From:	DMHC Licensing eFiling
Subject:	APL17 - 012 (OPL) - Compliance With SB 908's Requirements
Date:	Friday, September 22, 2017 10:51:58 AM
Attachments:	APL17-012 (OPL) - SB 908 compliance.pdf

Dear Health Plan Representative,

Please find the attached All Plan Letter, Compliance with SB 908's Requirements Regarding Notice of Unreasonable or Not Justified Rate Increases for Individual or Small Group Products.

If you have any questions regarding the letter, please contact the Office of Plan Licensing through your assigned counsel.

Thank you.

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th St., Ste. 500, Sacramento, CA 95814
Telephone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: September 22, 2017

TO: All Full-Service Health Plans[1]

FROM: Sarah Ream, Deputy Director
Office of Plan Licensing

SUBJECT: APL17-012 (OPL) Compliance With SB 908's Requirements Regarding Notice of Unreasonable or Not Justified Rate Increases For Individual Or Small Group Products

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The purpose of this letter is to provide health plans with guidance concerning the deadlines by which health plans must send notices of unreasonable or not justified premium rate increases as required by Senate Bill (SB) 908 (Hernandez – Stats. 2016, ch. 498).

SB 908, among other things, requires a health plan to notify subscribers and applicants in writing, using notice language developed by the DMHC, if the DMHC determines the plan's premium rate increase is unreasonable or not justified.

Timing of Notices to Plan Applicants and/or Members

If the DMHC determines an individual or small group health plan contract rate increase is unreasonable or not justified, the health plan must notify in writing the contract holder and/or applicant of that determination. The plan must send notice to applicants and/or subscribers by **no later than fifteen (15) days** after the DMHC issues its determination that the premium rate increase is unreasonable or not justified.

Content of Notices

The notice of unreasonable or not justified premium rate increase must contain the language developed by the DMHC (see attached) and be in the font size specified by the DMHC. The Attachments to this APL contain the required language for the notices of unreasonable or not justified rate increase.

[1] This APL only applies to health plans that are required to file their individual or group rates with the DMHC for review. The APL does not apply to the following types of health plans or health plan products: specialized, Medicare Advantage, or Medi-Cal.

- Attachment 1—**Notice to Small Group *Applicant*** of Unreasonable or Not Justified Rate Increase
- Attachment 2—**Notice to Small Group *Employer*** of Unreasonable or Not Justified Rate Increase
- Attachment 3—**Notice to Individual and Family Plan *Applicant*** of Unreasonable or Not Justified Rate Increase
- Attachment 4— **Notice to Individual and Family Plan *Member*** of Unreasonable or Not Justified Rate Increase

A health plan may include the notice of unreasonable or not justified rate increass with the health plan's notification to contract holders and applicants regarding the change in premium rates or changes in coverage, as required pursuant to Health and Safety Code sections 1374.21, subdivision (a)(1), and 1389.25, subdivision (b)(1), so long as the plan can satisfy both the timing requirements of section 1374.21 or 1389.25, as applicable, and the timing requirements outlined in this APL. A single letter containing the language developed by the DMHC and consistent with other areas of the law is acceptable.

If you have questions regarding this APL, please contact the Office of Plan Licensing through your assigned counsel.

Attachment 1— Notice to Small Group *Applicant*

The health plan must use the language set forth below in its notice to Small Group Applicants that the DMHC determined the health plan's contract rate increase to be unreasonable or not justified.

Notice of Unreasonable Rate Determination

Dear <Employer or Plan Administrator>;

We received your application for coverage for your small business under <health plan product> ("product"). *{Optional/Dynamic for Covered California Plans} Your small business is enrolled in coverage under <health plan product> ("product").* We are required to provide you the following information regarding the premium rate for the product and your options.

{14-point type} The Department of Managed Health Care has determined that the premium rate increase for this product is unreasonable or not justified after reviewing information submitted to it by <plan name>.

{14-point type} This means that the plan did not provide enough information to support the rate increase or the rate was found unjustified or unreasonable for other reasons. You have the option to continue with your current application, keep any other coverage you may have, or seek other coverage. Small group purchasers may want to contact Covered California for Small Business at (844) 332-8384 or www.coveredca.com for help in understanding available options

{Optional} Our explanation for why we are finalizing a rate increase the Department of Managed Health Care has determined is unreasonable or not justified may be found at <web site address for justification pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations>.

If you have any questions, you can reach the <Plan's Member Services Department> at <Phone Number>, <Days>, <Times>. For questions about the California Department of Managed Health Care's Rate Review Program contact (888) 466-2219, Monday through Friday 8:00am-5:00pm.

