From: DMHC Licensing eFiling

Subject: APL 22-031 – Newly Enacted Statues Impacting Health Plans (2022 Legislative Session)

Date: Thursday, December 22, 2022 11:36 AM

Attachments: APL 22-031 – Newly Enacted Statutes Impacting Health Plans – 2022 Legislative Session (12.22.2022).pdf

Dear Health Plan Representative:

This All Plan Letter (APL) 22-031 outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: December 22, 2022

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 22-031 (OPL) Newly Enacted Statutes Impacting Health Plans (2022 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 19 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 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 2022 Legislation Amendment filing.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by February 27, 2023, 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 2022 Legislation.**"

- In the Compliance with 2022 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 2024 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 988 (Bauer-Kahan, Ch. 747, Stats. 2022)—Mental health: 988 Suicide and Crisis Lifeline

Codified in Health and Safety Code § 1374.724.

a. Overview of the bill:

- Applies to all plans that cover mental health and substance use disorder treatment. Excludes plans that offer only dental, vision, acupuncture/ chiropractic and/or Medi-Cal products.

- Effective immediately, requires plans' coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 to include medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, regardless of whether the service is provided by an in-network or out-of-network provider.

[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.

- Requires plans to cover such services without prior authorization.

- Requires plans to reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for medically necessary treatment of a mental health or substance use disorder consistent with the requirements of Section 1371.4 and any other applicable requirements.

- Requires plans, if care for such covered services is received out-of-network, to ensure the enrollee does not pay more than the cost sharing the enrollee would pay if the covered service was received from an in-network provider. An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the enrollee for covered services except for the in-network cost sharing amount.

b. Compliance and filing requirements:

- Affirm the plan's coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 will include medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, regardless of whether the service is provided by an in-network or out-of-network provider.

- Affirm the plan will cover medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team without prior authorization.

- Affirm if care for such covered services is received out-of-network, the plan will ensure the enrollee will only pay the same cost sharing the enrollee would pay if the covered service was received from an in-network provider.

- Provide the steps the plan will take to ensure that an out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the enrollee for covered services except for the in-network cost sharing amount.

- Provide updated claims policies and procedures, as an Exhibit II-4, to demonstrate the plan's reimbursement of a 988 center, mobile crisis team, or other provider of behavioral health crisis services for medically necessary treatment of a mental health or substance use disorder is consistent with the requirements of Section 1371.4 and any other applicable requirements.

- State either:

    - The plan reviewed its current policies and procedures, current provider contracts, administrative service agreements (ASAs), plan-to-plan

contracts, Summaries of Benefits or other detailed cost sharing documents (collectively referred to as "SOBs"), Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 988.

OR

- The plan reviewed its current policies and procedures, current provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 988. The plan will amend these documents to comply with AB 988 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

2. AB 1982 (Santiago, Ch. 525, Stats. 2022)—Telehealth: dental care

Codified in Health and Safety Code § 1374.142.

a. Overview of the bill:

- Applies to all plans that issue, sell, renew, or offer a plan contract covering dental services. Excludes plans that offer only behavioral health, vision, acupuncture/chiropractic, and/or Medi-Cal products.

- Requires plans, on or after January 1, 2023, offering dental services via telehealth to an enrollee through a third-party corporate telehealth provider to report to the DMHC the information set forth in Section 1374.141(a) for each product type.

- Requires plans offering dental services via telehealth to disclose to the enrollee the impact of the third-party corporate telehealth provider visits on the enrollee's benefit limitations, including frequency limitations and the enrollee's annual maximums.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective January 1, 2023. 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 2127 (Santiago, Ch. 118, Stats. 2022)—Health care coverage: dependent adults

Codified in Health and Safety Code § 1374.1.

a. Overview of the bill:

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

- Requires plans, on or after January 1, 2023, to provide applicants seeking to add a dependent parent or stepparent who is eligible for or enrolled in Medicare with written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge, including the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222. This notice shall be provided to applicants who do not apply through Covered California at the time of solicitation and on the application. In addition, the eligible dependent parent or stepparent needs to be informed of and understand their specific rights and health care options before enrolling in an individual product, including the potential benefits, financial assistance, and tax liability under those options.

b. Compliance and filing requirements:

- Provide the enrollment form, as an Exhibit Q-4, that provides written notice that the HICAP provides health insurance counseling to senior California residents free of charge, including the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222.

- State either:

    - The plan reviewed its current Disclosure Forms and EOCs and those documents are consistent with the requirements of AB 2127.

OR

    - The plan reviewed its current Disclosure Forms and EOCs, and those documents are not consistent with the requirements of AB 2127. The plan will amend these documents to comply with AB 2127 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

4. AB 2134 (Weber, Ch. 562, Stats. 2022)—Reproductive health care

Codified in Health and Safety Code § 1367.32.

a. Overview of the bill:

- Applies to all plans that offer coverage to employees of a religious employer that does not include coverage and benefits for abortion and contraception. Excludes specialized plans and plans that only offer Medi-Cal products.

