Medi-Cal. Do I qualify for MRMIP?

Yes, you qualify for MRMIP as long as you meet all of the program requirements but you should carefully consider the cost of MRMIP coverage. MRMIP subscribers are responsible for paying their monthly premiums, annual deductible, cost sharing, and copayments for covered services.

How much will the monthly premium cost for MRMIP?

The MRMIP monthly premium costs are based on your age, where you live in California, and the number of dependents that are enrolled in MRMIP. If you have dependents enrolled in the program, MRMIP monthly premiums will be based on your age category.

You **must** include a full month's premium payment with your application. This payment is required for MRMIP to process your application. If you do not send the full premium amount, it will delay the processing of your application. Send a check, money order or cashiers' check made payable to the **California Major Risk Medical Insurance Program.**

Do MRMIP monthly premiums change?

Yes, monthly premiums may change. MRMIP premiums are based on your age, where you live and the number of dependents enrolled.

Your monthly premium may change if:

- You move; **or**
- Your age changes and you fit into a different premium category; **or**
- You transfer to a different MRMIP health plan; **or**
- You change the number of dependents enrolled in MRMIP.

We also update and change the MRMIP monthly premiums on January 1st of each year.

What health benefits are offered in MRMIP?

There is a wide variety of services covered by MRMIP; including preventive care, hospital care, physician office visits, prescription drugs, laboratory and x-ray services, and home health/hospice care.

How much do subscribers pay for MRMIP services?

In addition to monthly premiums, the amount subscribers pay towards their coverage includes copayments and coinsurance. The amount you pay for copayments and coinsurance depends on the MRMIP health plan you select. **Please carefully review the MRMIP Costs and Benefits Chart in the MRMIP Application and Handbook to select a plan that is right for you.**

Is there an annual deductible for MRMIP?

Yes, the annual household deductible is $500. You must meet your deductible first before the MRMIP health plan begins paying for covered services. The only payments that count toward a deductible are those payments that you make for covered services that are **subjected to the deductible. Each health plan applies the deductible differently.** However, these preventive services are **not** subjected to the $500 deductible:

- Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women,
- Cytology Examinations,
- Periodic Health Examinations,
- Hearing Tests and Eye Exams for Children,
- Newborn Blood Tests,
- Prenatal Care (care during pregnancy),
- Prostate Exams for Men,
- Venereal Diseases Tests,
- Well-Baby and Well-Child Visits,
- Certain Immunizations for Children and Adults,
- Laboratory Services in connection with Periodic Health Evaluations, and
- Other types of benefits and services (depends on the plan).

Please carefully review the MRMIP Costs and Benefits Chart in the MRMIP Application and Handbook for more details about which services are subject to the deductible. The $500 deductible is applied towards the annual out-of pocket maximum. Once you've met your $500 deductible (for the remaining calendar year), you will only pay copayments or coinsurance subject to the annual out-of-pocket maximum.

Does MRMIP have a cap on how much I have to pay out-of-pocket each year?

Yes. The annual out-of-pocket maximum is $2,500 for individuals and $4,000 for an entire household. The maximum does not apply to services received by providers that do not participate in the subscriber's chosen MRMIP health plan **or** for services not covered by MRMIP.

Once a subscriber reaches the out-of-pocket maximum for amounts paid towards in-network providers, MRMIP will pay 100% of your in-network medical and prescription drug services for the remaining calendar year. There is no out-of-pocket maximum for out-of-network services.

Does MRMIP have a $75,000 annual benefit cap? What happens when I meet this cap?

There is an annual benefit maximum of $75,000 per member, per calendar year. MRMIP will not cover any more services, if you reach this annual benefit maximum. Once you reach the annual benefit maximum, then you are responsible to pay for all services rendered in-network or out-of-network.

Does MRMIP have a $750,000 lifetime cap? What happens when I meet this cap?

There is a lifetime maximum cap of $750,000 per member for all covered services. MRMIP will not cover any more services if you reach the lifetime benefit maximum. Once you reach the lifetime benefit maximum, then you are responsible to pay for all services rendered in-network or out-of-network.

Does MRMIP cover dental and vision care?

No. There is no dental or vision coverage in MRMIP. If you need this coverage, you will need to obtain it separately.

Which plans and providers are available in MRMIP?

MRMIP benefits and services are delivered through licensed health plans (Anthem Blue Cross and Kaiser). Each plan has its own in-network providers. To find a provider for a specific MRMIP health plan, call the plans directly:

- ***Anthem Blue Cross (PPO):*** 1-877-687-0549
  Monday – Friday (8:30 a.m. – 7:00 p.m.)
- **Kaiser Permanente:** 1-800-464-4000
  (Northern & Southern Region) Monday – Sunday (24 hours, except Holidays)

How long does it take to process my MRMIP Application?

If your complete application is received with all required documentation by the 10th of the month, coverage will begin the 1st day of the following month. For example, if we receive a complete application by October 10th, the start date of coverage will be on November 1st.

