From: DMHC Licensing eFiling

Subject: APL 21-025 – Newly Enacted Statutes Impacting Health Plans (2021 Legislative Session)

Date: Monday, December 20, 2021, 3:53 PM

Attachments: APL 21-025 – Newly Enacted Statutes Impacting Health Plans.pdf

Dear Health Plan Representative:

Please see attached All Plan Letter 21-025 regarding newly enacted statutory requirements for Health Care Service Plans (Plans) regulated by the Department of Managed Health Care (DMHC).

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: December 20, 2021

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 21-025 (OPL) Newly Enacted Statutes Impacting Health Plans (2021 Legislative Session)

This All Plan Letter (APL) outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).[1]

In this APL, the Office of Plan Licensing (OPL) identifies and discusses 15 bills enacted this session that may require plans to update Evidences of Coverage (EOCs), disclosure forms, provider contracts and/or other plan documents. Plans must review relevant plan documents to ensure those documents comply with newly enacted legislation. The DMHC expects plans to comply with all applicable statutes upon the statutes' effective dates.

This APL does not identify or address every newly enacted statutory requirement that may apply to plans. Plans should consult with their legal counsel to ensure compliance with all newly enacted statutes that may impact the plan. Discussion of each bill may be found in the APL on the pages identified below.

[1] Unless specifically indicated below, the newly enacted legislation does not apply to Medicare Advantage plans or Employee Assistance Program (EAP) plans and therefore these plans are not required to make the Compliance with 2021 Legislation Amendment filing.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by February 22, 2022, one filing to demonstrate or affirm compliance with all newly enacted statutory requirements discussed in this APL.

- Submit the filing via eFiling as an **Amendment** titled "**Compliance with 2021 Legislation.**"

- In the Compliance with 2021 Legislation Amendment filing, include an Exhibit E-1 (the "Compliance E-1") that addresses how the plan intends to comply with newly enacted legislation discussed below.

- Plan documents (EOCs, provider contracts, notices, etc.) must be consistent with newly enacted legislation and should be filed pursuant to the timelines and requirements of the Knox Keene Health Care Service Plan Act of 1975, as amended, (Health and Safety Code Section 1340, *et seq*.) (Act)[2] and other applicable laws. For example, plans on Covered California must file 2023 plan year documents according to timeframes set forth by Covered California and the DMHC. Plans do not need to refile previously filed and approved documents, unless otherwise directed by the DMHC.

- If you have questions regarding the applicable timelines for filing or other questions about the requirements of this APL, please contact your plan's assigned reviewer in the OPL.

1. AB 342 (Gipson, Ch. 436, Stats. 2021)—Colorectal Cancer Screening and Testing

Codified in Health and Safety Code § 1367.668.

a. Overview of the bill:

- Applies to all full service plans that offer commercial products. Excludes specialized plans and plans that offer only Medi-Cal products.

- Requires plans, on or after January 1, 2022, to cover, at zero cost-sharing, a colorectal cancer screening test assigned either a grade A or B by the United States Preventative Services Task Force (USPSTF). The required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory

[2] References to California Code of Regulations sections will be designated as "Rule," e.g., Rule 1300.67.1, and references to California Health and Safety Code sections will be designated as "Section," e.g., Section 1367.016.

test identified assigned either a grade A or B by the USPSTF shall also be provided without any cost-sharing.

- Allows plans that have coverage for out-of-network benefits to impose cost-sharing requirements for the items or services described in this Section that are delivered by an out-of-network provider.

b. Compliance and filing requirements:

- Affirm the plan will cover, at zero cost-sharing, a colorectal cancer screening test assigned either a grade of A or B by the USPSTF.

- Affirm the plan will also cover, at zero cost-sharing, the required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test identified assigned either a grade of A or B by the USPSTF.

- State either:

  - The plan reviewed its current Summaries of Benefits or other detailed cost-sharing documents (collectively referred to as "SOBs"), Disclosure Forms and EOCs, and those documents are consistent with the requirements of AB 342.

OR

  - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of AB 342. The plan will amend these documents to comply with AB 342 and file the documents per the Act's applicable timeframes.

