From: DMHC Licensing eFiling
Subject: APL 17-006 (OPL) Newly Enacted Statutes and Regulations
Date: Friday, March 03, 2017 8:34:00 AM
Attachments: APL - New Legislation and Regulation (APL 17--006).pdf

Dear Health Plans,

I am resending the same All Plan Letter email from yesterday, as I was informed by multiple Plans that their email servers do not accept Microsoft Office file attachment versions that are earlier than 2010. The document is the same, but has been changed to a pdf file.

Dear Health Plans,

The attached All Plan Letter (APL) outlines newly enacted statutory and regulatory requirements. Health plans (Plans) must review relevant plan documents to ensure those documents comply with the information outlined in this APL. While Plans must comply with statutes and regulations upon their effective date, Plans shall submit filings demonstrating this compliance in accordance with the Department of Managed Health Care's (DMHC's) usual filing timelines and requirements.

Edmund G. Brown Jr., Governor State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th St., Ste. 500, Sacramento, CA 95814
Telephone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: March 2, 2017

TO: All Health Plans

FROM: Sarah Ream, Deputy Director
Office of Plan Licensing

SUBJECT: APL 17-006 (OPL) Newly Enacted Statutes and Regulations

---

This All Plan Letter (APL) outlines newly enacted statutory and regulatory requirements. Health plans (Plans) must review relevant plan documents to ensure those documents comply with the information outlined in this APL. While Plans must comply with statutes and regulations upon their effective date, Plans shall submit filings demonstrating this compliance in accordance with the Department of Managed Health Care's (DMHC's) usual filing timelines and requirements.

Compliance with Newly Enacted Statutes & Regulations[1]

(1) AB 1954 (Burke, Ch. 495, Stats. 2016)

AB 1954, codified in Health and Safety Code section 1367.31, prohibits Plans from requiring an enrollee to obtain a referral from a primary care physician prior to seeking sexual and reproductive health care services. Plans shall review their Evidences of Coverage (EOCs) and revise any language requiring referrals for sexual and reproductive health care services, including but not limited to:

- The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures.
- The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases.
- The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault.

[1]The DMHC will address compliance with other recently-enacted legislation—specifically, AB 72 (Bonta, Ch. 492, Stats. 2016) and SB 908 (Hernandez, Ch. 498, Stats. 2016)—in more detail at later date.

- The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).

(2) SB 999 (Pavley, Ch. 499, Stats. 2016)

SB 999, codified in Health and Safety Code section 1367.25, requires Plans to cover a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time. Plans shall review and revise their EOCs to disclose the coverage of a 12-month supply and/or revise any language inconsistent with the requirement to cover a 12-month supply.

(3) SB 1135 (Monning, Ch. 500, Stats. 2016)

SB 1135, codified in Health and Safety Code section 1367.031, requires Plans to add a new EOC section entitled "Timely Access to Care."

- The new section must include the following timely access standards as set forth in California Code of Regualtions, title 28, section 1300.67.2.2:
    - Urgent care
    - Non-urgent primary care
    - Non-urgent specialty care
    - Telephone screening

    - Current timely access standards in section 1300.67.2.2 include:
        - Urgent care appointments not requiring prior authorization: within 48 hours
        - Urgent care appointments requiring prior authorization: within 96 hours
        - Non-urgent appointments for primary care: within 10 business days
        - Non-urgent appointments with specialists: within 15 business days
        - Non-urgent appointments with a non-physician mental health care providers: within 10 business days
        - Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions: within 15 business days
        - Telephone triage waiting time not to exceed 30 minutes

- For dental, vision, chiropractic and acupuncture plans, timely access standards shall be consistent with California Code of Regulations, title 28, section 1300.67.2.2, subdivision (a)(2).

- The new EOC section may indicate that exceptions may apply to the timely access standards if the DMHC has found exceptions to be permissible.

- The new EOC section must include a notice of the availability of interpreter services pursuant to Health and Safety Code section 1367.04. (Pursuant to California Code of Regulations, title 28, section 1300.67.04, subdivision (c)(2)(G), interpretation services must be provided to enrollees at all Plan points of contact where an enrollee might reasonably need such services.)

(4) Essential Health Benefit (EHB) Regulation

On November 28, 2016, the DMHC adopted an emergency regulation regarding recent changes to Health and Safety Code section 1367.005, relating to the provision of essential health benefits by Plans subject to that statute. The regulation is codified in California Code of Regulations, title 28, section 1300.67.005. Documentation on the adoption of the regulations is available on the DMHC's website at www.HealthHelp.ca.gov. Plans shall implement any necessary changes to comply with these regulations immediately and file revisions to EOCs and any other relevant plan documents consistent with existing DMHC filing processes and timelines.