

From: [DMHC Licensing eFiling](#)
Subject: APL 19-002 (OPL) - Newly Enacted Statutes Impacting Health Plans
Date: Friday, January 11, 2019 4:20:30 PM
Attachments: [APL 19-002 \(OPL\) - 2018 Leg Implementation.pdf](#)

Dear Health Plan Representative,

Please find the attached All Plan Letter regarding newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (Department or DMHC).

Thank you.

ALL PLAN LETTER

DATE: January 11, 2019

TO: All Health Care Service Plans

FROM: Sarah Ream, Deputy Director
Office of Plan Licensing

SUBJECT: APL 19-002 (OPL) Newly Enacted Statutes Impacting Health Plans

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

This APL identifies and discusses those bills 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 Department expects plans to comply with all applicable statutes upon the statutes' effective dates.

This APL does not necessarily identify 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.

Please note: **SB 1008 (Skinner, Ch. 933, Stats. 2018)—Dental Plan Disclosure Matrix** is not discussed in this APL; additional guidance regarding this bill will be forthcoming.

Compliance With Newly Enacted Statutes

Unless otherwise indicated below, please submit by **March 1, 2019**, one compliance filing to demonstrate compliance with all of the following newly enacted statutory requirements discussed in this APL.

- Submit the filing via eFiling as an Amendment titled "**Compliance with 2018 Legislation.**"

- In that amendment filing, please include an Exhibit E-1 (the “Compliance E-1”) that addresses how the plan is complying with the newly enacted legislation discussed below.
- Going forward, plan documents (EOCs, provider contracts, notices, etc.) must be in compliance with the newly enacted legislation and should be filed pursuant to the timelines and requirements of the Knox-Keene Act and other applicable laws. For example, plans on Covered California must file their 2020 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 Office of Plan Licensing (OPL).

1. AB 315 (Wood, Ch. 905, Stats. 2018)—Pharmacy Benefit Managers

Codified in Business and Professions Code §§4079.5 and 4441; Health and Safety Code Article 6.1 (commencing with §1385.001).

- a. Overview of the bill (please note: the following overview is limited to the provisions of the bill that are effective on January 1, 2019. Additional guidance regarding the remaining provisions of the bill will be forthcoming):*
- Applies to all plans that cover prescription drugs.
 - Requires a pharmacy to inform an enrollee at the point of sale for a covered prescription drug whether the retail price is lower than the applicable cost-sharing amount for the prescription drug, unless the pharmacy automatically charges the enrollee the lower price.
 - If the enrollee pays the retail price, the pharmacy must submit the claim to the plan in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount.
 - Requires the payment rendered by the enrollee to constitute the applicable cost-sharing and apply to the deductible, if any, and out-of-pocket maximum limit in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount.
- b. Compliance and filing requirements:*
- In the Compliance E-1:
 - Demonstrate how the plan will ensure the plan and its claims payment delegates, such as vendors and PBMs, will properly calculate enrollee

cost-sharing in light of the requirements outlined in Business and Professions Code Sections 4079.5(b) and (c). The plan should include a description of the timeframes for implementation of any new policy, procedure, or contract amendment intended to ensure compliance with Business and Professions Code Sections 4079.5(b) and (c). In the event that the plan needs to revise its claims processing procedures to comply with Business and Professions Code Section 4079.5, contact the plan's OPL assigned reviewer to discuss next steps to ensure timely compliance.

- Provide an affirmation that any cost-sharing rendered pursuant to Business and Professions Code Section 4079.5 will apply to the enrollee's deductible and/or out-of-pocket maximum.
- State *either*:
 - The plan has reviewed its current EOCs, Schedules of Benefits and disclosure forms and those documents are not inconsistent with the requirement that, for any offered pharmacy benefit, an enrollee's cost-sharing will be the lower of the pharmacy's retail price for a prescription drug or the applicable cost-sharing amount for the drug. The applicable cost-sharing paid by the enrollee will apply to both the deductible, if any, and the out-of-pocket maximum limit in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount.

OR

- The EOCs and/or disclosure forms conflict with AB 315. The plan will amend its EOCs, Schedules of Benefits and/or disclosure forms and will file those per the Knox-Keene Act's applicable timeframes.
- If the plan contracts directly with pharmacy providers, pharmacy provider groups and/or PBMs, state *either*:
 - The plan has reviewed its provider contracts and/or administrative services agreements (ASAs) and those documents do not conflict with AB 315 or Business and Professions Code Section 4079.5.

OR

- The provider contracts and/or administrative services agreements conflict with AB 315 and/or Business and Professions Code Section 4079.5. The plan will amend its

contracts and/or ASAs per the Knox-Keene Act's applicable timeframes.