2. AB 347 (Arambula, Ch. 742, Stats. 2021)—Step Therapy

Codified in Health and Safety Code §§ 1367.206, 1367.241 and 1367.244.

a. Overview of the bill:

- Applies to all plans that provide prescription drug coverage. This new law does not require or authorize a plan that offers Medi-Cal products to expand or limit the prescription drug coverage for those Medi-Cal products.

- Requires plans, on or after January 1, 2022, to expeditiously grant a request for a step therapy exception within the applicable time limits required by Section 1367.241 if a prescribing provider:

- determines use of the prescription drug required under step therapy is inconsistent with good professional practice for the provision of medically necessary covered services, while taking into consideration the enrollee's needs, medical history, and professional judgment and

- submits justification and clinical documentation supporting the provider's determination to the plan.

- Requires a plan to notify the prescribing provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, if a request for prior authorization or a step therapy exception is incomplete or additional clinical material information is necessary to make a coverage determination is needed. Once the requested information is received, the applicable time period to approve or deny a prior authorization or step therapy exception request, or to appeal, shall begin to elapse.

- Allows enrollees to appeal to the plan through existing grievance procedures pursuant to Section 1368 and provider to appeal a denial as permitted under the plan's existing utilization management procedures. The external exception request review process shall apply to a denial of a prior authorization or step therapy exception request.

- Requires a plan contract delegating utilization review or utilization management functions to include terms that require the contracted entity to comply with Sections 1367.206 and 1367.241.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective January 1, 2022. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

3. AB 457 (Santiago, Ch. 439, Stats. 2021)—Protection of Patient Choice in Telehealth Provider Act

Codified in Health and Safety Code §§ 1374.14 and 1374.141.

a. Overview of the bill:

- Applies to all plans except plans that offer only Medi-Cal products.

- Requires plans, on or after January 1, 2022, to comply with specified notice and consent requirements if the plans offer a service via telehealth to an enrollee through a third-party corporate telehealth provider.

- Requires plans that contract with third-party corporate telehealth providers to notify enrollees of their right to access their medical records and that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their primary care provider unless the enrollee objects.

- Requires a plan contract delegating responsibility of the provisions of this new law to require the entity with whom the plan is contracting to comply with Section 1374.141.

- Requires plans to submit information regarding third-party corporate telehealth providers in the annual timely access and annual network submission.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective January 1, 2022. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

- Report forms for submitting the annual data will be forthcoming and issued under a separate communication to the plans.

4. AB 570 (Santiago, Ch. 468, Stats. 2021)—Dependent Parent Care Coverage

Codified in Health and Safety Code §§ 1374.1 and 1399.845.

a. Overview of the bill:

- Applies to all plans that offer individual commercial products. Excludes specialized plans and plans who only offer Medi-Cal products.

- Requires plans, on or after January 1, 2023, that offer individual products that provide dependent coverage to make dependent coverage available to dependent parents or stepparents who live or reside within the plan's service area.

- Requires plans to provide enrollees, seeking to add their dependent parent or stepparent, with written notice about the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP).

b. Compliance and filing requirements:

- Affirm the plan's individual products that provide dependent coverage make coverage available to qualifying dependent parents or stepparent who live or reside within the plan's service area.

- Affirm the plan will provide enrollees, seeking to add their dependent parent or stepparent, with written notice about the HICAP.

- State either:

    - The plan reviewed its current SOBs, Disclosure Forms, EOCs and Enrollment Forms and those documents are consistent with the requirements of AB 570.

OR

    - The plan reviewed its current SOBs, Disclosure Forms, EOCs and Enrollment Forms, and those documents are not consistent with the requirements of AB 570. The plan will amend these documents to comply with AB 570 and file the documents per the Act's applicable timeframes.

5. AB 1184 (Chiu, Ch. 190, Stats. 2021)—Confidentiality of Medical Information

Codified in Civil Code §§ 56.05, 56.35 and 56.107.

a. Overview of the bill:

- Applies to all plans.

- Revises certain provisions in the Confidentiality of Medical Information Act to require plans, on or after July 1, 2022, to protect the confidentiality of a subscriber or enrollee's medical information, to not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care.

