CAHP IMPLEMENTATION GUIDELINE

AB 1180 (Pan)
Chapter 441, Statutes of 2013

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

HIPAA/CONVERSION COVERAGE

BACKGROUND
Assembly Bill 1180 (Pan) is a CAHP supported bill that received nearly unanimous support in the Legislature. The bill is designed to ensure existing state laws regarding the Health Insurance Portability and Accountability Act (HIPAA) guaranteed issue and conversion coverage are in conformity with the Affordable Care Act (ACA).

Specifically AB 1180 makes inoperative, but does not repeal, non-ACA compliant HIPAA and conversion laws relating to rates and benefit design. The bill also requires health plans to provide HIPAA and conversion members with appropriate and timely notice about their options in the new guaranteed issue market. A tie-back mechanism is included in the bill that would reactivate the relevant state laws if specified provisions of the ACA are repealed at the federal level. In addition, those in grandfathered plans will be able to continue with their existing coverage. A new grandfathered rate formula for enrollees in these products is specified in the bill.

Inoperability of HIPAA and Conversion Guaranteed Issue (GI) Laws
In support of AB 1180 CAHP and the health plans argued that guaranteed issue health coverage is broadly available under the ACA, thus making state laws requiring guaranteed coverage for subgroups of individuals obsolete and in direct conflict with the ACA. For example, state law places limits on the rates charged to HIPAA and conversion eligible members. These rate limits cannot be met in the future because, under the ACA, rates may only vary by the factors specifically outlined in federal law. State law also requires HIPAA and conversion offerings to be based on specific individual market products that will no longer be ACA compliant due to comprehensive changes to benefits and cost-share arrangements. This level of coverage can only continue for those in “grandfathered” plans that existed when President Obama signed the ACA into law.

AB 1180 is consistent with the intent of the ACA. A Q&A issued by The Center for Consumer Information & Insurance Oversight on the Maintenance of Alternative Mechanisms clearly states that the new guaranteed issue right under the ACA makes HIPAA guaranteed issue obsolete and allows states to discontinue state requirements on health plans to offer these products in the future. Combined with state law conflicts mentioned above, the health plans felt it was particularly important to push AB 1180 to ensure consistency with federal law.
“Trigger” Provisions
As discussions advanced over the shape of this bill, Assembly and Senate Health Committee staff indicated that they would not support a full repeal of state level HIPAA and conversion laws. Thus AB 1180 makes them inoperative unless or until certain events happen at the federal level. Specifically, the inoperability of HIPAA and conversion GI laws would be repealed if the federal mandate on individuals to purchase insurance is repealed or amended to no longer apply to the individual market. This “trigger” language was placed in the bill to protect consumers and provide them with coverage options if important aspects of the federal market reforms were repealed.

Model Notices
AB 1180 contains various notice requirements on the health plans in order to ensure existing HIPAA and conversion members understand their rights and options in the new guaranteed issue marketplace. Additional notice requirements relate to Major Risk Medical Insurance Program (MRMIP) members as plan coverage requirements in that program are phased out by this bill.

The bill requires the Department of Managed Health Care and the Department of Insurance to develop the uniform notice for affected consumers and exempts the development of the uniform notice from the Administrative Procedure Act.

REQUIREMENTS
Makes several Health and Safety Code provisions in existing law inoperative on January 1, 2014, unless and until Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91). This is the federal individual mandate. These inoperative provisions are as follows:

1) 1363.06 – Comparative Benefit Matrices.

2) 1363.07 – Annual Update of Comparative Benefit Matrix by Health Care Service Plan; Copies to be mailed to solicitors and employees; Availability of link to matrix on website.

3) 1366.35 – Required Coverage: Coverage for federally eligible defined individuals.