2. AB 595 (Wood, Ch. 292, Stats. 2018)—Mergers and Acquisitions

Codified in Health and Safety Code §§1399.65 and 1399.66.

a. Overview of the bill:

- Applies to all plans.
- A plan that intends to merge with, or enter into other specified transactions or agreements with, any entity must notify and secure prior approval from the DMHC.
- The plan must meet specified requirements and provide information necessary for the DMHC to make the determination to approve, conditionally approve, or disapprove the transaction.
- For “major transactions,” the DMHC must:
 - obtain an independent analysis of the impact of the transaction on enrollees and the stability of the health care delivery system;
 - hold a public meeting regarding the transaction; and,
 - make findings regarding the impact of the transaction.
- Prior to approval, conditional approval, or denial of the proposed transaction, the DMHC is required to hold a public meeting regarding the proposal and make specified findings.

b. Compliance and filing requirements:

- Beginning on January 1, 2019, ensure all mergers and related transactions comply with AB 595's requirements.
- This bill does not require a filing with the Department at this time.

3. AB 1092 (Cooley, Ch. 525, Stats. 2018)—Vision Care Service Plans

Codified in Health and Safety Code §1371.

a. Overview of the bill:

- Applies only to specialized vision plans.

- Permits a specialized vision plan to use a statistically reliable method to investigate suspected fraud and recover overpayments resulting from fraud after timely and proper notice to providers.

b. Compliance and filing requirements:

- If the plan uses statistical methods to investigate suspected fraud and to recover overpayments due to fraud in its specialized vision plans, the plan must submit in a separate filing an Exhibit J-8 describing the method(s) and process(es) the plan uses or will use and how those comply with AB 1092.

4. AB 1860 (Limón, Ch. 427, Stats. 2018)—Oral Anticancer Medications

Codified in Health and Safety Code §1367.656; Insurance Code §10123.206.

a. Overview of the bill:

- Applies to all plans that cover prescription drugs.
- Allows a plan to increase the total cost-sharing limits for a 30-day supply of a prescribed orally administered anticancer medication from \$200 to \$250.¹

b. Compliance and filing requirements:

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

5. AB 2193 (Maienschein, Ch. 755, Stats. 2018)—Maternal Mental Health

Codified in Health and Safety Code §1367.625; Insurance Code §10123.867.

a. Overview of the bill:

- Applies to full-service plans and specialized behavioral health-only plans offering professional mental health services.
- By July 1, 2019, plans must develop a maternal mental health program designed to promote quality and cost-effective outcomes and that is consistent with sound clinical principles and processes.

¹ Plans participating on Covered California will need to confer with Covered California regarding whether Covered California will allow or require plans to increase the cost-sharing amount consistent with AB 1860.

b. Compliance and filing requirements:

- In the Compliance E-1, affirm the plan will develop by July 1, 2019 a maternal mental health program that meets AB 2193's requirements. Also affirm that the plan will also amend any plan documents to the extent those documents contain language that conflicts with the requirements of AB 2193 and will file those documents per the Knox-Keene Act's applicable timeframes.

6. AB 2863 (Nazarian, Ch. 770, Stats. 2018)—Prescription Drug Cost-Sharing

Codified in Business and Professions Code §4079; Health and Safety Code §1367.47; Insurance Code §10123.65.

a. Overview of the bill:

- Applies to all plans that cover prescription drugs.
- Mirrors the requirements of AB 315 with respect to when the retail cost of a prescription drug is less than an enrollee's cost-sharing amount.

b. Compliance and filing requirements:

- This bill does not require a compliance filing at this time, other than what was required for AB 315 set forth above.

7. AB 2941 (Berman, Ch. 196, Stats. 2018)—States of Emergency

Codified in Health and Safety Code §1368.7; Insurance Code §10112.95.

a. Overview of this bill:

- Applies to all plans.
- Requires a plan to provide its enrollees who have been displaced by a declared state of emergency with continued access to medically necessary health care services.
- Requires a plan, within 48 hours of a declaration of emergency by the Governor that displaces or has the immediate potential to displace plan enrollees, to file a notification with the DMHC containing specified information regarding how the plan is addressing the needs of its enrollees during the state of emergency.

b. Compliance and filing requirements:

- Plans have indicated concern about how they will learn the Governor has declared a state of emergency. The Department is reviewing the plans' concerns to determine whether there is an efficient and timely way for plans to get notice of states of emergency. Further information will be forthcoming.
- Under a separate filing, plans are encouraged (but not required) to file their general policies and procedures outlining how it will ensure enrollees impacted by a declared state of emergency will continue to receive necessary services. Plans should file these policies and procedures as Exhibit J-17s. The filing type should be an Amendment in eFiling.
- Once the plan's Exhibit J-17 is on file with the DMHC, if the Governor declares a state of emergency, the plan can submit a short filing stating it is activating its previously filed Exhibit J-17 and any additional steps the plan is taking with respect to the particular emergency. These short filings should also be submitted as an Exhibit J-17 and an Amendment filing in eFiling. Contact the plan's OPL assigned reviewer to discuss next steps to submitting the plan's Exhibit J-17.