- Requires plans, on or after January 1, 2023, to provide written notice with the following information to each enrollee, upon initial enrollment and annually thereafter: (1) the Abortion and contraception benefits or services that are not included in the enrollee's health care service plan contract and (2) the Abortion and contraception benefits or services that may be available at no cost through the California Reproductive Health Equity Program.

b. Compliance and filing requirements:

- Affirm the plan will provide written notice with the following information to each enrollee who is obtaining coverage through a religious employer who does not include coverage and benefits for abortion and contraception upon initial enrollment and annually thereafter: (1) the Abortion and contraception benefits or services that are not included in the enrollee's health care service plan contract and (2) the Abortion and contraception benefits or services that may be available at no cost through the California Reproductive Health Equity Program.

- State either:

  - The plan reviewed its current enrollee notices, enrollment forms, Disclosure Forms and EOCs, and those documents are consistent with the requirements of AB 2134.

OR

  - The plan reviewed its current enrollee notices, enrollment forms, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of AB 2134. The plan will amend these documents to comply with AB 2134 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

5. AB 2205 (Carrillo, Ch. 563, Stats. 2022)—California Health Benefit Exchange: abortion coverage reporting

Codified in Health and Safety Code § 1347.8.

a. Overview of the bill:

- Applies to all qualified health plans through the California Health Benefit Exchange.
- Requires qualified health plans through the California Health Benefit Exchange, on or after July 1, 2023, and annually thereafter, to report the total amount of funds maintained in a segregated account pursuant to subdivision (a) of Section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). This annual report shall contain the ending balance of the account and the total dollar amount of claims during the reporting year.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective July 1, 2023. 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. AB 2352 (Nazarian, Ch. 590, Stats. 2022)—Prescription drug coverage

Codified in Health & Safety Code § 1367.207.

a. Overview of the bill:

- Applies to all plans that provide prescription drug coverage. Excludes plans that only offer Medi-Cal products.
- Requires plans, on or after July 1, 2023, that provide prescription drug benefits and maintain one or more formularies to do the following:
    - Upon request of an enrollee or an enrollee's prescribing provider, furnish all the following information regarding a prescription drug to the enrollee or the enrollee's prescribing provider:
        - The enrollee's eligibility for the prescription drug.
        - The most current formulary or formularies.
        - Cost sharing information for the prescription drug and other formulary alternatives, accurate at the time it is provided, including any variance in cost sharing based on the patient's

preferred dispensing pharmacy, whether retail or mail order, or the provider.

- Applicable utilization management requirements for the prescription drug and other formulary alternatives.

- Respond in real time to a request made by an enrollee or enrollee's prescribing provider through a standard Application Programming Interface (API).

- Allow the use of an interoperability element (integrated technologies or services necessary to provide a response to an enrollee or an enrollee's prescribing provider) to provide information to the enrollee or enrollee's prescribing provider.

- Ensure that the information provided to the enrollee or the enrollee's prescribing provider is current no later than one business day after a change is made and is provided in real time.

- Provide the information to the enrollee or to the enrollee's prescribing provider if the request is made using the drug's unique billing code and National Drug Code.

- Prohibits plans from doing any of the following:

  - Deny or delay a response to a request for the purpose of blocking the release of information pursuant to subsection (a).

  - Restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing any of the following information to an enrollee: (1) the information provided pursuant to subdivision (a), (2) additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the enrollee's health care service plan contract and (3) information about the cash price of the drug.

  - Interfere with, prevent, or materially discourage access, exchange, or use of the information provided pursuant to subdivision (a).

  - Penalize a prescribing provider for disclosing the information pursuant to subdivision (a).

  - Penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

b. Compliance and filing requirements:

- Affirm the plan, on or after July 1, 2023, upon request of an enrollee or an enrollee's prescribing provider, will furnish all the following information regarding a prescription drug to the enrollee or the enrollee's prescribing provider:
    - The enrollee's eligibility for the prescription drug.
    - The most current formulary or formularies.
    - Cost sharing information for the prescription drug and other formulary alternatives, accurate at the time it is provided, including any variance in cost sharing based on the patient's preferred dispensing pharmacy, whether retail or mail order, or the provider.
    - Applicable utilization management requirements for the prescription drug and other formulary alternatives.
- Affirm the plan, on or after July 1, 2023, will respond in real time to a request made by an enrollee or enrollee's prescribing provider through a standard Application Programming Interface (API).
- Affirm the plan, on or after July 1, 2023, will allow the use of an interoperability element (integrated technologies or services necessary to provide a response to an enrollee or an enrollee's prescribing provider) to provide information to the enrollee or enrollee's prescribing provider.
- Affirm the plan, on or after July 1, 2023, will ensure that the information provided to the enrollee or the enrollee's prescribing provider is current no later than one business day after a change is made and is provided in real time.
- Affirm the plan, on or after July 1, 2023, will provide the information to the enrollee or to the enrollee's prescribing provider if the request is made using the drug's unique billing code and National Drug Code.
- Affirm the plan, on or after July 1, 2023, will not deny or delay a response to a request for the purpose of blocking the release of information pursuant to subsection (a).
- Affirm the plan, on or after July 1, 2023, will not restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing any of the following information to an enrollee: (1) the information provided pursuant to subdivision (a), (2) additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the enrollee's health care service plan contract and (3) information about the cash price of the drug.