However, if your complete application is received with all required documentation after the 10th of the month, coverage will begin on the 1st day of the second month following your application. For example, we receive a complete application after October 10th, the start date of coverage will be on December 1st. Incomplete applications will result in a denial of coverage. We will send you a letter informing you if you are enrolled in MRMIP.

How do I make sure that my application is complete?

Carefully review the MRMIP Application and Handbook, which contains a checklist. The checklist explains the supporting documents and monthly premium you need to send with your application.

Once I am enrolled in MRMIP, when can I access my health care coverage?

When you are enrolled in MRMIP, we will send you a letter informing you when your start date of coverage begins. You may be subjected to either the pre-existing condition exclusion or the post enrollment waiting period.

Will MRMIP cover any medical expenses that I received before my coverage begins?

The MRMIP program **will not** cover any medical expenses incurred prior to the start date of coverage.

How do I pay my MRMIP monthly premiums once I am enrolled? When are monthly premiums due?

Once you are enrolled in MRMIP, you will receive a billing statement for your monthly MRMIP premiums in the mail. The billing statement will be sent out 30 days before the due date. Your premium payment is due by the **1st of each month**. Subscribers can pay their premiums on a monthly, bi-monthly or quarterly basis. There are different ways to pay monthly premiums:

1. You can send us a:
    - Personal check; **or**
    - Cashier's check; **or**
    - Money order; **or**
    - Electronic funds withdrawal from a banking account. To sign up for an electronic withdrawal, call MRMIP at 1-800-289-6574, Monday – Friday from 8:30 a.m. - 5:00 p.m.

Make your payment to the **California Major Risk Medical Insurance Program**. Make sure you write your HCID or Subscriber Number on the check. Mail your payment to:

MRMIP
P.O. Box 54808
Los Angeles, CA 90054-0808

Subscribers are responsible to pay their monthly premiums even if they do not receive a billing statement or their premiums are paid by a third party. A federally recognized California Indian Tribal Government can make premiums on behalf of a member of the tribe.

Is there a grace period for monthly premiums?

Yes. There is a grace period of 31 days from the due date. A subscriber's coverage will remain in effect during this grace period. If your payment is not received by the grace period, you will be disenrolled. **Your end date of coverage in MRMIP will be retroactive to the last day of the month in which your coverage was paid in full.** Subscribers are responsible for the cost of any services received after their coverage with the MRMIP ends.

If I am disenrolled from MRMIP because of non-payment, can I get reinstated back into the program with no break in coverage?

Yes. If you were disenrolled for non-payment, you may be reinstated once in a 12-month period. Your request for reinstatement must be in writing and must be received **within 60 calendar days** when you were disenrolled. You will have to make a full payment to bring your account current before you can be reinstated.

What happens if my payment does not clear the bank?

MRMIP will charge you a $25 returned check fee. You must send another payment (which includes the $25 return check fee). This payment must be received by the grace period. If the full payment is not received by the grace period, you will be disenrolled from MRMIP. Your end date of coverage in MRMIP will be retroactive to the last day of the month in which your coverage was paid in full.

Subscribers are responsible for the cost of any services received after their coverage with the MRMIP ends.

If you are requesting a reinstatement, you must send a payment (which includes the $25 return check fee). You will have to make a full payment to bring your account current before you can be reinstated.

If you are signed up for electronic funds withdrawal **and** your payment did not clear the bank, you will no longer be able to pay your premiums through this electronic process.

I am currently enrolled in MRMIP and also have other health care coverage. How does MRMIP coordinate benefits with my other insurance?

Your MRMIP health plan will coordinate coverage of benefits with any other health coverage you have. The MRMIP is secondary to other insurance coverage. By State law, MRMIP will only pay after your other insurance has paid (not including Medi-Cal or other types of State programs). MRMIP will not duplicate other coverage you have (whether you use it or not).

If I am not happy with my MRMIP health plan, can I transfer to another plan?

Yes. You can transfer to another MRMIP health plan if:

- You request for a plan transfer during the Open Enrollment process. Each year, Open Enrollment occurs November 1st through November 30th. Subscribers will receive an Open Enrollment packet that identifies the health plans available to them. The packet also includes the new MRMIP monthly premiums. Open Enrollment transfers are effective January 1st; **or**
- You move and your current health plan does not serve the area where you now live. Your request for a transfer to another health plan must be in writing. Send your request to:

California Major Risk Medical Insurance Program

P.O. Box 9044

Oxnard CA 93031-9938;

or

Fax to:

1 (805) 987-6084

- You are unable to establish a satisfactory subscriber/plan relationship and there is another plan that serves your area. The Department of Health Care Services (DHCS) must determine that the transfer is in the best interest of the MRMIP. DHCS is the state agency that oversees and administers the MRMIP program. Send your transfer request to:

Department of Health Care Services
MCOD – MS 4703
Major Risk Medical Insurance Program
P.O. Box 2769
Sacramento, CA 95812-2769

Subscribers who transfer to another MRMIP health plan are **not subject** to the pre-existing condition exclusion **or** post-enrollment waiting period.

How do I resolve a dispute with my MRMIP health plan?

