

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

**TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 1. DEPARTMENT ADMINISTRATION
ARTICLE 6. APPEALS ON CANCELLATION**

SECTIONS 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, AND 1300.65.5

(Control No. 2017-5214)

INITIAL STATEMENT OF REASONS

**CANCELLATIONS, RESCISSIONS, AND NONRENEWALS OF HEALTH CARE
SERVICE PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT**

Pursuant to Government Code section 11346.2, the Director of the Department of Managed Health Care (Department) submits this Initial Statement of Reasons in support of the proposed deletion of sections 1300.65, 1300.65.1, and 1300.65.2 and addition of new sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, and 1300.65.5 of title 28 of the California Code of Regulations.

I. GENERAL PURPOSE

The purpose of the proposed regulatory action is to amend sections 1300.65, 1300.65.1, 1300.65.2 of title 28, California Code of Regulations (CCR), and add sections 1300.65.3, 1300.65.4, and 1300.65.5 to title 28 of the CCR, to implement, interpret and make specific the rights and requirements under Health and Safety Code sections 1365 and 1389.21, and parts 156.270 and 155.430 of title 45, Code of Federal Regulations (CFR).¹ The California Health and Safety Code statutes impose limitations on the cancellation, rescission, and nonrenewal of health care service plan contracts (health plan contracts), and provide enrollees, subscribers, and group contract holders with a right to file a grievance with the Department under certain types of coverage cancellations, rescissions, and nonrenewals, among other things, consistent with federal law under the Patient Protection and Affordable Care Act (PPACA).² Proposed amendments to sections 1300.65, 1300.65.1, and 1300.65.2, and the addition of sections 1300.65.3, 1300.65.4,

¹ References to California Code of Regulations sections will be designated as "Rule," e.g., Rule 1300.65, and references to California Health and Safety Code sections will be designated as "Section," e.g., Section 1365.

² Codified at Title 42, United States Code (USC) sections 300gg-2, 300gg-12, and 300gg-42.

and 1300.65.5 build on current regulations to remedy identified questions regarding interpretation and to update the regulations to comply with current federal regulations.

The proposed amendments and additions will allow the Department to consistently implement the provisions of sections 1365 and 1389.21, including timelines for notice and grace period requirements and the rights and responsibilities of health care service plans (“plans”), enrollees, subscribers, and group contract holders prior to, during, and following cancellations, rescissions or nonrenewals of health care coverage.

II. AUTHORITY

Section 1341(a), authorizes the Department to regulate health plans.

Section 1344 authorizes the Director of the Department (“Director”) to adopt, amend and rescind regulations as necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director’s discretion such a requirement is not necessary for the public interest or for the protection of the public, enrollees, subscribers, group contract holders, and persons or plans subject to the Knox-Keene Act.

Section 1345(f)(1), defines a “health care service plan” as “any person who undertakes to arrange for the provision of health care subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services, in return for a prepaid or periodic charge paid by or on behalf of subscribers or enrollees.”

Section 1346 vests in the Director additional powers to administer and enforce the Knox-Keene Act, including but not limited to, the power to study, investigate, research and analyze matters affecting the interests of plans, subscribers, enrollees and the public and to promote and establish standards of ethical conduct for the administration of health plans.

Federal law, under the PPACA, prohibits the cancellation, rescission, or nonrenewal of health care coverage contracts except in certain enumerated circumstances, pursuant to title 42, United States Code (“USC”) sections 300gg-2, 300gg-12, and 300gg-42. In 2010, Assembly Bill 2470 (Stats. 2010, ch. 658 § 4) amended sections 1365, 1368 and 1389.21, to conform the Knox-Keene Act to federal requirements.

In 2011, the Department issued Director’s Letter 10-K, often referred to as the “AB 2470

Guidance.” In 2013, the Department began the process to promulgate the AB 2470 Guidance, which became effective January 1, 2015. Since the effective date of the current regulations, the Department has witnessed a significant increase in the number of grievances relating to enrollment disputes due questions surrounding the interpretation of the current law.

Proposed amendments to sections 1300.65, 1300.65.1 and 1300.65.2, as well as the addition of sections 1300.65.3, 1300.65.4, and 1300.65.5, are the Department’s efforts to resolve the identified questions of interpretation, and are based both on the authority granted to the Department by the statutes cited above, and the requirements imposed by federal law on plans regulated by the Department under the Knox-Keene Act.

III. SPECIFIC PROBLEMS, PURPOSE, AND NECESSITY OF REGULATIONS

The Department determined the amendments to Rules 1300.65, 1300.65.1, 1300.65.2, and the adoption of Rules 1300.65.3, 1300.65.4 and 1300.65.5, are necessary to interpret, implement, and make specific the requirements for cancellations, rescissions, and nonrenewals under section 1365. Furthermore, amendments and additions are necessary to conform existing regulatory provisions to federal law and guidance.

This rulemaking package is necessary to streamline and clarify the requirements for cancellations of coverage and related grievance procedures.

- A. Proposed Rule 1300.65 is substantially the same as the current rule, and the amendments that were made to this rule include updating the definitions sections with previously undefined or unclear terms to assist both enrollees and health plans in understanding their rights and obligations under current law. In addition, provisions were added to clarify the format and transmission requirements of the required notices.
 - 1. Subdivision (a) provides definitions for terms used in section 1365 and the entirety of Article 6 of Division 1, Chapter 2 of Title 28. The amendments in proposed Rule 1300.65(a) are necessary to address the undefined terms in current Rules 1300.65 and 1300.65.1, which created questions in interpretation and potential misunderstanding of obligations and rights under the law. These definitions are necessary to define key terms used in the underlying statutes dealing with cancellations, rescissions and nonrenewals and specifying the meaning of these terms will prevent confusion within the health care industry in the interpretation and requirements of the regulations contained in this rulemaking package.
 - APTC Enrollee - The amendments in proposed Rule 1300.65(a)(1)

restate the definition of Advance Premium Tax Credit (APTC) Enrollee from current Rule 1300.65.2(a)(1). It also makes a technical, nonsubstantive change: replaces the phrase “the Affordable Care Act (“ACA”)” with “the federal Patient Protection and Affordable Care Act (“PPACA”) at...”

- Billed for the Charge - The amendments in proposed Rule 1300.65(a)(2) are necessary to restate and amend the provisions of current Rule 1300.65(a)(3), to clarify the meaning of “Billed for the Charge” and to add language regarding the consequences for not paying premiums. This provides necessary clarity to impacted stakeholders of their responsibilities for notifying impacted enrollees, subscribers and group contract holders of their rights under the law. Proposed Rule 1300.65(a)(2), also renumbers the provision to reflect the revised organization of the proposed rules.
- Cancelled, Not Renewed, or Nonrenewal - Proposed Rule 1300.65 (a)(3) restates the provisions of current Rule 1300.65(a)(1)(A) through (D), without change, and renumbers the provision to reflect the revised organization of the proposed rules.
- Contractholder or Contract holder - Proposed Rule 1300.65(a)(4) restates the provisions of current Rule 1300.65(a)(2) without change, and renumbers the provision to reflect the revised organization of the proposed rules.
- Enrollee - Proposed Rule 1300.65(a)(5) addresses the problem of a previously undefined term, i.e., it defines “enrollee” consistent with its definition in section 1345(c). This definition is necessary for clarity and to prevent confusion amongst stakeholders and impacted parties who are affected by the proposed regulation.
- Enrollment or Subscription - Proposed Rule 1300.65(a)(6) restates current Rule 1300.65(a)(4), without change, and renumbers the provision to reflect the revised organization of the proposed rules.
- Exchange or Covered California - The amendments in proposed Rule 1300.65(a)(7) are necessary to address the clarity a previously undefined term, i.e., proposed Rule 1300.65(a)(7), is a new provision that defines “Exchange” or “Covered California” as used in the article. The amendment is crafted so the scope of the definition applies throughout the Article to avoid the need to redefine the term in each proposed rule. This definition provides clarity and is necessary for the proper understanding of the regulations for enrollees, subscribers, group contract holder and other impacted stakeholders.
- Federal Grace Period - Proposed Rule 1300.65(a)(8) restates the

provision in current Rule 1300.65.2(a)(2), describing the federal grace period as three consecutive months pursuant to the CFR, title 45, parts 156.270 and 155.430. This provides clarity and consistency with the federal law for impacted stakeholders and is necessary to clearly state the rights of enrollees to obtain this amount of time prior to a cancellation of enrollment and the obligations of health plans to provide this time to their enrollees.