- Requires plans to direct certain communications regarding a protected individual's receipt of sensitive services directly to the protected individual receiving care.

- Requires plans to notify subscribers and enrollees that they may request a confidential communication in the following methods: (1) upon initial enrollment and annually thereafter upon renewal, (2) in the EOC, and (3) on the plan's website.

- Prohibits plans from disclosing medical information relating to sensitive health services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective July 1, 2022. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

6. SB 221 (Wiener, Ch. 724, Stats. 2021)—Timely Access to Care

Codified in Health & Safety Code §§ 1367.03 and 1367.031.

a. Overview of the bill:

- Applies to all plans.

- Codifies some of the timely access standards adopted in regulation by the DMHC.

- Requires, on or after July 1, 2022, that nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. This language does not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

- Adds references to mental health and substance use disorder providers to other provisions in Section 1367.03.

- Requires plans to ensure they have sufficient numbers of contracted providers to maintain compliance with timely access and other requirements in Section 1367.03.

- Adds a requirement that a plan that uses a tiered network demonstrate compliance with the standards established by Section 1367.03 based on providers available at the lowest cost-sharing tier.

- Provides the DMHC with the authority to adopt standardized methodologies for reporting that shall be used by plans to demonstrate compliance with Section 1367.03 and any regulations adopted pursuant to this Section, including demonstration of the average waiting time for each class of

appointment regulated under this Section. The methodology is exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until July 1, 2025. These methodologies may also impact other Sections of the Act that incorporate Section 1367.03 by reference.

- Provides that the obligation of a plan to comply with Section 1367.03 shall not be waived if the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform.

b. Compliance and filing requirements:

- Affirm that nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider will be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition.

- Affirm that the plan will not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

- Affirm that nonurgent appointments with a nonphysician mental health care or substance use disorder provider will be offered within 10 business days of the request for an appointment.

- Affirm that the plan has sufficient numbers of contracted providers to maintain compliance with the timely access and other requirements in Section 1367.03.

- Affirm that the plan will adhere to the standardized methodologies for reporting to demonstrate compliance with the requirements set forth in Section 1367.03 and any regulations adopted pursuant to this Section.

- If the plan delegates the obligations under Section 1367.03 to its medical groups, independent practice associations, or other contracting entities, affirm that the plan has a process in place to ensure those delegated entities are meeting the requirements of Section 1367.03.

- State either:

    - The plan reviewed its current provider contracts, administrative services agreements, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs and those documents are consistent with the requirements of SB 221.

OR

- The plan reviewed its current provider contracts, administrative service agreements, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 221. The plan will amend these documents to comply with SB 221 and file the documents per the Act's applicable timeframes.

- Additional compliance and filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

- This new law does not require a filing with the DMHC, at this time, for plans that only offer EAP products.

7. SB 242 (Newman, Ch. 538, Stats. 2021)—Health Care Provider Reimbursements

Codified in Health & Safety Code § 1374.192.

a. Overview of the bill:

- Applies to all plans, except plans that only offer Medi-Cal products.

- Requires plans, on or after January 1, 2022, to reimburse contracting providers for business expenses to prevent the spread of diseases causing public health emergencies.

- Requires plans to reimburse these business expenses for each individual patient encounter, limited to one encounter per day per enrollee for the duration of the public health emergency.

- Prohibits plan delegation of the financial risk to a contracted provider for the cost of enrollee services provided under this new law unless the parties have negotiated and agreed upon a new contract provision pursuant to Section 1375.7.

- Applies to public health emergencies declared on or after January 1, 2022.

b. Compliance and filing requirements:

- Affirm that the plan's contracting providers will be reimbursed for business expenses to prevent the spread of diseases causing public health emergencies declared on or after January 1, 2022.

- Affirm that the plan will negotiate and agree upon a new contract provision pursuant to Section 1375.7 with its contracted provider prior to the delegation

of the financial risk to its contracted provider for the cost of enrollee services provided under SB 242.

- State either:

  - The plan reviewed its current provider contracts, administrative service agreements and plan-to-plan contracts, and those documents are consistent with the requirements of SB 242.