- Affirm the plan, on or after July 1, 2023, will not interfere with, prevent, or materially discourage access, exchange, or use of the information provided pursuant to subdivision (a).

- Affirm the plan, on or after July 1, 2023, will not penalize a prescribing provider for disclosing the information pursuant to subdivision (a).

- Affirm the plan, on or after July 1, 2023, will not penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

- Provide a detailed explanation of how the plan is training its staff to timely respond to the requests of its enrollees or enrollee's prescribing provider as set forth in AB 2352.

- Provide a detailed explanation, along with any policies and procedures as an Exhibit J-21, of the standard API the plan intends on utilizing for compliance with AB 2352.

- Provide a detailed explanation, along with any policies and procedures as an Exhibit J-21, of the interoperability element the plan intends on utilizing for compliance with AB 2352.

- Explain how the plan is ensuring the information provided pursuant to subsection (a)(1) is current no later than one business day after a change is made and is provided in real time. If this information is provided in an enrollee notice, submit that enrollee notice as an Exhibit I-9.

- If the plan contracts with a Pharmacy Benefit Manager (PBM), provide the revised PBM contract to demonstrate compliance with AB 2352. In addition, provide any revised policies and procedures related to the plan's coverage of prescription drugs for compliance with AB 2352.

- State either:

    - The plan reviewed its current policies and procedures, enrollee notices, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, and EOCs and those documents are consistent with the requirements of AB 2352.

OR

    - The plan reviewed its current policies and procedures, enrollee notices, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 2352. The plan will

amend these documents to comply with AB 2352 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

7. AB 2581 (Salas, Ch. 533, Stats. 2022)—Health care coverage: mental health and substance use disorders: provider credentials

Codified in Health & Safety Code § 1374.197.

a. Overview of the bill:

- Applies to all plans that cover mental health and substance use disorder treatment. Excludes plans that offer only dental, vision, and/or acupuncture/ chiropractic products.

- Requires plans, on or after January 1, 2023, who credential health care providers for mental health and substance use disorder services for its networks to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application.

- Requires plans to notify the applicant within seven business days of receiving the application to verify receipt and inform the applicant whether the application is complete.

b. Compliance and filing requirements:

- Affirm the plan will assess and verify the qualifications of a health care provider for mental health and substance use disorder services within 60 days after receiving a completed provider credentialing application.

- Affirm the plan will notify the applicant within seven business days of receiving the application to verify receipt and inform the applicant whether the application is complete.

- State either:

  - The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, and those documents are consistent with the requirements of AB 2581.

OR

  - The plan reviewed its current policies and procedures, provider contracts, ASAs, and those documents are not consistent with the

requirements of AB 2581. The plan will amend these documents to comply with AB 2581 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

8. AB 2585 (McCarty, Ch. 160, Stats. 2022)—Nonpharmacological pain management treatment

Codified in Health & Safety Code § 124962.

a. Overview of the bill:

- Applies to all plans.
- Requires plans, on or after January 1, 2023, to encourage the use of evidence-based nonpharmacological therapies for pain management.

b. Compliance and filing requirements:

- Provide a detailed explanation of the steps the plan is taking to encourage the use of evidence-based nonpharmacological therapies for pain management. Provide any updated policies and procedures as an Exhibit J-9, as needed, for compliance with AB 2585.
- Provide who at the plan is responsible for the creation of any plan policies and procedures encouraging the use of evidence-based nonpharmacological therapies for pain management.
- State either:
    - The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, and those documents are consistent with the requirements of AB 2585.

OR

    - The plan reviewed its current policies and procedures, provider contracts, ASAs, and those documents are not consistent with the requirements of AB 2585. The plan will amend these documents to comply with AB 2585 and file the documents per the Act's applicable timeframes.
- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2)

whether the amended documents will be submitted in this filing or in a separate filing.

9. SB 107 (Wiener, Ch. 810, Stats. 2022)—Gender-affirming health care

Codified in Civil Code § 56.109, Code of Civil Procedure §§ 3421, 3424, 3427 and 3428, Family Code § 3453.5, Penal Code §§ 819 and 1326.

a. Overview of the bill:

- Applies to all plans that provide gender-affirming health care or mental health care. Excludes plans that offer only dental, vision or acupuncture/chiropractic products.

