Legislative Update

November 18, 2020

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Acting Director

AB 80 (Budget Committee)

Effective July 1, 2020:

- Revises the permitted range for the actuarial value of specified nongrandfathered bronze-level health plans.
- Provides the DMHC with authority to take enforcement action if a health plan is not in compliance with the requirements related to the Health Care Payments Data Program administered by the Office of Statewide Health Planning and Development.

AB 1124 (Maienschein)

- No later than May 1, 2021, the DMHC may approve two 4-year pilot programs that would permit risk-bearing organizations and restricted health plans to undertake risk-bearing arrangements with either a qualifying voluntary employees' beneficiary association (VEBA) or a qualifying trust fund.
- Pilot duration: January 1, 2022 through December 31, 2025.
- DMHC report to the Legislature by January 1, 2027.

AB 2118 (Kalra)

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

AB 2157 (Wood)

- Effective January 1, 2021, revises the requirements of the Independent Dispute Resolution Process (IDRP) to address the confidentiality of evidence submitted for review, the qualification of IDRP reviewers, and the scope of IDRP review.
- Consistent with recent changes made to the IDRP.

SB 406 (Pan)

- Effective September 29, 2020, codifies select Affordable Care Act requirements into state law:
  - Ban on lifetime and annual limits on essential health benefits.
  - Coverage of preventive services without cost-sharing.
- Extends the sunset date of the California Health Benefits Review Program by two years.
- Urgency bill, effective Sept. 29, 2020

SB 855 (Wiener)

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

SB 855 (Wiener)

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

Questions