

Resolution on the Future of the Major Risk Medical Insurance Program

Whereas, the federal government has adopted the law known as the Affordable Care Act (ACA), creating guaranteed issue, guaranteed renewal, and affordable rates in the California individual health insurance market;

Whereas, California has adopted laws to implement the ACA;

Whereas, the California purchasing exchange for individuals, known as Covered California, has successfully enrolled several million persons in the individual market;

Whereas, enrollment in the Major Risk Medical Insurance Program (MRMIP) has markedly diminished because of other better benefits available through Covered California and individual health insurance market;

Whereas, persons who are eligible for Medicare by reason of being diagnosed with End Stage Renal Disease and who may be utilizing MRMIP as a Medicare supplement may be served by the regular Medicare supplement marketplace if the code changes described in Exhibit A are enacted;

Whereas, persons with pre-existing conditions can obtain health insurance coverage under the ACA;

And, whereas a denial of coverage letter from an insurance entity is, and always has been, a necessity of coverage in MRMIP, but the circumstances under which coverage can be denied have been dramatically reduced under the ACA;

Therefore, be it resolved that the Managed Risk Medical Insurance Board (MRMIB) instructs the staff of MRMIB to work with the California Health and Human Services Agency, the Legislature and other stakeholders toward a timely and appropriate termination of the MRMIP.

CERTIFICATION

I, John Ramey, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing resolution was duly adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on April 23, 2014.

Dated this 23rd day of April, 2014

John Ramey, Executive Director
Managed Risk Medical Insurance Board

Exhibit A to Resolution on the Future of MRMIP

Potential solution to allow persons who have Medicare by virtue of being diagnosed with End Stage Renal Disease to purchase Medicare supplement coverage (i.e., by requiring plans and insurers to offer this coverage), alleviating the pressure on the MRMIP program to fill this gap with its taxpayer-subsidized product.

Amend Health & Safety Code Section 1358.11:

(a) (1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger ~~and who does not have end-stage renal disease~~. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

... *[balance of section unchanged]*

Amend Insurance Code Section 10192.11:

(a) (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger ~~and who does not have end-stage renal disease~~. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

... *[balance of section unchanged]*