- Grace Period - The amendments in proposed Rule 1300.65(a)(9) are necessary to define the term “grace period” as the period of at least 30 consecutive days beginning on the date of the Notice of Start of Grace Period. This amendment will give stakeholders, enrollees, subscribers, and group contractholders greater clarity in understanding their rights and obligations under the proposed regulations and ensure that enrollees are given the full amount of time to make a payment to prevent cancellation of enrollment.
- Grievance - The amendments in proposed Rule 1300.65(a)(10) are necessary to remove “Request for Review,” as defined in current Rule 1300.65(a)(13), and clarify that such written or oral expressions of dissatisfaction are “grievances.” Section 1365(b)(1) states that an enrollee, subscriber, and group contract holder who believes coverage was improperly canceled, rescinded, or not renewed may “request a review by the director pursuant to section 1368.” The reference to the enrollee, subscriber, and group contract holder’s right to request a review by the director in the current regulation has been misunderstood by impacted parties to mean the enrollee, subscriber, and group contract holder is entitled to a grievance right other than the process outlined in section 1368 and its corresponding regulations, contained in Rules 1300.68 and 1300.68.01. The plain language of section 1365(b)(1) references the grievance rights in section 1368 and its corresponding regulations for an enrollee, subscriber, and group contract holder. For consistency and clarity, the proposed amendment to Rule 1300.65(a)(10), amends the current regulation to remove the term, “Request for Review.” In its place, the proposed regulation, including proposed Rule 1300.65(a)(10), will refer to the right to request a review by the director as a “grievance,” as that term is used in section 1368 and its corresponding regulations. By using the term “grievance” both enrollees and health plans will gain a better understanding of their rights and obligations related to a cancellation, rescission or nonrenewal of a health plan contract. Further, the amendments reflected in the proposed rule clarify that the grievance right authorized under sections 1368 and 1365 shall be handled pursuant to the requirements of current Rule 1300.68.01. This

amendment is necessary because it clarifies the grievance procedure that governs cancellations, rescissions, and nonrenewals under this Article, and will prevent confusion concerning the rights and responsibilities of affected parties. The right to a grievance process is a fundamental right for health plan enrollees who believe their cancellation, rescission or nonrenewal was improper.

- Group contract holder - The amendments in proposed Rule 1300.65(a)(11) are necessary to restate the provisions of 1300.65(a)(6) without change, and reflect the organization of the proposed rules.
- Individual - Proposed Rule 1300.65(a)(12), restates the provisions of current Rule 1300.65(a)(7) without change, to reflect the revised organization of the proposed rules.
- Non-Suspension QHP Issuer - The amendments in proposed Rule 1300.65(a)(13) are necessary to address the currently undefined term. The term “Non-Suspension QHP Issuer” is a plan that does not pend claims for health care services provided to an enrollee in the second and third months of the federal 3-month grace period. The purpose of the provision is to define a new term to reflect that under part 156.270 of title 45 of the CFR, suspension of an enrollee receiving advanced premium tax credits in months two and three of the federal 3-month grace period is optional. The term “Non-Suspension QHP Issuer” will assist the Department, plans, providers, and enrollees in identifying and differentiating those plans that do not exercise the discretion to suspend enrollees during the federal 3-month grace period. This amendment is necessary because the rights and responsibilities of the parties differ depending on whether a health plan chooses to exercise the discretion to suspend.
- Nonpayment of premiums - Proposed Rule 1300.65(a)(14) restates current Rule 1300.65(a)(8), with the addition of the phrase, “or portion of premium.” This amendment is necessary to clarify how the term is interpreted and prevents confusion amongst impacted parties who may not understand that it applied to portions of premiums and not just the total amount of the premium when dealing with cancellations of enrollment.
- Notice of Cancellation, Rescission, or Nonrenewal - Proposed Rule 1300.65(a)(15) renumbers and restates current Rule 1300.65(a)(11), to reflect the revised organization of the proposed rules. It also includes a nonsubstantive change to update internal references: the phrase “as permitted under this section or section 1300.89.21 of this title, or section 1365 or 1389.21 of the Act” has been replaced with “as permitted under

California Code of Regulations, title 28, sections 1300.65.1, 1300.89.21, or Health and Safety Code Sections 1365 or 1389.21.”

- Notice of End of Coverage - The amendments in proposed Rule 1300.65(a)(16) define a new notice, the “Notice of End of Coverage.” This notice is necessary to address the question of whether plans are required to provide enrollees, subscribers, or group contract holders with a final notice that their health care coverage has ended. The Department is adding this requirement because of enrollee and health plan confusions regarding the obligations to send a notice when coverage is ending. This new notice is similar to one currently required for health care coverage purchased on the California Health Benefit Exchange pursuant to section 6506(e) of title 10 of the CCR. The addition of this notice in the proposed rules implements an existing notice requirement, and serves to benefit the enrollees by providing the final notice to the enrollee, subscriber, or group contract holder that health coverage has ended and prevents confusion regarding the rights and responsibilities that occur upon a notice that coverage has ended.
- Notice of Start of Federal Grace Period - Proposed Rule 1300.65(a)(17) restates current Rule 1300.65(a)(10). In addition, proposed Rule 1300.65(a)(17), amends the current regulation to change the name of the notice from “Notice of Cancellation for Nonpayment of Premiums and Grace Period” to “Notice of Start of Federal Grace Period,” and in so doing, distinguishes the notice APTC enrollees receive from the notice all other enrollees receive in this instance. The name change clarifies the key purpose of the notice, which is to notify the recipient enrollee, subscriber, or group contract holder that nonpayment of the required premium has triggered the start of a federal grace period and the rights and obligations of the enrollee during this federal grace period. Further, the proposed rule renumbers the provision to reflect the revised organization of the proposed rules.
- Notice of Start of Grace Period - Proposed Rule 1300.65(a)(18) restates current Rule 1300.65(a)(10). In addition, proposed Rule 1300.65(a)(18), amends the current regulation to change the name of the notice from “Notice of Cancellation for Nonpayment of Premiums and Grace Period” to “Notice of Start of Grace Period.” The name change clarifies the key purpose of the notice, which is to notify the recipient enrollee, subscriber or group contract holder that nonpayment of the required premium has triggered the start of a grace period and the rights and responsibilities of the enrollee during this grace period. Further, the proposed rule renumbers the provision to reflect the revised organization of the

proposed rules.

- Notice-unique identification number - The addition of proposed Rule 1300.65(a)(19) is necessary to address a currently undefined term, by defining a “notice-unique identification number” as a number that is unique to the type of notice, subject to federal law or guidance. The purpose of this definition is to clarify an element in a required notice, thus making compliance with the requirement more understandable for the impacted stakeholders. The Department has added this definition because of confusion within the industry regarding the meaning of the notice-unique identifier. This definition will assist the enrollee and the health plans when a notice is sent or received to understand their rights and obligations depending on the type of notice in question.
- Outstanding premium - The addition of proposed Rule 1300.65(a)(20) is necessary to address a previously undefined term, by defining “outstanding premium” as the total premium amounts that have been duly billed and are past due by the enrollee, subscriber or group contract holder. The purpose of this definition is to clarify which premium amounts are required for notice and reinstatement purposes, and to prevent confusion regarding the obligations of the impacted enrollee, subscriber or group contract holder. The Department has added this definition because it is necessary for health plans and enrollees to have a clear understanding of the meaning of a premium in circumstances involving health plan contracts.
- Plan - The addition of proposed Rule 1300.65(a)(21) is necessary to restate that “plan” is used in this Article as it is defined in section 1345(f) and is necessary for consistency in the proposed regulations. By defining this term, the Department is preventing any confusion as to its application and meaning throughout the regulations.
- Premium payment threshold policy - The amendments in proposed Rule 1300.65(a)(22) are necessary to establish that notwithstanding proposed Rule 1300.65(a)(14), a plan may implement a premium payment threshold policy in order to consider an enrollee, subscriber or group contract holder to have paid all amounts due if the enrollee pays an amount sufficient to maintain a percentage of total premium owed equal to or greater than a level prescribed by the plan. This level is required to be reasonable and the level and policy shall be applied in a uniform manner to all enrollees, subscriber or group contract holders. This amendment is necessary to align the authority provided by federal law to permit state-based exchanges to allow plans to implement a premium payment threshold, pursuant to part 155.400(g), title 45 of the CFR, and

to prevent confusion by health plans when reviewing premiums paid by enrollees, subscribers or group contract holders.