- Prohibits plans, on or after January 1, 2023, from releasing medical information related to a person or entity allowing a child to receive gender-affirming health care or mental health care in response to any civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.

- Prohibits plans from releasing medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

b. Compliance and filing requirements:

- Affirm the plan will not release medical information related to a person or entity allowing a child to receive gender-affirming health care or mental health care in response to any civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.

- Affirm the plan will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

- Provide the plan's revised policies and procedures required by Section 1364.5, as an Exhibit J-18, to demonstrate compliance with SB 107.

- State either:
  - The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 107.

OR

  - The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 107. The plan will amend these documents to comply with SB 107 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

10. SB 225 (Wiener, Ch. 601, Stats. 2022)—Health care coverage: timely access to care

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

a. Overview of the bill:

- Applies to all plans.

- Revises subsection (a)(7) to require plans to arrange for the provision of covered services from providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition. A plan shall ensure that enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable in-network copayments, coinsurance, and deductibles.

- Requires plans to incorporate the standards set forth in subdivision (a) into the plan's quality assurance systems and processes set forth in Sections 1367 and 1370 and Rules 1300.67.2, 1300.67.2.2, 1300.68 and 1300.70.

- Prohibits plans from preventing, discouraging, or disciplining a network provider or employee for informing an enrollee or subscriber about the timely access requirements.

- In addition to the items listed in Section 1367.031(e), SB 225 requires plans to provide the following information to the plan's contracting providers at least annually: the toll-free telephone number and internet website address for the DMHC where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

- Extends to December 31, 2025, the exemption to the Administrative Procedures Act (APA) in subsection (f)(3), allowing the DMHC to develop and adopt standardized methodologies for demonstrating compliance with Section 1367.03 and related regulations. Requires plans to adhere to the APA-exempt methodologies adopted by the DMHC.

- Beginning on January 1, 2023, allows the DMHC to develop and adopt APA-exempt standards concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care until December 31, 2028. Requires plans to adhere to the APA-exempt standards adopted by the DMHC.

- Revises Section 1367.03 for consistency to use terms defined in Rule 1300.67.2.2 (as amended April 1, 2022), including, but not limited to, the following terms: network, network provider, preventive care, and provider group.

b. Compliance and filing requirements:

- Update the plan's documents filed with the DMHC to be compliant with the new requirements in SB 225, in accordance with the timeframes set forth in the Act and in APL 22-026: Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation (Issued November 4, 2022). The plan shall include in the filing the relevant filing grid identifying where each new requirement is addressed within the exhibit. The DMHC may revise the following filing grids to the extent necessary to reflect new SB 225 requirements:

    - *Timely Access Policies and Procedures Filing Grid for Exhibit J-13-a;*

    - *Annual Network Data Collection Filing Grid for Exhibit J-19; and*

    - *Standards of Accessibility Filing Grid for Exhibit I-5-a.*

  The DMHC will notify plans when these documents are available for download in the efiling web portal.

- Affirm the plan shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition. In addition, affirm the plan shall ensure that enrollee costs for medically necessary referrals to non-

network providers will not exceed applicable in-network copayments, coinsurance, and deductibles.

- Provide, in detail, the steps the plan takes to arrange for the provision of covered services for enrollees from providers outside the plan's network when providers are unavailable within the plan's network in accordance with APL 22-030 (Issued December 22, 2022).

- Affirm the plan will incorporate the standards set forth in Section 1367.03(a) into the plan's quality assurance systems and processes set forth in Sections 1367 and 1370 and Rules 1300.67.2, 1300.67.2.2, 1300.68 and 1300.70.

- Affirm the plan will incorporate the APA-exempt standards and methodologies developed and adopted by the DMHC into plan operations, including the plan's quality assurance systems and processes.

- Affirm the plan will not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access requirements.

- In addition to the items listed in Section 1367.031(e), affirm the plan will provide the following information to the plan's contracting providers at least annually: the toll-free telephone number and internet website address for the DMHC where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

- State either:

    - The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs and plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 225.

    OR

    - The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs and plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 225. *The plan will amend these documents to comply with SB 225 and file the documents per the Act's applicable timeframes and APL 22-026: Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation (Issued November 4, 2022)*.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) *whether the amended documents will be submitted in this filing, in a separate*

filing, or in the filings requested in APL 22-026: Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation.