Beginning on January 1, 2014, the reference to conversion coverage is made inapplicable in Section 1366.3 (a), which requires an offer of coverage when a plan ceases to offer individual coverage in California. The inapplicability of conversion coverage will apply unless and until Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91):

On January 1, 2014, the following provisions of state law will apply only to grandfathered plans unless and until Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91):

1) 1399.810 – Renewal of Contracts; Federally eligible defined individuals
2) 1399.815 – Notice of plan contract amendments

AB 1180 deletes the current rate increase formula and establishes a rate cap for individuals enrolled in HIPAA and conversion grandfathered products by limiting the premium charged for coverage provided in 2014 to the rate charged in 2013 multiplied by 1.09 and limits the rate of growth thereafter. Establishes a formula with respect to the rate charged for coverage provided in 2015 and each subsequent year. The following sections are amended to make this change:

1) 1399.805 – Notification of premium charges

2) 1399.811 – Premium Requirements

Section 1373.621 deletes a provision which requires a health plan or disability insurance policy to notify the former spouse of an employee about the right to a conversion plan or policy, as specified, and deletes obsolete inoperative dates (AB 254 Montañez, Chapter 64, Statutes of 2004).

Under 1373.622 a plan is not required to offer MRMIP coverage on or after January 1, 2014. As such, the bill further states that the Managed Risk Medical Insurance Board (MRMIB) is not obligated to provide any payment to any health care service plan under MRMIP for health care expenses incurred on or after January 1, 2014, or the standard monthly administrative fee, as defined as it existed on January 1, 2007, for any month after December 2013. This section requires plans to send a specified notice.

This bill adds provisions to the Health and Safety Code requiring consumer notification as follows:

1) Section 1373.620 requires carriers to issue notices to individuals affected by this bill informing them of changes in insurance laws beginning January 1, 2014. Requires uniform model notices to be adopted by CDI and DMHC no later than September 1, 2013, and exempts the departments from the Administrative Procedure Act for purposes of adopting the model notices.

2) Section 1373.622 permits the Directors of CDI and DMHC to modify these model notices specifically for the purposes of clarity, readability and accuracy. Includes in this authority notices related to the ending of the MRMIP pilot program and pursuant to provisions under AB 792 (Bonilla) Chapter 851, Statutes of 2012.

COMPLIANCE DATES
AB 1180 was enacted as an urgency statute and took effect on October 1, 2013. There are varying compliance dates for notices and other requirements under AB 1180, some of which are based on contract renewal dates. Specific implementation dates are noted in the implementation section.

Also, it should be noted that throughout AB 1180 the changes and additions to state law become inoperative if certain portions of the ACA are repealed. If this occurs plans will no longer have to comply with the updated provisions.

IMPLEMENTATION ISSUES
**Applicability:** AB 1180 applies to health plans offering individual and group coverage. It specifically makes certain provisions of law related to HIPAA and Conversion products only applicable to grandfathered products.

**Implementation Issues:**

**Section 5- Grandfathered Coverage**
Section 1373.6 of the Health and Safety Code was amended to only apply to individual grandfathered health plans issued pursuant to Health and Safety Code § 1373.6.

A health plan with individual grandfathered products issued pursuant to Health and Safety Code § 1373.6 will need to ensure that coverage and pricing for these products remains compliant with the law as outlined in the requirements section.

**Section 6- Enrollee Notices**
Section 1373.620 (a)(1) was added to the Health and Safety Code and applies to plans that do not offer products in the individual market other than to comply with HIPAA/conversion requirements in Section 1373.6 or Section 1366.35. This Section does not apply if the individual product is a grandfathered product.

Impacted plans are required to send a notice that informs individuals enrolled in the product that it will no longer be available effective on the renewal date of the contract. The required notice also informs the enrollee of market reform changes that take effect in 2014 and the possibility that they may be eligible for coverage through Covered California or Medi-Cal and is designed to meet the requirements of AB 792 (2012) and SB1x 2 (2013 special session), both of which had similar notification requirements for enrollees in the individual and small group market terminating coverage, in addition to the requirements in AB 1180.

Section 1373.620 (b)(1) was added to the Health and Safety Code and applies to plans that offer products in the individual market. These plans are required to provide the notification described above (see supporting document link), but for these plans the notice must also provide information to the enrollee on the most comparable nongrandfathered plan product that will be available.

Since the notices described in this section must be sent 60 days prior to the plan renewal date, many plans may have already implemented this notice. On October 31st DMHC issued its final notices and a Director’s Letter (see supporting document links) that includes instructions on the notice and other relevant information. Use of the notice does not require prior approval by DMHC and DMHC has confirmed in its Director’s Letter that if a plan had implemented earlier/different versions of the notices it will not be required to resend notices.