- QHP Issuer - The addition of proposed Rule 1300.65(a)(23) is necessary because current Rule 1300.65.2(a)(3) does not differentiate between a QHP Issuer and a QHP Issuer plan contract. The benefit of this definition is it clarifies the definition of a QHP Issuer. The proposed amendment also clarifies that any of the requirements contained in Rules 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 that are delegated by a QHP Issuer to a delegated group shall also apply to that delegated group.
- Qualified health plan or QHP - The addition of proposed Rule 1300.65(a)(24), is necessary because current Rule 1300.65.2(a)(3) does not differentiate between a QHP Issuer and a QHP contract. The benefit and necessity of this definition is the amendment clarifies a QHP is a plan contract; and that, a QHP Issuer is the health care service plan that offers the plan contract on the Health Exchange thereby preventing confusion by impacted stakeholders in understanding their obligations under these regulations.
- Rescission or rescind - Proposed Rule 1300.65(a)(25) renumbers and restates current Rule 1300.65(a)(12). It also includes a technical, nonsubstantive change: it replaces the phrase “as defined in section 1300.89.21 of this title” with “as defined in California Code of Regulations, title 28, section 1300.89.21.”
- Small employer - Proposed Rule 1300.65(a)(26) restates current Rule 1300.65(a)(14), without change, to reflect the revised organization of the proposed rules.
- Suspension QHP Issuer - The addition of proposed Rule 1300.65(a)(27) is necessary to address an undefined term and defines the term “Suspension QHP Issuer” as a plan that pends claims for health care services rendered to the enrollee, subscriber or group contract holder in the second and third months of the federal grace period, pursuant to part 156.270 of title 45 of the CFR. The purpose of the section is to clarify a new term to reflect that under part 156.270 of title 45 of the CFR, suspension of an enrollee, subscriber or group contract holder receiving APTC in months two and three of the federal 3-month grace period is optional. The term “Suspension QHP Issuer” will assist the Department, plans, providers, and enrollees in identifying and differentiating those plans that exercise the discretion to suspend enrollees, subscriber, or group contract holders during the federal 3-month grace period. This amendment is necessary because the rights and responsibilities of the parties are different depending on whether a QHP Issuer chooses to

exercise the discretion to suspend.

2. Subdivision (b) contains the revised grievance provisions, as follows:

- The amendments in proposed Rule 1300.65(b)(1), restate current Rule 1300.65(d)(1) and also amend it to replace the phrase “from date of the Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal” with “from date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper.” This amendment clarifies that more than one type of notice can trigger a grievance and the corresponding rights and responsibilities of the plan, enrollee, subscriber, and group contract holder under the grievance provisions.
- The amendments in proposed Rule 1300.65(b)(2), restate current Rule 1300.65(d)(2) and also amend the language to add the following sentence at the beginning of the paragraph: “A grievance of an enrollee, subscriber, or group contract holder to the plan shall be processed pursuant to California Code of Regulations, title 28, section 1300.68.01.” Proposed Rule 1300.65(b)(2), also replaces “Request for Review” with “grievance” wherever it appears in the paragraph for consistency with the other proposed amendments in the rulemaking package. This amendment clarifies which rule governs the grievance process and the rights and obligations of the stakeholders under those rules. It also clarifies that section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) shall not exempt a plan from complying with any requirement for written acknowledgement and response to an enrollee’s grievance. The amendments in proposed Rule 1300.65(b)(3), amend current Rule 1300.65(d)(3), to replace “Request for Review” with “grievance from an enrollee, subscriber, or group contract holder,” and to clarify that the Director shall determine whether the request is timely, complete, and within the Director’s jurisdiction prior to accepting it for review. The term “Right to Request Review” is replaced with the term “grievance” for the reasons previously discussed, and is necessary for clarity and to allow the impacted parties to understand their rights and responsibilities under the proposed rules.
- The amendments in proposed Rule 1300.65(b)(4) restate current Rule 1300.65(d)(4), and amends it to replace “Request for Review” with “Grievance from an enrollee, subscriber or contract holder,” replaces “Within five (5) calendar days” with “within 24 hours of receipt” consistent with section 1368.01, and adds a reference to Rule 1300.68(g)(1) through (6). The term “Right to Request Review” is replaced with the term

“grievance” for the reasons previously discussed. The proposed amendments to this subdivision are necessary to clarify the timing of a grievance and to clearly state the rights and responsibilities of the impacted parties when a grievance is received and processed.

- The amendments in proposed Rule 1300.65(b)(5) restate current Rule 1300.65(d)(5), amend it to replace “Request for Review” with “grievance,” and update the reference to subdivision (c) of the proposed rule. The term “Right to Request Review” is replaced with the term “grievance” for the reasons previously discussed and is necessary for clarity of the term and to allow the impacted parties to understand their rights and responsibilities for grievances under the proposed rules.
 - The amendments in proposed Rule 1300.65(b)(6) restate current Rule 1300.65(d)(6), amend it to replace “Request for Review” with “grievance,” and clarify that the written notification is done pursuant to section 1368(b)(5). The term “Right to Request Review” is replaced with the term “grievance” for the reasons previously discussed, above, and is necessary to ensure the impacted parties understand their rights and responsibilities under the proposed rules.
 - The amendments in proposed Rule 1300.65(b)(7) restate and amend Rule 1300.65(d)(7) to clarify that reinstatement will be ordered if the Director determines the cancellation, rescission or nonrenewal fails to comply with all legal requirements, including but not limited to all notice and timing requirements in this article. This amendment is necessary so the impacted parties understand the Director’s authority with respect to reinstatement if a cancellation, rescission or nonrenewal is prohibited under the law and what can occur if the Director makes this determination.
 - Proposed Rule 1300.65(b)(8), restates current Rule 1300.65(d)(8) without change. It renumbers the provision to reflect the revised organization of the proposed Rules.
3. Subdivision (c) contains the continuation of coverage provisions, as follows:
- The amendments in proposed Rule 1300.65(c)(1) restate and amend current Rule 1300.65(e)(1) to change “Request for Review” to “grievance” where it appears in the paragraph, and to make non-substantive clarifying changes. This is done for consistency and clarity for health plans, enrollees, subscribers and group contract holders so they understand their rights and obligations under the grievance provisions. In addition, the amendments include a renumbering of the provision to reflect the revised organization of the proposed Rules. The term “Right to Request

Review” is replaced with the term “grievance” for the reasons previously discussed. The amendments in proposed Rule 1300.65(c)(2) are necessary to restate the provisions of current Rule 1300.65(e)(2), without change, to reflect the revised organization of the proposed rules.