11. SB 245 (Gonzalez, Ch. 11, Stats. 2022)—Health care coverage: abortion services: cost sharing

Codified in Health and Safety Code § 1367.251.

a. Overview of the bill:

- Applies to all plans that cover abortion services. Excludes specialized plans.
- Requires plans, on or after January 1, 2023, to not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on coverage for all abortion and abortion-related services, including preabortion and follow-up services. However, for plans who offer high deductible health products any cost sharing limits will apply once an enrollee's deductible has been satisfied for the benefit year.
- Prohibits plans from imposing any utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with Sections 1367.001 and 1367.005 on the coverage for outpatient abortion services.
- Requires plans who delegate responsibilities under SB 245 to a contracted entity, including a medical group or independent practice association, to ensure the delegated entity will comply with SB 245.

b. Compliance and filing requirements:

- Affirm the plan will not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on coverage for all abortion and abortion-related services, including preabortion and follow-up services.
- Affirm, if the plan offers high deductible health products, the plan will have any cost sharing limits apply once an enrollee's deductible has been satisfied for the benefit year.
- Affirm the plan will not impose any utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with Sections 1367.001 and 1367.005 on the coverage for outpatient abortion services.
- If the plan delegates responsibilities under SB 245 to a contracted entity, including a medical group or independent practice association, affirm the plan will ensure the delegated entity will comply with SB 245.

- State either:

    - The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 245.

OR

    - The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 245. The plan will amend these documents to comply with SB 245 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

12. SB 523 (Leyva, Ch. 630, Stats. 2022)—Contraceptive Equity Act of 2022

Codified in Health and Safety Code §§ 1343, 1367.25, 1367.255 and 1367.33.

a. Overview of the bill:

- Health and Safety Code § 1367.25.

    - Applies to all plans that provide coverage for outpatient prescription drugs. Excludes specialized plans.

    - On or after January 1, 2023, SB 523,

        - Requires plans to provide coverage for all services and contraceptive methods for all subscribers and enrollees as set forth in subsection (b)(1).

        - In addition to the required contraceptive methods set forth in subsection (b)(1), SB 523 amends Section 1367.25 to include coverage for the following:

            - All FDA approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.

- Voluntary tubal ligation and other similar sterilization procedures.
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.

- Requires plans to provide coverage without cost sharing for the original, brand name contraceptive if there is not a therapeutic equivalent generic substitute available in the market. Note: If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, a plan is not required to cover all the therapeutically equivalent versions as long as at least one is covered without cost sharing.

- Requires plans to defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the enrollee's provider.

- Requires plans to not infringe upon an enrollee's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.

- Clarifies the exclusion from contraception coverage for religious employers does not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

- Prohibits plans from requiring an enrollee to make any formal request (i.e. prior authorization requests, any utilization controls or any other forms of medical management restrictions), other than a pharmacy claim, for coverage of receiving a 12-month supply of self-administered hormonal contraceptives at one time.

- On or after January 1, 2024, SB 523,

  - Requires all health care service plan contracts to have the following conditions apply: (1) a prescription shall not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products and (2) point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network

pharmacies without cost sharing or medical management restrictions.

- Specifies that "over-the-counter FDA-approved contraceptive methods" are limited to those included as essential health benefits pursuant to Section 1367.005.

- Health and Safety Code § 1367.255.
  - Applies to all plans that cover contraceptive methods. Excludes specialized plans and plans who only offer grandfathered products.
  - Requires plans, on or after January 1, 2024, to not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on vasectomy services and procedures. However, for high deductible health products, plans shall establish cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance.
  - Prohibits plans from imposing any restrictions or delays, including but not limited to, prior authorization, on vasectomy services or procedures.
  - Allows a religious employer to request a health care service plan contract without coverage for contraceptive methods, including vasectomy services and procedures, that are contrary to the religious employer's religious tenets. This exclusion does not apply to vasectomy services or procedures for purposes other than contraception.
  - Requires plans that contract with a religious employer where the health care service plan contract does not include coverage and benefits for vasectomy services and procedures to provide written notification to each enrollee, upon initial enrollment and annually thereafter upon renewal, that vasectomy services and procedures are not included in the enrollee's health care service plan contract.

- Health and Safety Code § 1367.33.
  - Applies to all plans that offer products directly operated by a bona fide public or private institution of higher learning that directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

- Requires plans, on or after January 1, 2024, to comply with the contraceptive coverage requirements set forth in Sections 1367.25 and 1367.255.

b. Compliance and filing requirements

- Health and Safety Code § 1367.25.
  - Affirm the plan will provide coverage for the services and contraceptive methods for all subscribers and enrollees as set forth in subsection (b)(1).
  - In addition to the required contraceptive methods set forth in subsection (b)(1), affirm the plan will include coverage for the following:
    - All FDA approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.
    - Voluntary tubal ligation and other similar sterilization procedures.
    - Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
  - Affirm the plan will provide coverage without cost sharing for the original, brand name contraceptive if there is not a therapeutic equivalent generic substitute available in the market.
  - Affirm the plan will defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the enrollee's provider.
  - Affirm the plan will not infringe upon an enrollee's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.
  - Affirm, if the plan offers coverage to a religious employer, the exclusion from contraception coverage for religious employers does not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

- Affirm the plan will not require an enrollee to make any formal request (i.e. prior authorization requests, any utilization controls or any other forms of medical management), other than a pharmacy claim, for coverage of a 12-month supply of self-administered hormonal contraceptives at one time.