Plans that have not yet implemented this notice will want to take the final version from DMHC and make sure that it is appropriately distributed. This will involve identifying all of the products and enrollees for which this notice is required and identifying the renewal dates of all impacted products. Plans that will continue to operate in the individual market will also have to evaluate which nongrandfathered products are the most comparable to those that will no longer be available and adjust the notices to include that information, which may result in several variations of the notice. Plans that have used previous versions of the notice will need to work with DMHC to phase in the use of the final DMHC notice.

11/4/2013
Plans that are terminating products under this section will need to file a material modification with DMHC to reflect the changes to product offerings.

**Section 8- Graduate Insurance Program (GIP)**

Section 1373.622 of the Health and Safety Code was amended to relieve plans of the obligation to provide coverage under the California Major Risk Medical Insurance Program (MRMIP) pilot program referred to as the Graduate Insurance Program (GIP). Plans were required by October 1, 2013, to provide the information contained in the notice established under Section 6 to any enrollees remaining in the GIP. The notice may be slightly modified to contain only the provisions of the notice that are relevant to the GIP, and DMHC is expected to issue guidance on what a GIP specific notice would look like.

However, health plans that have enrollees in the GIP may have already completed the notice requirements in order to meet the deadline in AB 1180. Impacted plans that have not yet sent these notices because they were awaiting guidance from DMHC will need to reach out to DMHC. Additionally, impacted plans will need to make sure that the final annual reconciliation report is filed with the Managed Risk Medical Insurance Board by the date December 31, 2014, or an earlier date as specified in the statute (1373.62) in order to receive any final payments due.

Plans that have GIP enrollment will need to file a material modification with DMHC and determine the termination date for any remaining enrollees.

**Section 9- Premium Requirements**

Section 1399.805 of the Health and Safety Code was amended to update the methodology used to determine premiums for coverage after January 1, 2014. Plans will need to make sure that all premiums charged for HIPAA products are calculated in compliance with the updated formula as described in the requirements section. This section applies to individual grandfathered health plan contracts that were previously issued to federally eligible defined individuals. All plan notifications and marketing/enrollment materials will need to be appropriately updated with the new rates. In addition to the premium calculations defined in this Section, individual grandfathered product plans that were previously issued to federally eligible defined individuals will still have to comply with requirements for coverage effective dates as outlined in Section 1399.805 (c) and (d).

It should be noted that the subdivision that implements the changes to the premium calculation for federally eligible defined individuals becomes *operative* on January 1, 2014, but *inoperative* on January 1, 2020, and the subdivision that contains language on the current premium calculation formula becomes *inoperative* on January 1, 2014, but *operative* again on January 1, 2020. This was added to the bill at the request of consumer groups to avoid maintaining the new premium calculation for too long with no opportunity to make changes. Another bill will have to be approved prior to January 1, 2020, to avoid defaulting back to the current process.
Section 10 - Grandfathered Plans
Section 1399.810 of the Health and Safety Code was amended to acknowledge that requirements to renew coverage for federally eligible defined individuals are only applicable to grandfathered plans in the individual market effective January 1, 2014.

Section 11 - Premium Formula for Grandfathered Plans
Section 1399.811 of the Health and Safety Code was amended to make changes to the formula that determines what federally eligible defined individuals can actually be charged for grandfathered health plan contracts that were previously issued to federally eligible defined individuals. These mirror the requirements in Section 9 and also revert back to the old process if another bill is not passed by January 1, 2020.

For 2014 AB 1180 specifies that the formula for these rates is 1.09 times the rate charged in 2013 for that same product. For rates starting in 2015 and beyond, the formula will be based on the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on that region’s relative share of total enrollment in the Individual Exchange. Covered California is required to gather its most recent data and determine the percentage change in the statewide average premium no later than 30 days after its Individual Exchange rates for the applicable year have been finalized.

Plans will need to make sure that each year the appropriate percentage change for these rates are applied to all federally defined individuals that remain in grandfathered health plan contracts.

Section 12 - Grandfathered Contract Requirements
Section 1399.815 of the Health and Safety Code was amended to clarify that effective January 1, 2014, the requirements related to amending or renewing a contract under this article only apply to grandfathered health plan contracts that were previously issued to federally eligible defined individuals.

Any impacted plan will need to make sure it remains in compliance with this portion of the statute.

If you have any questions regarding this document, please contact Nick Louizos at 916-552-2910.