DEPARTMENT OF
Managed
Health Care

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

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IMPLEMENTATION OF AB 2244

The purpose of this letter is to provide health care service plans (health plans) with guidance concerning AB 2244 (Chap. 656, Stats. of 2010), a bill that took effect on January 1, 2011. AB 2244 implements the federal Patient Protection and Affordable Care Act (ACA) prohibition on pre-existing limitations (including denials of coverage) for children under the age of 19 and provides additional protections to consumers. AB 2244 establishes mandatory "open enrollment" periods in the individual market, during which health plans and insurers can adjust rates based on health status, up to two times the standard rate for a healthy child. Children without continuous coverage are subject to an additional surcharge. AB 2244 also prohibits health plans and insurers from offering new contracts in the individual market for five years if they fail to write new health plan contracts for children on or after January 1, 2011. Under AB 2244, 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, in consultation with the CDI, has developed the following guidance. Pursuant to Health and Safety Code section 1399.835, this guidance is binding and enforceable until such time that the DMHC and the CDI have jointly adopted regulations in accordance with the Administrative Procedures Act. The DMHC may provide additional guidance as necessary to ensure consistent and appropriate implementation of AB 2244. This guidance may be revised in the event of new federal regulations or federal guidance, or as otherwise necessary.

1. Applicability of Guidance

Consistent with the provisions of AB 2244, the guidance issued in this letter applies only to nongrandfathered individual health plan contracts.

2. Guaranteed Issuance of Coverage Outside of Open Enrollment

Federal laws and regulations categorically prohibit health plans from denying coverage to children based on a pre-existing condition at any time, without exception. Moreover, federal guidance issued on October 13, 2010, confirms that states "cannot allow insurers to selectively deny enrollment for children with a pre-existing condition while accepting enrollment from other children outside of the open enrollment periods."[1] This federal guidance confirms that health plans may never condition offer and acceptance of coverage for a child on a pre-existing condition, even outside of open enrollment.

Therefore, under Health and Safety Code section 1399.829(b)(4), health plans may never deny enrollment to any child on the basis of a pre-existing condition at any time, including outside of open enrollment.

3. Year-Round Availability of Coverage

AB 2244 requires a health plan to offer contracts to children or the responsible parties: 1) during any open enrollment period, 2) to late enrollees, and 3) during any other period in which health plans are expressly prohibited from conditioning the offer and acceptance of coverage on a pre-existing condition.

As noted above, federal authorities have confirmed that, under section 2704 of the Public Health Service Act and implementing rules, health plans cannot deny enrollment to children on the basis of a pre-existing condition at any time, including outside of open enrollment periods. Accordingly, Health and Safety Code section 1399.828(a) requires health plans to affirmatively offer and sell coverage on a guaranteed-issue basis to all children at all times, including outside of any open enrollment or late enrollment periods.

Furthermore, health plans are not permitted to limit the availability of any health plan product to open enrollment. The same health plan products must be available year-round, regardless of a child's open enrollment eligibility.

4. Products that Must be Offered to Children

Every nongrandfathered health plan product offered in the individual market must be offered and sold to any child or the responsible party of a child, on a guaranteed issue basis, including a child applying as the primary subscriber.

Adults applying for new enrollment in available family contracts may be subject to medical underwriting, except as provided in Health and Safety Code section 1389.5.

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[1] Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions, http://www.hhs.gov/ociio/regulations/children19/factsheet.html (Oct. 13, 2010).

5. Rating Outside of Open Enrollment Periods

Federal guidance, updated on October 13, 2010, expressly permits health plans to adjust rates for health status. Health and Safety Code section 1399.829(b)(3), in conjunction with this federal guidance, allows health plans to adjust rates based on a child's health status for coverage obtained outside of open enrollment. The rating limitation described in Health and Safety Code section 1399.829(b)(1) applies only to children who obtain coverage during open enrollment or who enroll as late enrollees.

Outside of open enrollment and enrollment periods for late enrollees, health plans may adjust rates based on health status, and need not comply with this rating limitation. However, all health plan rates must comply with any applicable state and federal laws, including the rate review requirements under SB 1163. Any offer of coverage at a higher-than-standard premium rate must include the specific reasons for that decision, as currently required under Health and Safety Code section 1389.25(b)(1).

If a health plan charges more than two times the standard risk rate for health coverage for a child, it must reduce the rate to no more than two times the standard risk rate, as of the next open enrollment period for that child. The health plan may require that the child apply for such a rate reduction at the next open enrollment period as a condition of reducing the rate. If the health plan requires the child to apply for the rate reduction, it must provide notification of this requirement as described in Section 8 below.

6. Surcharge

Health and Safety Code section 1399.829(b)(2) allows health plans to impose a 20-percent surcharge if the child to be covered has not maintained continuous coverage during the 90 days prior to the application for coverage.

At the conclusion of the 12-month surcharge period, the health plan must automatically discontinue the surcharge without requiring action on the part of the enrollee.

Consistent with Health and Safety Code section 1389.25(b)(1), health plans must provide notice to the consumer if the health plan charges the 20-percent surcharge, and must also inform the consumer that the surcharge will be automatically discontinued after 12 months.

7. Late Enrollees

If a child experiences any of the "qualifying events" described in Health and Safety Code section 1399.825(d), the child (or the child's responsible adult) is permitted to apply for coverage as a late enrollee for up to 63 days following the

qualifying event.

Under section 1399.825(d)(2), the late enrollment period for a child who is not born in California is 63 calendar days from the date the child became a resident of California.

Health and Safety Code section 1399.825(d)(3) applies to newborn children only. A child born as a resident of California after January 1, 2011, may apply for coverage as a late enrollee for up to 63 calendar days from the child's date of birth.

8. Notice and Disclosure Requirements

If a health plan charges a child a base premium rate that is more than two times the standard risk rate and the health plan requires the child to apply for a re-rating as a condition of reducing the premium rate upon the child's next open enrollment period, the health plan must provide written notice of this requirement at the commencement of coverage and must include instructions on how to initiate a rate reduction.

If the health plan charges a child a base premium rate that is more than two times the standard risk rate, and requires the child to apply for a re-rating as a condition of reducing the premium rate, it must also provide a second notice of the right and requirement to initiate a re-rating, together with any necessary instructions, at least 60 days prior to the child's next open enrollment period.

The notice required in Health and Safety Code section 1399.829(c), as well as the notices and instructions required above, shall be prominently displayed in bold-face (minimum 12-point) type and shall include the health plan's contact information.

The DMHC is committed to ensuring that children have access to health care coverage as required by state and federal law, in a manner that supports a viable marketplace in California. If you have any questions concerning the guidance in this letter, please contact the Office of Legal Services at (916) 322-6727.

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By _____

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