- The amendments in proposed Rule 1300.65(c)(3) are necessary to restate and amend current Rule 1300.65(e)(3). The purpose is to renumber the provision and change the internal references to reflect the revised organization of the proposed rules. The amendments also eliminate inaccurate references to rescission to provide clarity as to the circumstances of its application and prevent confusion amongst the parties impacted by the regulations.
 - The addition of proposed Rule 1300.65(c)(4) is necessary to state the requirements for continuation of coverage for rescissions, which are different from the requirements for cancellation or nonrenewal, as noted in the bullet above. The purpose of the amendment is to clarify the requirements if the Director upholds a rescission decision by a plan and the obligations of the enrollee, subscriber or group contract holder if such a decision is made.
4. Subdivision (d) contains the reinstatement of coverage provisions, as follows:
- The amendments in proposed Rule 1300.65(d)(1) are necessary to restate the provisions of current Rule 1300.65(f)(1), and to amend them to replace “Request for Review” with “grievance.” This is done for clarity and to ensure that all parties to the regulation understand their rights and obligations under this provision as previously discussed. The amended subdivision reflects the revised organization of the proposed rules.
 - The amendments in proposed Rule 1300.65(d)(2) restate and amend the provisions of current Rule 1300.65(f)(2), changing “may request” to “shall either.” This change is necessary to be consistent with Health and Safety Code section 1365(b)(3), which states “[w]ithin 15 days after receipt of that order, the health care service plan shall request a hearing or reinstate the enrollee or subscriber.” By making this amendment, the Department is preventing confusion or misinterpretation of these provisions of the Knox-Keene Act.
 - The amendments in proposed Rule 1300.65(d)(3) are necessary to restate and amend the provisions of current Rule 1300.65(f)(3). The purpose is to clarify that the deductibles, copayments, or coinsurance are the enrollee’s responsibility pursuant to the enrollee’s Evidence of Coverage, and to clarify that the plan shall contact providers to reconcile any completed claims in order to reimburse the enrollee, subscriber, or

group contract holder. The amendments also renumber the provision to reflect the revised organization of the proposed rules.

- The amendments in proposed Rule 1300.65(d)(4) are necessary to restate and amend the provisions of 1300.65(f)(4), to clarify that an enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the date of cancellation and to renumber the provision to reflect the revised organization of the proposed rules. This amendment will ensure that enrollees, subscribers, and group contract holders understand their obligations to pay for their health care coverage.
5. Subdivision (e) contains the applicability provision, as follows:
- The amendments in proposed Rule 1300.65(e) are necessary to restate the provisions of current Rule 1300.65(g), without change, to reflect the revised organization of the proposed rules.
6. Subdivision (f) contains the format and transmission requirements for notices, as follows:
- The amendments in proposed Rules 1300.65(f)(1) through (3) are necessary to restate, reorganize, and clarify the provisions of current Rules 1300.65(c)(1)(A) through (C), which deal with format and transmission requirements of the required notices within this Article. The purpose of the amendments is to clarify the requirements under the proposed rules are applicable to all notices under this Article unless otherwise stated. In addition, amendments constituting clarifying and non-substantive changes were made to eliminate redundancies in the text of the proposed regulation and to prevent confusion amongst parties when reading the proposed regulation.
 - The amendments in proposed Rule 1300.65(f)(4) are necessary to avoid restating the requirement that notices appear in at least 12 point font in each proposed rule. This ensures that parties receiving the notices are able to clearly read the information contained in the notices.
- B. Amendments to Rule 1300.65.1 will interpret, implement, and make more specific the terms and requirements set forth in section 1365. Current Rule 1300.65.1 contains the Form to Request a Review of Cancellation, Rescission, or Nonrenewal of Plan Contract. The proposed rules amend and relocate this form to Rule 1300.65.4. Proposed Rule 1300.65.1 contains provisions regarding Enrollee Cancellations, Rescissions, or Nonrenewal for Reasons Other than Nonpayment of Premiums.

1. Subdivision (a) provides the general requirements of this Rule, as follows:
 - The amendments in proposed Rule 1300.65.1(a)(1) are necessary to state that the Rule is applicable to all cancellations for reasons other than the nonpayment of premiums. This amendment aligns this proposed rule with the overall organization of the Article, and provides clarity for the types of cancellations falling within the scope of this proposed rule.
 - The amendments in proposed Rule 1300.65.1(a)(2), and 1300.65.1(a)(2)(A) through (C) are necessary to restate the provisions of current Rule 1300.65(c)(4)(B), and current Rule 1300.65(c)(4)(B)(i) through (iii), to reflect the revised organization of the proposed rule. The revised language also contains two amendments. First, the provisions are amended to replace the word “termination” with “cancellation” where it appears, for the purpose of using “cancellation” consistent with proposed Rule 1300.65(a)(2). This will prevent confusion and ensure consistency within the Article. Second, the language is amended to delete “no later than” from 1300.65.1(a)(2)(A), for the purpose of making a non-substantive change to eliminate a redundancy.
 - The amendments in proposed Rule 1300.65.1(a)(2)(D) are necessary to add the general requirements for withdrawals of a plan from the market pursuant to section 1365(a)(5). This addition is necessary to correct an omission from the current rule and provide clarity as to the requirements for a withdrawal.
 - The amendments in proposed Rule 1300.65.1(a)(3) restate the second sentence of 1300.65(c)(5). Proposed Rule 1300.65(a)(3)(A) through (B) restates the provisions of current Rule 1300.65(c)(5)(i) through (iii). These provisions are necessary to restate these provisions, without change, to reflect the revised organization of the proposed rule.
 - Proposed Rule 1300.65.1(a)(4) defines a new notice, “Notice of End of Coverage.” This notice and its requirements address the current rule’s lack of a final notice to inform enrollees, subscribers, or group contract holders that their coverage has ended, and to ensure that these impacted parties have a clear understanding of what has occurred and what it means for their health care coverage. The purpose of the proposed rule is to describe the requirements of this new notice.
 - Proposed Rule 1300.65.1(a)(5) is necessary because current rules do not contain a requirement that certain plans shall send a Notice of Termination to the Exchange when there has been a cancellation of coverage. The purpose of this addition is to make Knox-Keene Act requirements consistent with Covered California requirements when

applicable, and is necessary to prevent confusion. The Department finds it necessary to implement this requirement because of problems that could arise if this notice is not sent to the Exchange.

- Proposed Rule 1300.65.1(a)(6) is necessary to clarify that both the Notice of Cancellation, Rescission, or Nonrenewal, and the Notice of End of Coverage must contain language informing the enrollee as to the availability of the right to request completion of covered services pursuant to section 1373.96(m), as amended by Senate Bill No. 133 (Stats. 2017, ch. 481).
2. Subdivision (b) enumerates the elements for the required notices under this Rule, as follows:
- The amendments in proposed Rule 1300.65.1(b)(1) are necessary to address that in the current rule it is not clear what elements are required to be included in each type of notice. The proposed rule sets forth the elements required to be included in a Notice of Cancellation, Rescission or Nonrenewal, with the purpose of clarifying and streamlining the requirements for this notice and preventing plan confusion and ensuring that enrollees receive the type of information necessary under each type of notice.
 - The amendments in proposed Rule 1300.65.1(b)(2) are necessary to address that in the current rule it is not clear what elements are required to be contained in each type of notice. The proposed rule sets forth the elements required for an End of Coverage Notice, with the purpose of clarifying and streamlining the requirements for this type of notice and to prevent health plan confusion as to what information must be included in each notice that is sent to an enrollee.
- C. Amendments to Rule 1300.65.2 will interpret, implement, and make specific the terms and requirements set forth in section 1365. Current Rule 1300.65.2 sets forth the requirements for Suspension of Coverage Under Federal Grace Period for Nonpayment of Premiums, Notice Requirements. The proposed regulatory action amends and relocates these provisions to proposed Rule 1300.65.3. Proposed Rule 1300.65.2 now sets forth the requirements for Cancellations and Nonrenewals for Nonpayment of Premiums.
1. Subdivision (a) provides the general requirements of this Rule, as follows:
- The amendments in proposed Rule 1300.65.2(a)(1) are necessary to state that the section is applicable to all cancellations and nonrenewals for the nonpayment of premiums. This amendment aligns this proposed

rule with the overall organization of the Article, and serves to identify the particular types of cancellations, rescissions, and nonrenewals that are within the scope of this proposed Rule. This will prevent confusion as to its application by the impacted parties and ensure all impacted parties understanding their rights and obligations regarding types of cancellations, rescissions and nonrenewals of health plan contracts.