- Affirm the plan will apply the following conditions to all health care service plan contracts, on or after January 1, 2024: (1) a prescription shall not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products and (2) point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.

- Describe how the plan will ensure that the plan's in-network pharmacies are not overcharging enrollees for over-the-counter FDA-approved contraceptive drugs, devices, and products.

- Describe how the plan will educate its enrollees that over-the-counter FDA-approved contraceptive drugs, devices, and products will be provided at in-network pharmacies without cost-sharing or medical management restrictions, including information regarding how to determine whether a pharmacy is in-network.

- Health and Safety Code § 1367.255.

  - Affirm the plan, on or after January 1, 2024, will not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on vasectomy services and procedures.

  - Affirm if the plan offers a high deductible health product, the plan, on or after January 1, 2024, will establish cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance.

  - Affirm the plan, on or after January 1, 2024, will not impose any restrictions or delays, including but not limited to, prior authorization, on vasectomy services or procedures.

  - Affirm if a plan contracts with a religious employer and the health care service plan contract does not include coverage and benefits for vasectomy services and procedures, the plan, on or after January 1, 2024, will provide written notification to each enrollee, upon initial enrollment and annually thereafter upon renewal, that vasectomy

services and procedures are not included in the enrollee's health care service plan contract.

- Health and Safety Code § 1367.33.
  - Affirm if a plan offers products directly operated by a bona fide public or private institution of higher learning that directly provides health care services only to its students, faculty, staff, administration, and their respective dependents, on or after January 1, 2024, those products will comply with the contraceptive coverage requirements set forth in Sections 1367.25 and 1367.255.

- Submit revised Utilization Management Policies and Procedures, as an Exhibit J-9, to demonstrate compliance with the provisions of SB 523.

- State either:

  - The plan reviewed its current policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms and EOCs, are consistent with the requirements of SB 523.

OR

  - The plan reviewed its current policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of SB 523. The plan will amend these documents to comply with SB 523 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

13. SB 858 (Wiener, Ch. 985, Stats. 2022)—Health care service plans: discipline: civil penalties

Codified in Health and Safety Code §§ 1374.7, 1374.9, 1374.34, 1386, 1387, 1389.8, 1390, 1393.5 and 1393.6.

a. Overview of the bill:

- Applies to all plans.

- The Legislature declared its intention to raise enforcement penalties to track inflation and increased plan premium rates.

- The enumerated administrative penalties in the following sections were increased: Sections 1374.7, 1374.9, 1374.34, 1386, 1387, 1389.8, 1390, 1393.5 and 1393.6.
- The Director has the discretion to consider one or more factors in Section 1386(d)(1) and (d)(2) to determine the appropriate amount of the penalty for each violation.

- Any person who violates a provision of the Act and Rules shall be liable for a civil penalty of not more than $25,000 for each violation, which shall be assessed and recovered in a civil action. (Section 1387(a).)

- The acts and omissions constituting grounds for discipline in Section 1386(b) were expanded to now include the failure to comply with corrective action plans.

- Section 1386(c) was added, giving the Director of the DMHC authority to impose corrective action plans.

b. Compliance and filing requirements

- No compliance filing is required.

14. SB 923 (Wiener, Ch. 822, Stats. 2022)—Gender-affirming care

Codified in Health and Safety Code §§ 1367.043 and 1367.28.

a. Overview of the bill:

- Health and Safety Code § 1367.043.
    - Applies to all plans. Excludes specialized plans that only provide dental or vision products.
    - On or after January 1, 2023, SB 923,
        - Requires the DMHC to review individual case complaints received pursuant to Section 1368, alleging discrimination on the basis of gender identity and refer those complaints to the Civil Rights Department. For improper denials, delays, or modifications of trans-inclusive care, the DMHC shall review the complaints received to determine whether any enforcement actions may be appropriate.
        - Requires the DMHC to track and monitor complaints received by the DMHC, pursuant to Section 1368, related to trans-inclusive health care and publicly report this data with other

complaint data in its annual report, on its website, or with other public reports containing complaint data.

- On or before March 1, 2025, SB 923,
  - Requires plans to have all its staff who are in direct contact with enrollees in the delivery of care or enrollee services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).
  - Requires plans to implement an evidence-based cultural competency training and include all the criteria set forth in subsection (a)(2).
  - Requires plan staff to complete a refresher course if a complaint has been filed with the plan or the DMHC pursuant to Section 1368, and a decision has been made in favor of the complainant, against the plan staff member for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by the plan or the DMHC for purposes of providing trans-inclusive health care.
  - Requires plans that delegate responsibilities under SB 923 to a contracted entity, including a medical group or independent practice association, to ensure the delegated entity will comply with SB 923.

