From: DMHC Licensing eFiling

Subject: APL 20-041 (OPL) Newly Enacted Statutes Impacting Health Plans

Date: Tuesday December 15, 2020 9:37 AM

Attachments: APL 20-041 - Newly Enacted Statutes Impacting Health Plans.pdf

Dear Health Plan Representative,

Please see attached All Plan Letter 20-041 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 15, 2020

TO: All Health Care Service Plans

FROM: Nancy Wong
Acting Deputy Director
Office of Plan Licensing

SUBJECT: APL 20-041 (OPL) Newly Enacted Statutes Impacting Health Plans (2020 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 five bills enacted this session that may require plans to update 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 2020 Legislation Amendment filing.

Please note **SB 855 (Wiener, Ch. 151, Stats. 2020)—Mental Health or Substance Use Disorders** is not discussed in this APL. Guidance regarding SB 855 is forthcoming.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by **February 1, 2021**, 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 2020 Legislation.**"

- In the Compliance with 2020 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 2022 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 80 (Committee on Budget, Ch. 12, Stats. 2020)— Public Health Omnibus

Codified in Health and Safety Code §§ 1367.0085, 1386, Chapter 8.5 (commencing with Section 127671).

a. Overview of the bill:

- Section 1367.0085: Applies to plans who offer a nongrandfathered bronze level product that either covers and pays for at least one major service, other than preventive services, before the deductible is applied or meets the

[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.

requirements to be a high deductible health product under section 223(c)(2) of title 26 of the United States Code.

  - Revises the actuarial value for a nongrandfathered bronze level health product, to range from plus 5 percent to minus 2 percent.

- Article 8.5 (commencing with Section 127671): Applies to all plans, including specialized plans.

  - Section 127671.1(a) provides that the Office of Statewide Health Planning and Development (OSHPD) shall establish, implement, and administer the Health Care Payments Data Program, which requires mandatory data submissions from plans.

  - Section 127672(a)(1) provides that OSHPD shall convene a Health Care Payments Data Program advisory committee, composed of stakeholders including plans.

  - Section 127673 requires OSHPD to develop guidance for health care payment data submission, on or before December 31, 2021, effective immediately upon initial adoption by OSHPD. Data to be submitted by mandatory submitters includes, but is not limited to, claim and encounter, member enrollment, provider and supplier information, nonclaims-based payments, premiums, and pharmacy rebate data.

  - On or before March 1, 2024, OSHPD shall submit a report to the Legislature, including in its report the data collected from mandatory submitters.

  - 127673.8(a) requires OSHPD to use the program data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support the goals of the program.

  - Section 127674.1 provides that OSHPD shall notify the DMHC if a plan fails to comply with the requirements of the Health Care Payments Data Program. The DMHC is authorized to take appropriate enforcement action necessary to bring the plan into compliance.

- Section 1386(a)(18) provides if a Plan violates Chapter 8.5 (commencing with Section 127671) it constitutes grounds for disciplinary action by the Director of the DMHC.

- AB 80 is effective immediately as a bill related to the budget.

b. Compliance and filing requirements:

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

2. AB 1124 (Maienschein, Ch. 266, Stats. 2020)—Voluntary Employee Benefit Association (VEBA) Exemptions

Codified in Health and Safety Code § 1343.3.

a. Overview of the bill:

- Applies to plans with restricted or limited licenses, and risk-bearing organizations (RBOs) registered with the DMHC.

- Authorizes two pilot programs, one in northern California and one in southern California, whereby risk-bearing providers may undertake risk-bearing arrangements with a VEBA subject to Section 1349.2 or a multi-employer trust fund subject to ERISA.

- Allows the DMHC, no later than May 1, 2021, to authorize the two pilot programs noted in the previous bullet point to take place from no earlier than January 1, 2022, to December 31, 2025.

- VEBA or trust fund pilot program participants must meet certain criteria, including demonstration to the DMHC's satisfaction of adequate enrollee protection, and must submit a pilot program application to the DMHC for approval. Global and risk-bearing providers must be approved by the DMHC.

- Risk-bearing providers must register as RBOs with the DMHC. Global risk-bearing providers must hold or will obtain in conjunction with the pilot program application a limited or restricted license.

- Allows enrollees access to the DMHC's grievances and appeals processes if the VEBA or trust fund's response to complaints does not satisfy the enrollee.

