DEPARTMENT OF
Managed
Health Care

State Of California
Business, Transportation And Housing Agency
DEPARTMENT OF MANAGED HEALTH CARE

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Edmund G. Brown Jr.
Governor

Edward G. Heidig
Interim Director
Department of Managed Health Care

DATE: June 30, 2011 **LETTER No. 10-K**

IMPLEMENTATION OF AB 2470

The purpose of this letter is to provide health care service plans (health plans) with guidance concerning Health and Safety Code section 1365 as amended by AB 2470. AB 2470 was enacted, in part, to implement certain provisions of the federal Patient Protection and Affordable Care Act (ACA).

Under AB 2470, the Director of the Department of Managed Health Care (DMHC) may issue guidance to health plans, effective until the DMHC and the California Department of Insurance (CDI) formally adopt regulations. The DMHC has developed the following guidance. Pursuant to Health and Safety Code Section 1365(e), this guidance is binding and enforceable through December 31, 2013, or until the Director adopts regulations pursuant to the Administrative Procedure Act, whichever occurs first.

1. Applicability of Guidance

Consistent with the provisions of AB 2470, the guidance issued in this letter generally applies to both individual and group health plan contracts. The specific permissible reasons for cancellation or nonrenewal described in Health and Safety Code section 1365 apply to all health plan contracts, except as specified in the statute.

2. Applicability of Prior Regulations

In the event of conflict between this guidance and any existing DMHC regulations in Title 28 of the California Code of Regulations, the provisions of AB 2470 and this guidance shall control.

3. Prohibition on Cancellation and Nonrenewal of Enrollment or Subscription

Health plans may cancel or nonrenew health plan enrollment or subscriptions only as set forth in Health and Safety Code section 1365(a).

4. Application of Grace Period for Cancellations or Nonrenewals Due to Nonpayment of Premiums

While the ACA permits retroactive cancellation for nonpayment, AB 2470 contemplates prospective cancellation only. Health and Safety Code section 1365(a)(1) permits health plans to cancel or nonrenew a health plan contract for nonpayment of premiums only if the individual, employer, or contractholder has been "duly notified" and billed for the charge, and the health plan has provided the contractholder with at least a 30-day "grace period."

4.1. The grace period shall not begin until after the conclusion of any coverage period for which the plan has received full payment. The grace period must continue for a minimum of 30 days, during which the health plan must continue to provide coverage consistent with the terms of the health plan contract.

4.2. An individual, employer, or contractholder is "duly notified" if the health plan has provided, no later than the first day after the last day of paid coverage, a notice of cancellation or nonrenewal due to nonpayment of premiums, separate from the original premium bill. This notice must include the dollar amount due to the health plan, disclosure of the grace period, and any other necessary information.

4.3. *Grace Period Example*. Contractholder has paid the premium required for the month of September. Health Plan billed Contractholder for the October premium on September 1, due by September 30. Health Plan has not received any payment by September 30 and provides a notice of cancellation (including notice of the grace period) on October 1. The 30-day grace period may begin on October 1. The Health Plan must continue coverage until October 31. If payment is not received on or before October 31, the delinquent Contractholder's coverage may be terminated on November 1, effective on November 1.

4.4. If the individual, employer, or contractholder, or a party acting on his or her behalf, submits the necessary premium payment to the health plan on or before the last day of the grace period, the health plan must ensure that coverage is continued pursuant to the terms health plan contract without interruption.

5. Notice of Cancellation or Nonrenewal

Health and Safety Code section 1365(b) provides that an enrollee or subscriber who alleges that an enrollment or subscription has been "improperly cancelled,

rescinded or not renewed" may request review pursuant to section 1368.

5.1. A health plan must provide the individual, employer, or contractholder with appropriate notice of cancellation or nonrenewal of the health plan enrollment or subscription. A notice of cancellation or nonrenewal must be in writing and dated, and must include:

(a) The reason for cancellation or nonrenewal of the health plan contract;

(b) The time when the cancellation or nonrenewal takes effect; and

(c) A notice of the right to request review of the cancellation or nonrenewal of the health plan contract. This notice must state that a subscriber, contractholder, or enrollee who believes that his or her health plan enrollment or subscription has been improperly canceled or not renewed may request a review from the Director.

(d) For cancellations or nonrenewals based on nonpayment of premiums, the health plan must also "duly notify" the consumer, as specified in section 5.2 of this guidance. The information required under this section and section 5.2 may be combined into a single document.

(e) For cancellations or nonrenewals based on any reason other than nonpayment of premiums, the health plan must also include notice of the opportunity to continue coverage, as specified in section 5.3 of this guidance. The information required under this section and section 5.3 may be combined into a single document.

5.2. If the cancellation or nonrenewal is based on nonpayment of premiums, the notice of cancellation or nonrenewal must also "duly notify" the individual, employer or contractholder, consistent with section 4.2 of this guidance, including:

(a) a statement of the dollar amount due;

(b) appropriate disclosure of the availability of the grace period; and

(c) any other necessary information.