- Health and Safety Code § 1367.28.
  - Applies to all plans. Excludes specialized plans.
  - Requires plans, on or before March 1, 2025, to include information within or accessible from the plan's provider directory, and accessible through the plan's call center, that identifies which of a plan's in-network providers have affirmed that they offer and have provided gender-affirming services, including but not limited to feminizing mammoplasty, male chest reconstruction, mastectomy, gender-conforming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitoplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions. This information is required to be updated when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services.

b. Compliance and filing requirements

- 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.

15. SB 979 (Dodd, Ch. 421, Stats. 2022)—Health emergencies

Codified in Health & Safety Code § 1368.7.

a. Overview of the bill:

- Applies to all plans.
- Requires plans, on or after January 1, 2023, to provide enrollees who have been displaced or whose health may otherwise be affected by a state of emergency, declared by the Governor, or a health emergency, declared by the State Public Health Officer, access to medically necessary health care services.
- Within 48 hours of a declaration of a state of emergency or a health emergency in the county or counties in which the plan operates that displaces, or has the immediate potential to displace, enrollees or health care providers, or that otherwise affects, or may affect, health care providers or the health of enrollees, plans must file with the DMHC a notification describing whether the plan has experienced or expects to experience any disruption to the operation of the plan, explaining how the plan is communicating with potentially impacted enrollees, and summarizing the actions the plan has taken or is in the process of taking to ensure that the health care needs of enrollees are met.
- Requires plans to potentially take the following action in addition to the ones listed in subsection (b): shorten time limits for health care service plans to approve prior authorization, precertification, or referrals, and extend the time that prior authorizations, precertifications, and referrals remain valid.

b. Compliance and filing requirements:

- Plans are required to comply with this law effective January 1, 2023. 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.

16. SB 1207 (Portantino, Ch. 618, Stats. 2022)—Health care coverage: maternal and pandemic-related mental health conditions

Codified in Health and Safety Code § 1367.625.

a. Overview of the bill:

- Applies to all plans that cover mental health services. Excludes plans that only offer dental, vision or chiropractic/acupuncture products.
- Requires plans, by July 1, 2023, to develop a maternal mental health program consistent with sound clinical principles and processes, and include quality measures to encourage screening, diagnosis treatment and referral.

- Require plans to provide the program guidelines and criteria to relevant medical providers, including all contracting obstetric providers.

- As part of a maternal mental health program the plan is encouraged to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees about the program.

b. Compliance and filing requirements:

- Affirm the plan, by July 1, 2023, will develop a maternal mental health program consistent with sound clinical principles and processes, and include quality measures to encourage screening, diagnosis treatment and referral.

- Affirm the plan, by July 1, 2023, will provide the program guidelines and criteria to relevant medical providers, including all contracting obstetric providers.

- Describe how the plan will develop a maternal mental health program consistent with sound clinical principles and processes, and include quality measures to encourage screening, diagnosis treatment and referral. Provide any updated policies and procedures, as an Exhibit J-9, needed to demonstrate compliance with SB 1207.

- Describe how the plan will provide the program guidelines and criteria to relevant medical providers, including all contracting obstetric providers. Provide any provider notices, as an Exhibit I-7, to demonstrate compliance with SB 1207.

- Provide the steps the plan is taking to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees about the program. Provide any updated policies and procedures needed to demonstrate compliance with SB 1207.

- State either:

    - The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms and EOCs, and those documents are consistent with the requirements of SB 1207.

OR

- The plan reviewed its current policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of SB 1207. The plan will amend these documents to comply with SB 1207 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

17. SB 1338 (Umberg, Ch. 319, Stats. 2022)—Community Assistance, Recovery, and Empowerment (CARE) Court Program

Codified in Health & Safety Code § 1374.723.

a. Overview of the bill:

- Applies to all plans that cover mental health and substance use disorder treatment. Excludes plans that offer only dental, vision, acupuncture/ chiropractic and/or Medi-Cal products.

- Requires plans, on or after July 1, 2023, to cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider.

- Prohibits plans from requiring prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court.

- Prohibits plans from denying payment for services unless the plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

- Requires plans to provide for reimbursement of services provided to an enrollee pursuant to SB 1338, other than prescription drugs, at the greater of either of the following amounts: (1) the plan's contracted rate with the provider, or (2) the fee-for-service of case reimbursement rate paid in the

Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

- Requires plans to provide for reimbursement of prescription drugs provided to an enrollee pursuant to SB 1338 at the plan's contracted rate.

- Prohibits plans from charging copayments, coinsurance, deductibles, or any other form of cost sharing for services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs.

- Prohibits individuals or entities from billing the enrollee or subscriber or seeking reimbursement from the enrollee or subscriber for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

b. Compliance and filing requirements:

- Affirm that the plan, on or after July 1, 2023, will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider.

- Affirm the plan, on or after July 1, 2023, will not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court.