- The VEBA or trust fund and each provider participating in the pilot program will annually report to the DMHC information regarding the comparative cost savings when compared to fee-for-service payment, performance measurements for clinical patient outcomes, and enrollee satisfaction.

- After the termination of both pilot programs, and before January 1, 2027, the DMHC will submit a report to the Legislature regarding costs and clinical patient outcomes of the pilot programs compared to fee-for-service payment models.

b. Compliance and filing requirements:

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

3. AB 2118 (Kalra, Ch. 277, Stats. 2020)—Reporting Requirements

Codified in Health and Safety Code § 1385.043.

a. Overview of the bill:

- Applies to all plans offering grandfathered and nongrandfathered individual and small group products, both on-Exchange and off-Exchange. Excludes specialized plans.

- Requires the plans noted in the bullet point above to annually report to the DMHC rate information for all grandfathered and nongrandfathered products, for rates effective during the 12-month period ending January 1 of the following year.

- Information required includes, but is not limited to, information on premiums, cost sharing, benefits, standard and nonstandard benefit designs, enrollment, and trend factors.

- Requires plans to submit annual reports by October 1, 2021, and annually thereafter.

- Beginning in 2022, the DMHC shall annually present the information provided in the plans' annual reporting at the meeting specified in Section 1385.045, a meeting of the Financial Solvency Standards Board, or at any other public meeting the DMHC deems appropriate. The DMHC also shall post the information reported on its internet website no later than December 15 of each year.

- Until January 1, 2023, plans are not required to report share of premium paid by enrollee, or enrollment by benefit design, deductible, or share of premium.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan will submit its annual rate reports for individual and small group products by October 1, 2021, and annually thereafter.

4. AB 2157 (Wood, Ch. 278, Stats. 2020)—Independent Dispute Resolution Process

Codified in Health and Safety Code § 1371.30.

a. Overview of the bill:

- Applies to all full service, restricted and specialized plans. Excludes Medi-Cal plans.
- Revises the AB 72 independent dispute resolution process (IDRP) for nonemergency services.
- Requires the IDRP to include a process that would allow each party to submit into evidence information that will be kept confidential from the other party.
- Requires the independent organization deciding the dispute to conduct a *de novo* review to determine the appropriate reimbursement based solely on the information and documents timely submitted into evidence by the parties to the dispute.
- Requires the independent organization to assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

b. Compliance and filing requirements:

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

5. SB 406 (Pan, Ch. 302, Stats. 2020)—Omnibus Bill

Codified in Health and Safety Code §§ 1367.001, 1367.002.

a. Overview of the bill:

- Section 1367.001 (lifetime and annual limits): Applies to plans offering individual, small group and/or large group products. Excludes Medi-Cal products, Medi-Cal Access products, the California Major Risk Medical Insurance Program, specialized plans that do not cover an essential health benefit,[3] and Medicare supplement products.

[3] If a stand-alone dental plan offers a product that covers an essential health benefit, the stand-alone dental plan is subject to Section 1367.001.

- Plans may not establish lifetime or annual limits on the dollar value of any covered benefits for an enrollee, whether provided in network or out of network.

- Section 1367.002 (preventive health care services): Applies to plans offering individual, small group and/or large group products. Excludes specialized plans that do not cover an essential health benefit as defined in Section 1367.005.

  - Requires a plan offering a group or individual nongrandfathered product to, at a minimum, provide coverage for specified preventive health care services without any cost-sharing requirements for those preventive health care services. This requirement applies to a health savings account-eligible product only to the extent the product qualifies to be treated as a high deductible health plan under section 223 of title 26 of the United States Code.

- SB 406 is effective immediately as an urgency statute.

- Deletes the previous requirement to comply "to the extent required by federal law."

b. Compliance and filing requirements:

- Affirm the plan will not establish lifetime or annual limits on the dollar value of any covered benefits for an enrollee, whether provided in network or out of network.

- Affirm the plan will provide coverage for preventive health care services specified by Section 1367.002 without any cost-sharing requirements for those preventive services.

- State either:

  - The plan reviewed its current provider contracts, administrative services agreements, contracts with plans, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are consistent with the requirements of SB 406.

OR

  - The plan reviewed its current provider contracts, administrative services agreements, contracts with plans, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing

materials, and those documents are not consistent with the requirements of SB 406. The plan will amend these documents to comply with SB 406 and file the documents per the Act's applicable timeframes.

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