Attachment 2—Notice to Small Group *Employer*

The health plan must use the language set forth below in its notice to Small Group Employers that the DMHC determined the health plan's contract rate increase to be unreasonable or not justified.

Notice of Unreasonable Rate Determination

Dear <Employer or Plan Administrator>;

You are enrolled in coverage under <health plan product> ("product"). Your health plan premium for this product will increase by {12-point type, *italics*} *<#%>, a $X.XX monthly increase in the premium payment{specify small group plan rate increases}*, effective <Month> <Day>, <yyyy>. We are required to provide you the following information regarding the premium rate for the product and your options.

{14-point type}The Department of Managed Health Care has determined that the premium rate increase for this product is unreasonable or not justified after reviewing information submitted to it by <plan name>.

{14-point type} This means that the plan did not provide enough information to support the rate increase or the rate was found unjustified or unreasonable for other reasons. You can keep your current plan product, choose a different plan product, or look for other coverage. Small group purchasers may want to contact Covered California for Small Business at (844) 332-8384 or www.coveredca.com for help in understanding available options.

{Optional} Our final explanation for why we are finalizing a rate increase the Department of Managed Health Care has determined is unreasonable or not justified may be found at <web site address for justification pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations>.

If you have any questions, you can reach the <Plan's Member Services Department> at <Phone Number>, <Days>, <Times>. For questions about the California Department of Managed Health Care's Rate Review Program contact (888) 466-2219, Monday through Friday 8:00am-5:00pm.

Attachment 3—Notice to Individual and Family Plan *Applicant*

The health plan must use the language set forth below in its notice to Individual and Family Plan Applicants that the DMHC determined the health plan's contract rate increase to be unreasonable or not justified.

Notice of Unreasonable Rate Determination

Dear <First Name Last Name>:

We have received your application for coverage under <health plan product> ("product"). *{Optional/Dynamic} You are enrolled in coverage under <health plan product> ("product").* We are required to provide you the following information regarding the premium rate for the product and your options.

{14-point type}The Department of Managed Health Care has determined that the premium rate increase for this product is unreasonable or not justified after reviewing information submitted to it by <plan name>.

This means that the plan did not provide enough information to support the rate increase or the rate was found unjustified or unreasonable for other reasons. During the open enrollment period, you have the option to continue with your current application, keep any other coverage you may have or look for other coverage. *{Optional/Dynamic} If outside the open enrollment period you may be eligible to choose a different plan if you qualify for a special enrollment period.* You may also contact Covered California at (800) 300-1506 or www.coveredca.com for help in understanding available options. Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

{Optional} Our explanation for why we are finalizing a rate increase the Department of Managed Health Care has determined is unreasonable or not justified may be found at <web site address for justification pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations>.

If you have any questions, you can reach the <Plan's Member Services Department> at <Phone Number>, <Days>, <Times>. For questions about the California Department of Managed Health Care's Rate Review Program contact (888) 466-2219, Monday through Friday 8:00am-5:00pm.

Attachment 4— Notice to Individual and Family Plan *Member*

The health plan must use the language set forth below in its notice to Individual and Family Plan Members that the DMHC determined the health plan's contract rate increase to be unreasonable or not justified.

Notice of Unreasonable Rate Determination

Dear <First Name Last Name>:

You are enrolled in coverage under <health plan product> ("product"). Your health plan premium for this product will increase by {12-point type, *italics*} *<#%>, a $X.XX monthly increase in the premium payment*, effective <Month> <Day>, <yyyy>. We are required to provide you the following information regarding the premium rate for the product and your options.

{14-point type} The Department of Managed Health Care has determined that the premium rate increase for this product is unreasonable or not justified after reviewing information submitted to it by <plan name>.

This means that the plan did not provide enough information to support the rate increase or the rate was found unjustified or unreasonable for other reasons. During the open enrollment period, you can keep your current plan product, choose a different plan product, or look for other coverage. *{Optional/Dynamic} If outside the open enrollment period you may be eligible to choose a different plan if you qualify for a special enrollment period.* You may also contact Covered California at (800) 300-1506 or www.coveredca.com for help in understanding available options. Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

{Optional} Our explanation for why we are finalizing a rate increase the Department of Managed Health Care has determined to be unreasonable or not justified may be found at <web site address for justification pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations>.

If you have any questions, you can reach the <Plan's Member Services Department> at <Phone Number>, <Days>, <Times>. For questions about the California Department of Managed Health Care's Rate Review Program contact (888) 466-2219, Monday through Friday 8:00am-5:00pm.