# Legislation Implementation

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# AB 731 (Kalra)

- Established rate review process for the large group market.
- Effective July 1, 2020, health plans with large group products must file specified information at least annually and 120 days before any change in methodology, factors or assumptions that would affect rate paid by a large group employer.
- Required health plans to submit specific geographic region data with all rate filings.

# AB 731 (Kalra)

- Additionally, effective July 1, 2021, a large group contract holder that meets specified criteria can apply to the DMHC within 60 days of receiving notice of a rate change to review a rate change and determine if it is unreasonable or not justified.
- **UPDATE: DMHC is currently working on an online application form for the large group contract holders to complete to request a rate review from the DMHC.**

# AB 1124 (Maienschein)

No later than May 1, 2021, the DMHC may approve two 4-year pilot programs that would permit risk-bearing organizations and restricted health plans to undertake risk-bearing arrangements with either a qualifying voluntary employees' beneficiary association (VEBA) or a qualifying trust fund.

# AB 1124 (Maienschein)

- Pilot duration: January 1, 2022 through December 31, 2025.
- DMHC report to the Legislature by January 1, 2027.
- **UPDATE: Application and checklist is under review and will be available by April 1, 2021.**

# AB 2118 (Kalra)

- Beginning October 1, 2021, requires full-service health plans to annually report specified rate information on premiums, cost sharing, benefits, enrollment, and trend factors for products in the individual and small group markets.
- Reporting on enrollee share of premium and on enrollment by benefit design, deductible, or share of premium delayed until 2023.
- **UPDATE: DMHC is currently working on the reporting templates.**

# SB 855 (Wiener)

- Effective Jan 1, 2021, SB 855 amends California's mental health parity statute, requiring full-service health plans in group and individual markets to cover treatment for all medically necessary mental health and substance use disorders listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Defines "medically necessary treatment" of a mental health or substance use disorder.
- Prohibits use of "discretionary authority" contract provisions.

# SB 855 (Wiener)

- Requires plans to arrange coverage for medically necessary out-of-network mental health and substance use disorder treatment services when in-network options within geographic and timely access standards are not available.
- Sets criteria for the use of clinical guidelines when making medical necessity and level of care placement decisions for mental health or substance use disorder treatment.
- Requires plans to establish specified procedures to ensure compliant utilization review processes.

# SB 855 (Wiener)

## UPDATE:

- DMHC issued initial guidance to plans and is reviewing compliance with broader MH/SUD diagnoses mandate, medical necessity definition, and adoption of non-profit clinical associations clinical care guidelines for utilization management.
- DMHC is working on a regulation to be released later this year.

# Questions?