8. SB 1021 (Wiener, Ch. 787, Stats. 2018)—Prescription Drug Tiers and Cost-Sharing

Codified in Health and Safety Code §§1342.71, 1342.72, 1342.73; Insurance Code §§10123.193, 10123.1931, 10123.1932.

a. Overview of the bill (please note that further clarification of the bill's provisions may be forthcoming):

- Applies to all plans that cover prescription drugs, excluding Medi-Cal plans.
- Prohibits a plan's drug formulary for Small Group or Individual plans from containing more than four (4) tiers.
- Requires a prescription drug benefit to provide that an enrollee is not required to pay more than the retail price for a prescription drug if a pharmacy's retail price is less than the applicable copayment or coinsurance amount, and the payment rendered by an enrollee would constitute the applicable cost-sharing.
- Extends the sunset date to January 1, 2024, for the following requirements:
 1. cost-sharing for a covered outpatient prescription drug for an individual prescription shall not exceed \$250 for a supply of up to 30 days (\$500 for bronze products); and,

2. plans whose Small Group or Individual plan formularies are grouped into four tiers must use specified definitions for each prescription drug tier. (This requirement does not apply to Large Group plans or Medi-Cal products.)
- Until January 1, 2023, plans must cover a single-tablet prescription drug regimen for combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV. (This requirement does not apply to Medi-Cal products.)

b. Compliance and filing requirements:

- In the Compliance E-1,
 - Affirm the plan has reviewed and revised its policies, as applicable, for combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, to ensure they do not have utilization management policies or procedures, including a standard of care, that rely on a multitablet drug regimen instead of a single-tablet drug regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and equally or more likely to result in adherence to a drug regimen.
 - Affirm the plan has reviewed and revised its contracts with pharmacy providers, pharmacy provider groups and/or PBMs and its pharmacy policies and procedures to ensure they are not inconsistent with the requirements of SB 1021, which require a member's cost-sharing be the lower of the pharmacy's retail price for a prescription drug or applicable cost-sharing in plan design, and such cost-sharing shall apply to both a member's deductible and out-of-pocket maximum.
 - State *either*:
 - The plan has reviewed its current EOCs, SBCs, Schedules of Benefits, pharmacy riders and disclosure forms and those documents:
 - contain language disclosing that, in any offered pharmacy benefit, an enrollee's cost-sharing will be the lower of the pharmacy's retail price for a prescription drug or the applicable cost-sharing amount for the drug. The applicable cost-sharing paid by the enrollee will apply to both the deductible, if any, and the out-of-pocket maximum limit in the same manner as if the enrollee had

purchased the prescription drug by paying the cost-sharing amount; and,

- do not contain language stating that the “essential health benefit” pharmacy design has more than four tiers.

OR

- The EOCs, SBCs, Schedules of Benefits, pharmacy riders and disclosure forms conflict with SB 1021 and the plan will amend these documents to comply with SB 1021 and file the documents per the Knox-Keene Act’s applicable timeframes.
- Contact the plan’s assigned OPL reviewer to discuss next steps to ensure timely compliance if the plan has revised its contracts with pharmacy providers, pharmacy provider groups and/or PBMs or its pharmacy policies and procedures (or those of its pharmacy providers, pharmacy provider groups and/or PBMs) for compliance with SB 1021.

9. SB 1375 (Hernandez, Ch. 700, Stats. 2018)—Small Employer Groups

Codified in Health and Safety Code §§1357, 1357.500, 1357.503, 1357.600, 1399.802, 1399.846; Insurance Code §§10700, 10753, 10753.05, 10755, 10965.02.

a. Overview of the bill (please note that additional guidance may be forthcoming):

- Applies to plans offering small employer group products.
- For plan years commencing on or after January 1, 2019, prohibits plans from issuing, marketing or selling small group products to a sole proprietorship or partnership that consists only of the sole proprietor/partner or the sole proprietor/partner and spouse. Existing health plan contracts issued by the plan to a small employer (“in force business”) may remain in effect for the duration of their contract term. However, upon renewal, SB 1375 shall apply.

b. Compliance and filing requirements:

- In the Compliance E-1, state *either*:
 - The plan has reviewed its underwriting guidelines, and any corresponding impact to existing language in current Group Subscriber Agreements, EOCs, disclosure forms and any other plan documents for consistency with SB 1375 and these documents are not inconsistent with SB 1375.

OR

- The underwriting guidelines, Group Subscriber Agreements, EOCs, disclosure forms or any other plan documents contain group eligibility provisions that conflict with changes made by SB 1375. The plan has or is in the process of updating these forms to ensure compliance with SB 1375 and will file those changes per the Knox-Keene Act's applicable timeframes.

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