OR

  - The plan reviewed its current provider contracts, administrative service agreements, and those documents are not consistent with the requirements of SB 242. The plan will amend these documents to comply with SB 242 and file the documents per the Act's applicable timeframes.

8. SB 255 (Portantino, Ch. 725, Stats. 2021)—Association Health Plan (AHP) and Multiple Employer Welfare Arrangement (MEWA)

Codified in Health & Safety Code § 1357.503.

a. Overview of the bill:

- Applies to all full service plans that offer a large group commercial product that meets the criteria set forth in this new law. Excludes specialized plans and plans that only offer Medi-Cal products.

- Creates an exception to existing law, on or after June 1, 2022, prohibiting the sale of group products to ineligible employers or individuals for a specific AHP or MEWA and allows for the sale of these products to employees and their dependents who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding 6 months in duration, if certain requirements are met.

b. Compliance and filing requirements:

- This new law does not require a filing with the DMHC at this time. However, further compliance and filing requirements for this new law, including the submission of the MEWA application for registration, will be forthcoming and issued under a separate communication.

9. SB 306 (Pan, Ch. 486, Stats. 2021)—Sexually Transmitted Disease Testing

Codified in Health and Safety Code § 1367.34.

a. Overview of the bill:

- Applies to all full service plans that offer commercial products. Excludes specialized plans and plans that offer only Medi-Cal products.

- Requires plans, on or after January 1, 2022, to cover, sexually transmitted disease home test kits, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

- Requires plans to cover the services set forth in this new law when ordered for an enrollee by an in-network provider.

b. Compliance and filing requirements:

- Affirm the plan will cover sexually transmitted disease home test kits, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

- State either:

  - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and those documents are consistent with the requirements of SB 306.

OR

  - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of SB 306. The plan will amend these documents to comply with SB 306 and file the documents per the Act's applicable timeframes.

10. SB 326 (Pan, Ch. 764, Stats. 2021)—Federal Health Care Reforms

Codified in Health & Safety Code §§ 1357.51, 1357.503, 1357.512, 1367.005, 1399.849 and 1399.855.

a. Overview of the bill:

- Applies to all plans that offer commercial products. Excludes plans that only offer Medi-Cal products.

- Deletes the conditional operation of the Health & Safety Code Sections referenced above based on the continued operation of the Patient Protection

and Affordable Care Act, the federal individual mandate, the federal coverage guarantee, and federal essential health benefits coverage requirements.

- Revisions to Section 1357.503 are referenced above in SB 255 on page 10 and below in SB 718 on page 15.

b. Compliance and filing requirements:

- This new law does not require a filing with the DMHC at this time.

11. SB 368 (Limón, Ch. 602, Stats. 2021)—Deductibles and Out-of-Pocket Expenses

Codified in Health and Safety Code § 1367.0061.

a. Overview of the bill:

- Applies to all plans, except plans that offer only Medi-Cal products.

- Requires plans, on or after July 1, 2022, to monitor an enrollee's accrual towards their annual deductible and annual out-of-pocket maximum (OOPM).

- Requires a plan to provide an enrollee with their accrual balance toward their annual deductible and annual OOPM for every month in which benefits were used and until the annual balance equals the full deductible amount or the full OOPM amount. In addition, a plan shall establish and maintain a system that allows an enrollee to request their most up-to-date accrual balance toward their annual deductible or annual OOPM from their plan at any time.

- Requires accrual updates to be mailed to enrollees until the enrollee has elected to opt out of mailed notices and elected to receive the accrual update electronically, or unless the enrollee has previously opted out of mailed notices. Plans must notify enrollees of their rights pursuant to this new law, including how to request information and how to opt out of mailed notices and elect to instead receive their accrual update electronically.