- Affirm the plan, on or after July 1, 2023, will not deny payment for services unless the plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

- Affirm the plan, on or after July 1, 2023, will provide for reimbursement of services provided to an enrollee pursuant to SB 1338, other than prescription drugs, at the greater of either of the following amounts: (1) the plan's contracted rate with the provider, or (2) the fee-for-service of case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

- Affirm the plan, on or after July 1, 2023, will provide for reimbursement of prescription drugs provided to an enrollee pursuant to SB 1338 at the plan's contracted rate.

- Affirm the plan, on or after July 1, 2023, will not charge copayments, coinsurance, deductibles, or any other form of cost sharing for services

provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs.

- Affirm the plan, on or after July 1, 2023, will not allow individuals or entities to bill the enrollee or subscriber or seek reimbursement from the enrollee or subscriber for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

- State either:

    - The plan reviewed its current policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms and EOCs, and those documents are consistent with the requirements of SB 1338.

OR

    - The plan reviewed its current policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms and EOCs, and those documents are not consistent with the requirements of SB 1338. The plan will amend these documents to comply with SB 1338 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

18. SB 1419 (Becker, Ch. 888, Stats. 2022)—Health information

Codified in Health & Safety Code § 1374.196.

a. Overview of the bill:

- Applies to all plans.

- Requires plans, on or after January 1, 2024, to establish and maintain the following application programming interfaces (API) for the benefit of enrollees and contracted providers to facilitate patient and provider access to health information, as applicable:

- Patient access API, as described in Section 422.119 (a) to (e), inclusive, of Title 42 of the Code of Federal Regulations[3].
- Provider directory API, as described in Section 422.120 of Title 42 of the Code of Federal Regulations[3].
- Payer-to-payer exchange API, as described in Section 422.119(f) of Title 42 of the Code of Federal Regulations[3].

b. Compliance and filing requirements:

- Affirm the plan, on or after January 1, 2024, will establish and maintain the following application programming interfaces (API) for the benefit of enrollees and contracted providers to facilitate patient and provider access to health information, as applicable:
  - Patient access API, as described in Section 422.119 (a) to (e), inclusive, of Title 42 of the Code of Federal Regulations.
  - Provider directory API, as described in Section 422.120 of Title 42 of the Code of Federal Regulations.
  - Payer-to-payer exchange API, as described in Section 422.119(f) of Title 42 of the Code of Federal Regulations.
- Provide a detailed explanation, along with any policies and procedures as an Exhibit J-21, of how the plan will establish and maintain the following APIs for the benefit of enrollees and contracted providers to facilitate patient and provider access to health information, as applicable:
  - Patient access API, as described in Section 422.119 (a) to (e), inclusive, of Title 42 of the Code of Federal Regulations.
  - Provider directory API, as described in Section 422.120 of Title 42 of the Code of Federal Regulations.
  - Payer-to-payer exchange API, as described in Section 422.119(f) of Title 42 of the Code of Federal Regulations.
- State either:
  - The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, and those documents are consistent with the requirements of SB 1419.

[3] Please note that the Code of Federal Regulations citation noted applies to Medicare Advantage plans, however, this bill expands the applicability set forth in the Code of Federal Regulation to all plans.

OR

- The plan reviewed its current policies and procedures, provider contracts, ASAs and plan-to-plan contracts, and those documents are not consistent with the requirements of SB 1419. The plan will amend these documents to comply with SB 1419 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC and (2) whether the amended documents will be submitted in this filing or in a separate filing.

19. SB 1473 (Pan, Ch. 545, Stats. 2022)—Health care coverage

Codified in Health & Safety Code §§ 1342.2, 1342.3 and 1399.848.

a. Overview of the bill:

- Sections 1342.2 and 1342.3.
  - Applies to all plans that cover hospital, medical or surgical services. Excludes specialized plans.
  - Requires plans to cover therapeutics for the treatment of COVID-19 without cost sharing, utilization management, or in-network requirements. Allows plans to apply a cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing, immunizations and COVID-19 therapeutics delivered by an out-of-network provider beginning 6 months after the federal public health emergency expires.
  - Prohibits out-of-network providers from reporting adverse information to a consumer credit reporting agency or commence civil action against an enrollee for payment of COVID-19 related items, services, or immunizations.
  - Requires plans to extend the provisions in Sections 1342.2 and 1342.3 to therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration when prescribed or furnished by a provider for the treatment of COVID-19 or other disease when the Governor has declared a public health emergency due to that disease.

- Section 1399.848.
  - Applies to all plans offering on-Exchange individual products through Covered California. Excludes specialized plans and plans who only offer Medi-Cal products.

- Requires plans, on or after January 1, 2023, offering on-Exchange individual products to provide an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive.

b. Compliance and filing requirements:

- Plans are required to comply with this law immediately. 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.

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