5.3. If the cancellation or nonrenewal is based on any reason described in Health and Safety Code sections 1365 other than nonpayment of premiums, the notice of cancellation or nonrenewal must disclose the opportunity to continue coverage, as applicable.

6. Model Language

6.1. Suggested language to satisfy the requirement to provide notice of the right to request a review, specified in section 5.1 of this guidance, appears below:

"Right to Request Review of Rescission, Cancellation, or Nonrenewal of Your Enrollment or Subscription

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

First, file your complaint with [*Health Plan Name*]:

- You can file a complaint with [*Health Plan Name*] by calling [*Health Plan phone number*] or visiting [*Health Plan web site address*].
- You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent [*Health Plan*] must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, [*Health Plan*] must give you a decision within 30 days.

Take your complaint to the California Department of Managed Health Care (DMHC):

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with [*Health Plan*'s] decision about your complaint, or;
- You have not received the decision within 30 days, or within 3 days if the problem is urgent.

- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

An optional DMHC complaint form is available at www.healthhelp.ca.gov.

For help, contact:

Help Center, DMHC
980 Ninth St., Suite 500

Sacramento, CA 95814-2725
1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.healthhelp.ca.gov

There is no charge to call. Help is available in many languages."

6.2. Suggested language to satisfy the requirement to provide an explanation of the grace period, required under section 5.2 of this guidance, appears below:

"**Grace Period**

If you receive notice that your coverage is being canceled or not renewed due to failure to pay your premium, [*the health plan*] must provide you with a 30-day "grace period." The grace period begins after the last day of paid coverage. [*The health plan*] must continue to provide coverage during the grace period, though you will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days after the date of last day of paid coverage.

During the grace period, you can avoid cancellation or nonrenewal by paying the premium you owe to [*the health plan*]. If you do not pay the premium by the end of the grace period, your coverage will be terminated at the end of the grace period. You will still be legally responsible for any unpaid premiums you owe to [*the health plan*].

If you wish to terminate your coverage immediately, contact [your health plan] as soon as possible."

6.3. Suggested language to satisfy the requirement to provide an explanation of continuation of coverage, required under section 5.3 of this guidance, appears below:

"**Continuation of Coverage**

If you receive notice that your coverage is being rescinded, canceled or not renewed for any reason besides failure to pay premiums, **and** if your coverage is still in effect when you submit your complaint, [*the health plan*] must continue your coverage until the review process is completed (including any review by the DMHC Director). If your coverage is continued, **you must still pay your usual premiums**.

If your coverage has already ended when you submit your request for review, [*the health plan*] is not required to continue your coverage. However, you can still request a review of [*the health plan*'s] decision to rescind, cancel or not

renew your coverage by following the complaint process described above. If you submit a complaint to the DMHC and the Director decides in your favor, [*the health plan*] must reinstate your coverage, back to the date of the rescission, cancellation, or nonrenewal."

7. Continuation of Coverage During Pendency of Appeal

Section 1365(b)(4) of the Health and Safety Code requires health plans to continue coverage under the terms of the contract until the review process is completed and a final determination has been made by the Director. Section 1365(b)(4), specifically provides that the requirement to continue coverage during an appeal does not apply to appeals of cancellation or nonrenewal of coverage due to nonpayment of premiums.

7.1. For the purposes of Health and Safety Code section 1365(b), a health plan must continue coverage if the individual, employer, or contractholder has submitted a request for review to the health plan or the Director, consistent with grievance processes required under Health and Safety Code section 1368, before the rescission, cancellation or nonrenewal of the enrollment or subscription takes effect.

7.2. When coverage is continued pursuant to Health and Safety Code section 1365(b)(4), the individual, employer, or contractholder must also continue to timely pay their premiums and any other cost-sharing obligations required under the contract.

7.3. If coverage is continued and the Director determines that the individual's, employer's, or contractholder's enrollment or subscription has been properly rescinded, canceled or nonrenewed, the affected individual, employer, or contractholder shall only be responsible for the required premium and any cost-sharing obligations under the terms of the continued health plan contract.

8. Reinstatement of Enrollment or Subscription

For the purposes of Health and Safety Code section 1365(b), if the individual, employer, or contractholder requesting review of a rescission, cancellation, or nonrenewal does not submit his or her request for review before the rescission, cancellation, or nonrenewal takes effect, the health plan is not required to continue coverage.

However, in the event that the Director determines that the health plan has improperly rescinded, canceled, or not renewed coverage, the health plan must reinstate the canceled or nonrenewed enrollment or subscription as required under Health and Safety Code section 1365(b)(5).

The DMHC is committed to ensuring that health plan consumers are afforded

their rights as required by State and federal law, in a manner that supports a viable and vibrant marketplace in California. If you have any questions concerning the guidance issued in this letter, please contact Sherrie Lowenstein at slowenstein@dmhc.ca.gov; 980 9th Street, Suite 500, Sacramento, CA 95814; or (916) 322-5874.

Edward G. Heidig, Interim Director