- The amendments in proposed Rule 1300.65.2(a)(2)(A) are necessary to restate and amend the first two sentences of current Rule 1300.65(a)(5) to clarify the meaning of a grace period. The amendment also clarifies when a grace period starts, stating that the grace period begins on the date of the Notice of Start of Grace Period, and that it may not start until after the later occurrence of the following: the day after the premium is due, and the day after the last date of paid coverage. This amendment is necessary to bring the length of the grace period in alignment with the 30-day requirement in section 1365(a)(1)(A) and to ensure that enrollees, subscribers, and group contract holders have a complete understanding of the meaning of grace period and receive the full benefit of their required grace period.
- The amendment to the first sentence of proposed Rule 1300.65.2(a)(2)(B) is necessary to restate the provisions of current Rule 1300.65(c)(3)(A)(ii). The amendment in the second sentence of proposed Rule 1300.65(a)(2)(B), restates the second sentence of current Rule 1300.65(a)(5) with minor technical and nonsubstantive changes for clarity.
- The addition of proposed Rule 1300.65.2(a)(3)(A) is necessary to clarify the requirements for the Notice of Start of Grace Period, and to clearly identify the type of required notice as the “Notice of Start of Grace Period.” The name of the notice is changed from its previous name, “Notice of Cancellation,” pursuant to current Rule 1300.65(c) and is necessary for consistency in the Article. The name change and the accompanying enumerated elements will better clarify to all parties that the date of this notice is the trigger for the start of the required 30-day grace period thereby ensuring enrollees have a clear understanding of what will occur if obligations regarding payment of premium are not met.
- The addition of proposed Rule 1300.65.2(a)(3)(B)(i) through (ii) restates the second sentence of current Rule 1300.65(c)(5), as well as current Rule 1300.65(c)(5)(i) through (ii), to make clarifying, nonsubstantive changes, and to update the name of the notice. This amendment is necessary to reflect the revised organization of the proposed rule.
- The addition of proposed Rule 1300.65.2(a)(3)(C) is necessary to restate

the second sentence of current Rule 1300.65(c)(3)(A)(i). The proposed Rule also amends the current rule to update the section reference. This amendment is necessary to reflect the revised organization of the proposed rule.

- The addition of proposed Rule 1300.65.2(a)(3)(D) is necessary to clarify that when a plan delegates the responsibility for sending the Notice of Start of Grace Period to a group contract holder, the Notice of Start of Grace Period sent to the group contract holder triggers the 30-day grace period. This will prevent confusion amongst subscribers in group contracts as to their grace period rights and responsibilities. In addition, the proposed Rule will clarify that any subsequent notice to the subscribers in the group does not restart the 30-day grace period.
- The addition of proposed Rule 1300.65.2(a)(3)(E) is necessary to address the lack of a final notice to enrollees, subscribers or group contract holders regarding the end of their health care coverage. The current regulation only requires notification of the potential prospective end of health coverage; however, it is necessary that enrollees, subscribers, and group contract holders are notified that their health care coverage has ended and what the end of coverage means for them. These requirements are consistent with the rules promulgated by the Exchange and with the purpose of section 1365 to provide enrollees, subscribers, and group contract holders with the final notice and an opportunity to restore their health care coverage. The specific purpose of Proposed Rule 1300.65(a)(3)(D), is to describe the requirements of this new type of notice, including the timeframe in which to send the notice. The benefit is a greater transparency and less confusion for a plan to comply with the obligations of this particular notice requirement.
- The addition of proposed Rule 1300.65.2(a)(3)(F) is necessary to ensure consistency in the regulation's requirements with Exchange requirements, when applicable. The purpose of the proposed Rule is to inform plans that they may be required to send a Notice of Termination to the Exchange pursuant to section 6505(e), title 10 of California Code of Regulations. This proposed rule will clarify the notification obligations for plans.
- The amendments in proposed Rule 1300.65.2(a)(4) are necessary to establish that notwithstanding proposed Rule 1300.65(a)(15), a plan may implement a premium payment threshold policy. This adds clarity to the plans as to when a cancellation is required and is consistent with the other proposed amendments in the Article.
- The addition of proposed Rule 1300.65.2(a)(5) is necessary to restate

and amend the provisions from current Rule 1300.65(c)(3)(A)(iii), by adding “after compliance with all timing and notice requirements of this section” between “plan” and “fails,” by changing “past due” to “outstanding,” and by changing the name of the notice to the Notice of Start of Grace Period. These changes are necessary to clearly explain the circumstances in which a plan may cancel the coverage of an enrollee, subscriber, or group contract holder.

- The addition of proposed Rule 1300.65.2(a)(6) is necessary to rewrite and clarify the provisions from current Rule 1300.65(c)(3)(F). This provisions clarifies when a grace period ends and will prevent confusion amongst plans, enrollees, subscribers and group contract holders as to the timing requirements of the required grace period.
 - The addition of proposed Rule 1300.65.2(a)(7) is necessary to restate and amend current Rule 1300.65(c)(3)(A)(iv). The proposed rule adds “[e]xcept for cases where the Director has ordered reinstatement pursuant to California Code of Regulations, title 28, section 1300.65, subdivision (d)(3)” to the start of the paragraph for the purpose of making the section consistent with proposed Rule 1300.65(d)(3). The second amendment to the proposed rule changed the phrase “including those incurred during the grace period” to “obligated under the plan contract for services received during the grace period.” The purpose of the second amendment is to make a non-substantive, clarifying change to prevent confusion or misunderstanding of the requirements of the rule.
2. Subdivision (b) enumerates the required elements contained in the notices under this Rule, as follows:
- The amendments in proposed Rule 1300.65.2(b)(1) are necessary to enumerate the required elements for a Notice of Start of Grace Period. The purpose of the amendment is to clarify and streamline the requirements for this type of notice, which will assist plans in complying with the notice requirement and provide enrollees, subscribers, and group contract holders with proper notification of the status of their health care coverage.
 - The amendments in proposed Rule 1300.65.2(b)(2) are necessary to set forth the required elements in the Notice of End of Coverage. Its purpose is to clarify and streamline the requirements for this notice. This will assist plans in complying with the notice requirement and provide enrollees, subscribers, and group contract holders with proper notification of the status of their health care coverage.

D. Amendments to Rule 1300.65.3 will interpret, implement, and make more specific the terms and requirements for the notice, grace period and other provisions for enrollees receiving APTC pursuant to federal law, as set forth in section 1365, section 18082 of title 42 of the USC, and part 156.270 of title 45 of the CFR.

1. Subdivision (a) provides the general requirements of this Rule, as follows:

- The addition of proposed Rule 1300.65.3(a)(1) states that the section is applicable to all cancellations for the nonpayment of premiums for enrollees receiving the APTC. This amendment aligns this Rule to the overall organization of the Article and identifies the types of cancellations within the scope of this proposed Rule.
- The addition of proposed Rule 1300.65.3(a)(2)(A) is to restate the provision in current Rule 1300.65.2(a)(2), stating that an enrollee shall pay at least one full month's premium before any nonpayment of premiums to qualify for the federal grace period. This is necessary to ensure the enrollee understands their obligations concerning payment of premiums. This section omits the phrase "benefit year" from the language in current Rule 1300.65.2(a)(2), for clarity purposes.
- The addition of proposed Rule 1300.65.3(a)(2)(B) is necessary to address the lack of a clear designation for the start of the federal grace period, and clarifies that the 3-month federal grace period "begins the first day after the last day of paid coverage and lasts for three full consecutive months." The clarification of the start date of the federal grace period will remove any question of when a plan may begin, suspend, or end an enrollee's health care coverage.
- The addition of proposed Rule 1300.65.3(a)(2)(C) is necessary to establish that notwithstanding current Rule 1300.65(a)(15), a plan may implement a premium payment threshold policy. This is consistent with other proposed amendments in this Article and will prevent confusion as to a plan's options for non-payment of premiums
- The addition of proposed Rule 1300.65.3(a)(2)(D) is to clarify the notice requirements for the Notice of Start of Grace Period for an APTC Enrollee, and to identify the name of the required notice as the "Notice of Start of Grace Period." This type of notice is referenced as a notice of non-payment of premium in part 156.270, subdivision (f), title 45 of the Code of Federal Regulations. Naming this previously unnamed notice requirement, in combination with the newly enumerated elements, will clarify that this type of notice informs the enrollee that his or her payment delinquency has resulted in the start of the federal grace period. This

notice requires the enrollee to act in order to avoid losing health care coverage. The purpose of the amendment is to clarify and streamline the requirements for this type of notice and assisting plans in complying with the notice requirement and providing enrollees with proper notification of the status of his or her health care coverage.