If a subscriber is dissatisfied with any action (or inaction) of the health plan, the subscriber should first attempt to resolve the dispute with the participating plan. The subscriber must follow the plan's established policies and procedures in resolving the dispute.

What is binding arbitration?

Each plan has its own rules for resolving disputes about delivery, services, and other matters. Some plans say you must use binding arbitration for disputes (not including disputes with the program about which benefits are covered); others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court.

To find out how a plan resolves disputes and which MRMIP plans require binding arbitration, you can call the plan and request an Evidence of Coverage booklet. The plan's contact information can be found in the MRMIP Application and Handbook.

How do I get a copy of a MRMIP Evidence of Coverage and Disclosure Form Booklet?

Each health plan has an Evidence of Coverage and Disclosure Form Booklet. Contact the plans directly to obtain a copy. The plans' contact information can be found in the MRMIP Application and Handbook.

How is a person disenrolled from MRMIP?

A person will be disenrolled from MRMIP if **one** of the following occurs:

- Monthly premium payment is not received by the grace period (there is a grace period of 31 days from the due date); **or**
- The individual requested (in writing) disenrollment from MRMIP; **or**
- The individual no longer lives in California; **or**
- The individual passed away; **or**
- The individual becomes eligible for Medicare Part A and Part B unless they are solely eligible because of end-stage renal disease. Subscribers must inform the MRMIP in writing when they become eligible for Medicare Part A and Part B, **or**
- The individual provides false information during the application process.

Subscribers (or dependents) who are disenrolled from MRMIP for any reason **may not re-enroll** into the MRMIP for a period of 12 months.

I'm enrolled in MRMIP and am now eligible for Medicare. Am I still eligible for MRMIP?

You are required to inform the MRMIP once you become eligible for Medicare Part A **and** Part B, unless you are solely eligible because of end-stage renal disease.

- "Eligible" for Medicare Part A means that you are not required to pay a premium for Part A.
- "Eligible" for Medicare Part B means that you have the right to purchase Part B because you are Eligible for Part A. You do not qualify for MRMIP, even if you choose not pay the premium for Medicare Part B.

Most people who become eligible for Medicare because of their age or disability are entitled to purchase insurance to supplement their Medicare for **6 months after they first purchase Medicare Part B and** under other certain circumstances. For individuals who become eligible for Medicare

because of a disability, the right to buy this supplemental insurance is the result of State law. You may call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. HICAP provides free information and counseling about these rights.

If you qualify for only one part of Medicare, you are still eligible for the MRMIP.

How can I appeal a MRMIP decision?

The subscriber should first attempt to resolve the dispute with the health plan. The subscriber must follow the plan's established policies and procedures in resolving the dispute.

The MRMIP is a State program and the subscriber's rights and obligations will be determined under Part 6.5, Division 2, of the California Insurance Code **and** the Title 10, California Code of Regulations, Chapter 5.5, MRMIP Regulations.

Applicants or subscribers may file an appeal with the Department of Health Care Services (DHCS) on the following issues:

- Any action or failure to act which has occurred in connection with a participating health plan's coverage;
- Determination of an applicant's or dependent's eligibility for the MRMIP;
- Determination to disenroll a subscriber or dependent; and
- Determination to deny a subscriber's request or to grant a participating health plan's request to transfer the subscriber to a different health plan.

An appeal must **be filed in writing within 60 calendar days** of the action, failure to act, or receipt of notice of the decision being appealed to:

Department of Health Care Services
MCOD – MS 4703
Major Risk Medical Insurance Program
P.O. Box 2769
Sacramento, CA 95812-2769

Or fax to: (805) 987-6084

Include any other information you think will be helpful in DHCS' review. Write your Health Care Identification Number (HCID) or Subscriber Number on every document you send us.

DHCS cannot review a decision over the telephone. Once DHCS receives your written appeal, DHCS will send you a letter telling you the results of the review and any right to additional appeals.

Can Insurance Agents/Brokers assist people in applying for MRMIP?

Yes, they can assist people in applying for MRMIP. Insurance agent's/broker's information must be included on the Application in order for them to be paid for their assistance. Insurance agents/brokers are eligible for payment for each person they assist who is **successfully enrolled** into MRMIP.

How much will Insurance Agents/Brokers receive for assisting people enroll into MRMIP?

Insurance agents/brokers are eligible for a $100 payment for each person they assist who is **successfully enrolled** into MRMIP.

When will the $100 payment be issued to the Insurance Brokers/Agents?

Reimbursement payments will be issued after the applicant is enrolled in MRMIP.

My employer provides health insurance. But, my employer and insurance agent/broker suggested that I apply for MRMIP. Is that okay?

No. Insurance Code Section 12725.5 states that it shall constitute unfair competition **and** labor practice for an insurer, an insurance agent or broker, or administrator to:

- Refer or arrange for an individual employee (or their dependents) to apply for MRMIP, with the purpose of separating that employee (or their dependents) from group health coverage provided in connection with the employee's employment.

Who can I call if I have more questions?

For questions with MRMIP, please give us a call at 1-800-289-6574, Monday – Friday 8:30 a.m. – 5:00 p.m. The call is toll free!