- Requires a plan contract delegating claims payment functions to comply with the requirements of this new law with plan oversight of the delegated functions.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective July 1, 2022. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

12. SB 428 (Hurtado, Ch. 641, Stats. 2021)—Adverse Childhood Experiences Screenings

Codified in Health and Safety Code § 1367.34.

a. Overview of the bill:

- Applies to all plans that provide coverage for pediatric services and preventative care.
- Requires a plan, on or after January 1, 2022, that provides coverage for pediatric services and preventive care to additionally include coverage for adverse childhood experiences (ACEs) screenings.
- Allows a plan to apply cost-sharing requirements as authorized by law.

b. Compliance and filing requirements:

- Affirm the plan will cover ACEs screenings for children and adults, consistent with the Medi-Cal program's ACEs coverage requirements.
- Include the plan's policies and procedures for confirming providers are properly trained and certified to provide ACEs screening through the State's ACES training program. These policies and procedures should include an explanation of whether provider reimbursement is contingent on certification of training.
- Provide the number of unique providers included in the plan's network, in each service area county, who are qualified to administer the ACEs screening.
- Explain how the plan determined its provider network includes an adequate network of trained and certified providers to conduct ACEs screening
- State either:
    - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and the reimbursement language of plan contracts for the provision of pediatric services and preventative care, and those documents are consistent with the requirements of SB 428.

OR

    - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and the reimbursement language of plan contracts for the provision of

pediatric services and preventative care, and those documents are not consistent with the requirements of SB 428. The plan will amend these documents to comply with SB 428 and file the documents per the Act's applicable timeframes.

- This new law does not require a filing with the DMHC, at this time, for plans that only offer dental or vision products.

13. SB 510 (Pan, Ch. 729, Stats. 2021)—COVID-19 Cost Sharing

Codified in Health & Safety Code §§ 1342.2 and 1342.3.

a. Overview of the bill:

- Applies to all plans. Excludes specialized plans.

- Requires plans to cover the following costs without cost-sharing, prior authorization, or utilization management regardless of whether the services are provided by an in-network or out-of-network provider:

  - Costs associated with diagnostic and screening testing for COVID-19; and,

  - Costs associated with the item, service or immunization that is intended to prevent or mitigate COVID-19.

- Requires plans to cover COVID-19 diagnostic and screening tests and immunizations without cost-sharing when delivered by an out-of-network provider until the federal public health emergency expires. All other requirements remain in effect after the federal public health emergency expires.

- Requires plans to reimburse an in-network provider, to the extent a provider would have been entitled to receive cost-sharing for these services, the amount of that lost cost-sharing through a negotiated rate or an out-of-network provider in an amount that is reasonable as set forth in this new law.

- Prohibits plan delegation of the financial risk to a contracted provider for diagnostic and screening testing related to the public health emergency unless the parties have negotiated and agreed upon a new contract provision pursuant to Section 1375.7.

b. Compliance and filing requirements:

- Plans are required to comply with this law. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for

this new law will be forthcoming and issued under a separate communication to the plans.

14. SB 535 (Limón, Ch. 605, Stats. 2021)—Biomarker Testing

Codified in Health and Safety Code § 1367.665.

a. Overview of the bill:

- Applies to all full service plans. Excludes specialized plans.
- Prohibits plans, on or after July 1, 2022, from requiring prior authorization for biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer or biomarker testing for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer.
- Allows a plan to require prior authorization for biomarker-testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

b. Compliance and filing requirements:

- Affirm the plan will not require prior authorization for biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer or biomarker testing for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer.
- State either:
    - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and those documents are consistent with the requirements of SB 535.

OR

    - The plan reviewed its current SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of SB 535. The plan will amend these documents to comply with SB 535 and file the documents per the Act's applicable timeframes.

15. SB 718 (Bates, Ch. 736, Stats. 2021)—Association Health Plan (AHP) and Multiple Employer Welfare Arrangement (MEWA)

Codified in Health & Safety Code § 1357.503.

a. Overview of the bill:

- Applies to all full service plans that offer a large group commercial product that meets the criteria set forth in this new law. Excludes specialized plans and plans that only offer Medi-Cal products.

- Creates an exception to existing law, on or after June 1, 2022, to allow the sale of large group coverage to employees and their dependents who are employed by an AHP member in the biomedical industry and whose employer has operations in California, if certain requirements are met.

b. Compliance and filing requirements:

- This new law does not require a filing with the DMHC at this time. However, further compliance and filing requirements for this new law, including the submission of the MEWA application for registration, will be forthcoming and issued under a separate communication.

If you have questions or concerns regarding this APL, please contact your plan's assigned OPL reviewer.