- The addition of proposed Rule 1300.65.3(a)(2)(E) is to address the lack of specificity regarding when the Notice of Start of Grace Period must be sent by a plan to its enrollee. This amendment is necessary to prevent enrollees from being uninformed about the status of their health care coverage due to a plan's delay in sending the notice, which may reduce the time for the enrollee to cure any payment delinquency that triggered the start of the grace period. The proposed rule clarifies that the notice of start of grace period may not begin until after the premium due date passes. The proposed rule also clarifies that the plan has five calendar days from the start of the grace period to provide the required notice to the enrollee, which is consistent with the goal of providing enrollees with as much notice as possible so the enrollee can cure any payment delinquency. The proposed rule also adds a provision stating that if a plan learns of a payment delinquency after the last day of paid coverage due to the discovery of insufficient funds, a rejected credit card payment, or another similar event, the plan shall send the Notice of Start of Grace Period between the last day of paid coverage and the fifteenth (15th) day of the first month of the grace period. This additional provision addresses the potential problems associated with the proposed timeframe in circumstances relating to electronic payments, i.e., since it is likely that the discovery of a payment delinquency of an electronic payment will not align with a plan's monthly billing cycle, this language sets up an alternate timeframe for the plan to send the required notice. The benefit of this alternate timeframe is that plans may comply with the timing requirements of the proposed Rule even when they are unable to discover the payment delinquency under atypical circumstances due to electronic billing issues. In other words, the benefit of this alternate timeframe is that it allows plans to comply with the notice requirement even when a plan learns of a payment deficiency after it is too late to comply with the default timeframe for providing notice.
- The addition of proposed Rule 1300.65.3(a)(3)(A) is to address any perceived inconsistency between the current regulation and federal law regarding the suspension of an enrollee's health care coverage during months two and three of the federal 3-month grace period. Under current Rule 1300.65.2(b)(2)(A), suspension is mandatory; however, under CFR, title 45, part 156.270, subdivision (d)(1), suspension is optional, as

reflected in the use of the word “may” In the federal regulation. The benefit of this change is that plans wanting to provide enrollees with the greater protection against losing health care coverage through a lengthier 3-month grace period (to cure any payment deficiency) may do so, consistent with federal law. The relevant provisions in the current rule addressing suspension of coverage are amended to reflect the change from mandatory suspension to optional suspension, of the latter two months of the federal 3-month grace period.

- The addition of proposed Rule 1300.65.3(a)(3)(B) is to clarify that any plan that chooses not to suspend coverage during the second and third months of the 3-month federal grace period must provide coverage to the APTC enrollee for the entire 3-month grace period as required by the plan contract. In addition, the proposed rule provides that plans declining to suspend coverage are prohibited from taking or threatening action against the enrollee that causes or suggests that health care coverage is suspended. This restriction is necessary to deter plans that do not fully comply with the federal requirements regarding suspension from misrepresenting to enrollees that their health care coverage is suspended. The benefit of this provision is that it requires plans who wish to suspend health care coverage to comply with the suspension requirements as established under federal law and codified under proposed Rule 1300.65.3(a)(3)(C). This offers the greatest protection for enrollees and providers when there is any risk the plan will not reimburse for health care claims received for covered services.
- The addition of proposed Rule 1300.65.3(a)(3)(C) is based on current Rule 1300.65.2(b)(4), and addresses the risk that a plan will not reimburse providers, enrollees for claims for covered health care services during the 3-month grace period. Proposed Rule 1300.65.3(a)(3)(C) adopts the requirements under current Rule 1300.65.2(b)(2)(B) through (D), including the requirement that plans notify the enrollee’s health care providers about any suspension of coverage, and make system adjustments to the plan’s eligibility verification system to accommodate and correctly identify the suspension of coverage. The purpose of this provision is to reduce the risk that the plan will not reimburse (both the provider and the enrollee) for health care claims for covered services received during the grace period. The proposed Rule establishes that these eligibility provisions are required for a plan to suspend coverage, and any plan that is unable to comply shall not suspend, or attempt to suspend health care coverage for the enrollee.
- The addition of proposed Rule 1300.65.3(a)(3)(D) is to clarify the

requirements during the first month of the federal grace period for plans that are eligible to suspend and choose to suspend the health care coverage of enrollees. Proposed Rule 1300.65.3(a)(3)(D), adopts the requirements under current Rule 1300.65.2(b)(2)(B), specifying the requirement that a Notice of Suspension is sent to enrollees. The name of the notice has been revised from “Notice of Suspension of Coverage” in the current rule, to “Notice of Suspension” in the revised rule. Current Rule 1300.65.2(b)(1)(B), specifies that the Notice of Suspension of Coverage shall be provided if the enrollee fails to pay the premium by day 15 of the first month the federal grace period; however, it does not establish a due date for the notice to be sent. The proposed rule adds a deadline for sending the Notice of Suspension, i.e., the end of the first month of the federal grace period. It is necessary to reflect a timeframe for the Notice of Suspension to be sent between the 16th day of first month of the federal grace period and the end of the first month, providing a clear timeframe to the enrollee and provider for the notice of an upcoming suspension of health care coverage. The enrollee and providers will benefit from the notice about the upcoming suspension of an enrollee’s coverage and will better understand their rights and obligations once this type of notice is received.

- The addition of proposed Rule 1300.65.3(a)(3)(E) is to clarify the requirements during the second and third months of the federal grace period for plans that are eligible to suspend and choose to suspend health care coverage. Proposed Rule 1300.65.3(a)(3)(E) adopts the requirements under current Rule 1300.65.2(b)(2)(C), specifying the requirement that plans make adjustments to their eligibility verification system to correctly reflect the status of enrollees in a grace period. The adoption of the system adjustment requirement for a plan from the current regulation offers the greatest protection to enrollees and providers as it requires the plan, who is in the most knowledgeable position, to accurately and timely track the status of an enrollee’s health care coverage. This will benefit the parties involved by reducing the risk that the plan does not reimburse for claims for covered health care services due to miscommunication about the enrollee’s coverage status.
- The addition of proposed Rule 1300.65.3(a)(3)(F) is to restate the provisions in current Rule 1300.65.2(b)(3)(A) through (C). Non-substantive amendments were made to the proposed rule for organizational purposes.
- The addition of proposed Rule 1300.65.3(a)(3)(G) is to restate the provision in current Rule 1300.65.2(d)(2) through (5). Non-substantive

amendments were made to the proposed rule for organizational purposes.

- The addition of proposed Rule 1300.65.3(a)(4)(A) is to address the amount an enrollee is required to pay in order to leave the grace period and/or cure the payment delinquency resulting in the grace period. The proposed rule specifies that the plan shall bill the enrollee in the same form and manner of billing as is typically done for the enrollee. This proposed provision will prevent a plan from changing the billing process once an enrollee has a payment delinquency, and will benefit the enrollee by maintaining the typical billing process which the enrollee will easily recognize. This provision includes the total premiums owing at the end of the billing cycle for easy understanding by the enrollee. This provision maintains a plan's right to allow additional and alternative methods of billing.
- Proposed Rule 1300.65.3(a)(4)(B) restates current Rule 1300.65.2(e). The new rule replaces the use of "plan" with "QHP Issuer." In addition, the new rule changes the phrase "prior to the expiration of the federal grace period" to "at any time before the expiration of the federal grace period," in order to clarify that the delinquent enrollee can cure the nonpayment at any time before the end of the grace period.
- The addition of proposed Rule 1300.65.3(a)(4)(C), is to restate the provision in current Rule 1300.65.2(e)(2). In addition, language was added to require plans to contact providers to reconcile any completed health care claims to reimburse the APTC enrollee for expenses incurred. This amendment will ensure that enrollees receive a reimbursement from a plan in a timely manner. Non-substantive amendments were made to the proposed rule for organizational purposes.
- The addition of proposed Rule 1300.65.3(a)(5)(A) is to specify the timing for the end of the federal grace period. The proposed rule is based on current Rule 1300.65.2(f), which clarifies the plan's right to end the enrollee's health care coverage at the end of the federal grace period. However, the current rule does not specify the last day of the grace period. The proposed rule adds this necessary information and clarifies the last day of the federal grace period for enrollees whose grace period includes a suspension period, is "the day after the last day of the first month of the 3-month grace period." This amendment will benefit plans and enrollees by clarifying when an enrollee's health care coverage ends.
- The addition of proposed Rule 1300.65.3(a)(5)(B) is to address the absence of a clear ending date to the federal grace period. Like the preceding provision, this proposed rule is taken from current Rule

1300.65.2(f), which clarifies the plan's ability to cancel the enrollee's health care coverage at the end of the federal grace period. However, the current rule is silent about when the last day of the grace period is for enrollees with Non-Suspension QHP Issuers. The proposed rule states the grace period for enrollees with Non-Suspension QHP Issuers will be "the last day of the third month of the 3-month grace period." This amendment will benefit the plans and enrollees by clarifying when an enrollee's health care coverage ends.

- The addition of proposed Rule 1300.65.3(a)(5)(C) is to add the notice requirement for the Notice of End of Coverage. This notice is currently required for health care coverage purchased on the California Health Benefit Exchange pursuant to section 6506, subdivision (e)(1), of title 10 of the CCR. The addition of this notice in the proposed rules implements an existing notice requirement and benefits enrollees by providing the final notice that gives a clear understanding that health care coverage has ended.
 - The addition of proposed Rule 1300.65.3(a)(5)(D) is to state that QHP Issuers should send a Notice of Termination to the Exchange when required pursuant to California Code of Regulations, title 10, section 6506(e)(2). This ensures that the Exchange is receiving up to date current information regarding an enrollee's health care coverage status.
2. Subdivision (b) enumerates the elements for the required notices under this rule, as follows:
- The addition of proposed Rule 1300.65.3(b)(1) is to enumerate the elements required to be contained in the Notice of Start of Grace Period to APTC Enrollee. The purpose of the amendment is to clarify and streamline the requirements for this type of notice, which will help plans comply with the notice requirements and provide enrollees with proper notification and information regarding the status of his or her health care coverage.
 - The addition of proposed Rule 1300.65.3(b)(2) is to enumerate the elements of the required information for a Notice Start of Grace Period to the federal Department of Health and Human Services. The purpose of the amendment is to clarify and streamline the required information for this type of notice, which will assist plans in complying with the notice requirement under CFR, title 45, part 156.270, subdivision (d)(2).
 - The addition of proposed Rule 1300.65.3(b)(3) is to enumerate the required elements in the Notice of Start of Grace Period to the Exchange. The purpose of the amendment is to clarify and streamline the

requirements for this notice, which will assist plans in complying with the notice requirement and further implement provisions of the notice required under CCR, title 10, section 6506, subdivision (c)(3)(B).

- The addition of proposed Rule 1300.65.3(b)(4) is necessary to enumerate the required elements in a Notice of Suspension to APTC Enrollee. The purpose of the amendment is to clarify and streamline the requirements for this type of notice, which will assist plans in complying with the requirements and provide enrollees with proper notification of their health care coverage status.
- The addition of proposed Rule 1300.65.3(b)(5) is to enumerate the required elements in a Notice of Suspension to APTC Enrollee's Provider and is based on current Rule 1300.65.2(d). The purpose of the amendment is to clarify and streamline the requirements for this type of notice, which will assist in understanding their obligations and will implement the notice requirements contained in CFR, title 45, part 156.270, subdivision (d)(3).
- The addition of proposed Rule 1300.65.3(b)(6) is to enumerate the required elements in the End of Coverage Notice to the APTC Enrollee. The purpose of the amendment is to clarify and streamline the requirements for this type of notice, which will assist plans in complying with the notice requirement and provide enrollees with proper notification of their health care coverage status.

E. Proposed Rule 1300.65.4 will re-adopt the provisions in the current Rule 1300.65.1, "Form to Request for Review of Cancellation, Rescission, or Nonrenewal of Plan Contract," including the template form for enrollees, subscribers, and group contract holders to use to submit grievances to the Department. Proposed amendments to the grievance form template include the addition of several fields the Department has identified as necessary for the correct processing of grievances, including the contact information of the person(s) submitting the grievance. In addition, the proposed rule adds to the current regulations by clearly stating that enrollees, subscribers, and group contract holders are not required to use the template form to submit a grievance and specifies that grievances may be submitted by other methods.

1. Subdivision (a) - The addition of proposed Rule 1300.65.4(a) is to address the use of the term "Request for Review," in current Rule 1300.65.1. Section 1365(b)(1) states that an enrollee, subscriber, and group contract holder who believes coverage was improperly canceled, rescinded, or not renewed may "request a review by the director pursuant to Section 1368." The reference

to the enrollee, subscriber, and group contract holder's right to request a review by the Director in the current regulation has been misunderstood to mean the enrollee, subscriber, and group contract holder is entitled to a grievance right that is different from the process outlined in section 1368 and its associated regulations. The Department interprets section 1365 (b)(1)'s plain language reference to section 1368 to mean the grievance rights of the enrollee, subscriber, and group contract holder shall be handled pursuant to the requirements of section 1368 and its associated regulations. The proposed Rule 1300.65.4(a), and amends the existing regulation to removes usage of the term, "Request for Review." In its place, proposed Rule 1300.65.4(a) will refer to the right to request a review by the director as a "grievance," as that term used in the section 1368 and the regulations. This amendment is consistent with the other provisions in the proposed regulatory action.

2. Subdivision (b) - The addition of proposed Rule 1300.65.4(b) is to address any potential limitation for an enrollee, subscriber, and group contract holder in the submission of the grievance form. Current Rule 1300.65.1(b), provides that the enrollee, subscriber, and group contract holder "is not required to use the form below to initiate a [grievance]," but does not provide any information on whether some other form may be used to submit a grievance. Proposed Rule 1300.65.4(b), clarifies that enrollee, subscriber, and group contract holder are not required to use the template form and may submit a grievance in one of two (2) ways. Proposed Rule 1300.65.4(b)(1) and (2), enumerates the ways to submit a grievance: using the template form, or submitting any writing that contains all the required information set out in Proposed Rule 1300.65.4(d)(1) through (24), respectively.
3. Subdivision (c) - The addition of proposed Rule 1300.65.4(c) is to update the current Rule 1300.65.1(c)'s reference to the template grievance form. Proposed Rule 1300.65.4(c) adopts current Rule 1300.65.1(b), but amends the provision to update the reference. Specifically, proposed Rule 1300.65.4(c), adopts the current regulation's requirement that the plan shall make a grievance form readily available to its members; however, the subdivision amends the reference to the current template form. This subdivision now references Rule 1300.65.4(b), which list the three forms that an enrollee, subscriber, and group contract holder may use to submit a grievance.
4. Subdivision (d) - The addition of proposed Rule 1300.65.4(d) is to address what information is required to be submitted in the enrollee, subscriber, or

group contract holder's grievance. Proposed Rule 1300.65.4(d)(1) through (24), address this issue by enumerating twenty-four information fields that, if submitted, would constitute a proper and complete grievance. The twenty-four information fields listed in Proposed Rule 1300.65.4(d)(1) through (24), reflect the information the Department determined is necessary to properly process a grievance.

5. Subdivision (e) - The addition of proposed Rule 1300.65.4(e) is to address the absence of information fields in the template form contained in current Rule 1300.65.1(c). Proposed Rule 1300.65.4(e)'s template form updates the current template form by adding the necessary information requirements to process a grievance.

- Proposed Rule 1300.65.4(e)'s template form adds the following *information* to the current template form: (1) the Department's current telephone number, (2) the Department's updated fax number, and (3) the Department's Telecommunication Device for the Deaf (TDD) phone number.
- Proposed Rule 1300.65.4(e)'s template form adds the following *information fields* to the current template form: (1) enrollee, subscriber, and group contract holder's date of birth, (2) enrollee, subscriber, and group contract holder's daytime and evening telephone numbers, (3) enrollee, subscriber, and group contract holder's email address, (4) enrollee, subscriber, and group contract holder health plan member number, (5) enrollee, subscriber, and group contract holder's Group Identification number, if applicable, and (6) employer, if applicable, (7) Medi-Cal identification number, if applicable, (8) Medicare or Medicare Advantage identification number, if applicable, and (9) whether the enrollee, subscriber, and group contract holder submitting the grievance form has previously filed a complaint with another regulatory entity, such as Medi-Cal State Fair Hearing.
- Proposed Rule 1300.65.4(e)'s template form also adds the following *provisions* to the current template form: (1) voluntary statistical information regarding language and race/ethnicity, (2) medical release, (3) authorized assistant form, (4) complaint form instruction sheet, and (5) Information Practices Act of 1977 Notice.

F. Proposed Rule 1300.65.5 will adopt, with some edits, the model language in current Rule 1300.65(c)(6), notifying an enrollee, subscriber, or group contract holder of their right to submit a grievance regarding the cancellation, rescission, or nonrenewal of their health care coverage. Except for the removal of the term

and reference to “Right to Request Review,” the model language in the proposed rule will be identical to that in the current rule. The term “Right to Request Review” is replaced with the term “grievance” for the reasons previously discussed in this ISOR.

IV. BENEFIT OF THE REGULATION

The proposed regulations are intended to more clearly create a transparent, consistent, and predictable process for cancellation, rescission, or nonrenewal of health care coverage. All stakeholders, including the Department, plans, enrollees, subscribers, and providers, will benefit from these changes, as follows:

First, by reorganizing the regulations into six proposed rules, the Department clarifies which provisions apply to all types of cancellations, rescissions, or nonrenewals, and which provisions are specific to cancellations for nonpayment of premium for APTC enrollees, for nonpayment of premium in general, and for cancellations, rescissions, or nonrenewals for reasons other than nonpayment of premium. The new organization also clarifies required contents and timing of notices.

Second, the proposed regulations clarify when grace periods begin and end for all enrollees and subscribers.

Third, the proposed regulations bring the state requirements for notice, suspension, and cancellation of coverage for APTC enrollees in line with federal requirements.

Fourth, the proposed regulations streamline and clarify the model language.

Fifth, the proposed regulatory action updates the current regulations’ definitions section to define terms not currently defined in the Article but defined elsewhere in state and federal law.

Finally, the proposed regulations respond to identified questions and perceived inconsistencies in the current regulations by aligning state regulations with federal law and removing obsolete and unwieldy requirements.

In addition, the proposed regulatory action updates existing provisions with necessary amendments, including explicit timeframes for all types of required notices and grace periods. Furthermore, the necessary amendments provide clarification and make specific the requirements for the contents of each type of required notice, the prerequisites for sending such a notice, the method of transmission of the required notice, as well as the consequences for failing to provide the required notice and/or grace period to enrollees, subscribers, and group contract holders.

V. IDENTIFICATION OF EACH TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY OR REPORT CONSIDERED

No such studies or reports were considered in the drafting of the proposed and amended regulations.

VI. DOCUMENTS RELIED UPON

- A. California Health and Safety Code sections 1341, 1344, 1365, 1368, 1368.1, and 1389.21;
- B. Title 28 California Code of Regulations sections 1300.65, 1300.65.1, 1300.65.2, 1300.68, and 1300.68.01;
- C. Title 10, California Code of Regulations, section 6506;
- D. Title 45, Code of Federal Regulations, parts 156.270, 155.430, and 155.400;
- E. Public Health Service Act sections 2703 (42 USC § 300gg-2), 2712 (42 USC § 300gg-12), and 2742 (42 USC § 300gg-42);
- F. Department of Managed Health Care Director's Letter 10-K; and
- G. Title 42, United States Code section 18082.

VII. REASONABLE ALTERNATIVES TO THE REGULATION

The Department considered limiting the regulatory action to a less comprehensive series of amendments to the existing rules. However, because many of the identified issues, ambiguity, and problems resulting from inconsistencies, unidentified terms, and the organization of the existing provisions, the Department believes that re-organization of the regulation in conjunction with amendments to improve clarity will provide enrollees, subscribers, group contract holders, plans, and providers with the clearest communication of each party's rights and responsibilities regarding cancellations, rescissions, and nonrenewals of health care coverage.

The Department invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations and amendments during the rulemaking process. As part of this process, the Department must determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

VIII. ECONOMIC IMPACT

The Department has determined that the regulatory amendments will not have a significant statewide adverse economic impact directly affecting businesses because the amendments to the regulation are implementing current state and federal law. No additional economic impact should be incurred by the adoption of the proposed amendments and regulations.

IX. ECONOMIC IMPACT ANALYSIS

Pursuant to Government Code section 11346.2, the Director of the Department formally submits this rulemaking package in support of proposed amendments to sections 1300.65, 1300.65.1, and 1300.65.2, and the addition of 1300.65.3, 1300.65.4, and 1300.65.5 to title 28 of the California Code of Regulations.

Pursuant to Government Code section 11346.3(b)(1), all state agencies proposing to adopt, amend, or repeal a regulation that is not a major regulation or that is a major regulation proposed prior to November 1, 2013, shall prepare an economic impact analysis that assesses whether and to what extent it will affect the following:

A. Creation or Elimination of Jobs within California

The proposed amendments and additions to title 28 of the California Code of Regulations interpret, implement, and make specific current state and federal law. The amendments to sections 1300.65, 1300.65.1 and 1300.65.2, and the addition of sections 1300.65.3, 1300.65.4 and 1300.65.5 update the state regulatory scheme in conformity with the federal requirements under the PPACA and state law. The amendments and additions improve on the procedural requirements existing in current regulation by eliminating identified inconsistencies, ambiguity, and unintended consequences. The promulgation of the proposed regulatory amendments and additions will neither create nor eliminate jobs within the state of California, because the proposed regulatory action merely clarifies existing requirements for health plans when cancelling a consumer's health care coverage.

B. Creation of New Businesses or Elimination of Existing Businesses within the State of California

The proposed amendments and additions to the California Code of Regulation will neither create new businesses nor eliminate existing business. These regulations effect only Health Care Service Plans licensed under the Act, which are also subject to federal law under the PPACA, and are required to comply with state and federal rules related to cancellation, rescissions, and nonrenewal of health care service plan enrollment,

subscriptions, and contracts. As such, these regulations create no additional requirements that would affect businesses not licensed under the Act, and would not result in the elimination of existing health plan businesses.

C. Expansion of Businesses or Elimination of Existing Businesses Within the State of California

This regulation is intended to clarify and make specific the existing state and federal law for health plans under the Act. These plans are subject to federal law under the PPACA, and are required to comply with state and federal rules related to cancellations, rescissions, and nonrenewals. The substantive requirements in the proposed regulatory action are already required in existing law, and the regulatory action only updates the state regulatory scheme to remedy identified inconsistencies, ambiguity, and unintended consequences in the current regulation. Therefore, the Department determined this regulation will not significantly affect the expansion of businesses currently doing business within the State of California.

D. Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

The proposed regulatory action will provide health consumers with a consistent, timely, and predictable process when health coverage is canceled. Health Plan enrollees will also benefit from the regulatory action's updates to grievance processes. By clarifying the specific benefits that are required by both state and federal law, this regulation ensures consistency in health plans and health plan contracts, and allows consumers to obtain all the protections they are entitled to when their health coverage is at risk of cancellation. In clarifying and interpreting sections 1365 and 1389.21, and 45 Code of Federal Regulations parts 156.270 and 155.430, there will be no adverse effect on the health and welfare of California residents, worker safety, or California's environment.

The Department does not anticipate this regulatory action will have any impact on worker safety, or the state's environment.