From: DMHC Licensing eFiling

Subject: APL 22-013 – Compliance with Senate Bill 368 - Deductible and Out-of-Pocket Accrual Balances Guidance - Revised

Date: Monday, October 10, 2022 4:13PM

Attachments: APL 21-013 - Senate Bill 368 REVISED (10.10.22).pdf

Dear Health Plan Representative,

Please find attached, Revised All Plan Letter (APL) 22-013 – Senate Bill 368 - Deductible and Out-of-Pocket Accrual Balances Guidance. This APL discusses the requirements of Section 1367.0061 regarding enrollee deductible and out-of-pocket maximum accrual balances. Plans are asked to disseminate this information to their contracted entities that are delegated claims payment responsibilities. The revision made to this APL is on page 3 and is in regards to submitting new or revised Policies and Procedures related to the accrual of annual deductible and out-of-pocket maximum as Exhibit J-20.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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ALL PLAN LETTER

DATE: October 10, 2022

TO: All Commercial Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 22-013 – Senate Bill 368 - Deductible and Out-of-Pocket Accrual Balances Guidance - Revised

On October 6, 2021, Governor Gavin Newsom signed Senate Bill (SB) 368. SB 368 requires individual or group health care service plan (health plans or plans) contracts, issued, amended, or renewed on or after July 1, 2022,[1] to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. SB 368 also requires plans to notify enrollees of their rights to such accrual information and the ability to opt in to receiving the accrual information electronically instead of via mail. Delegated entities with claims payment functions must also comply with the provisions of SB 368.

This All Plan Letter (APL) sets forth the Department of Managed Health Care's (Department) guidance regarding how plans shall demonstrate compliance with SB 368. The Department expects plans to comply with SB 368 effective July 1, 2022.

I. Background

This bill, which adds Health and Safety code section 1367.0061, requires health care service plans to monitor an enrollee's accrual toward their annual deductible, if any, and annual out-of-pocket maximum for covered benefits for contracts issued, amended, or renewed on or after July 1, 2022, in the individual and group market. Plans must provide enrollees with their up-to-date accrual balance toward their annual deductible and out-

[1] This APL does not apply to health plan products that do not have a deductible or out-of-pocket maximum.

of-pocket maximum for every month in which benefits were used until the accrual balance equals the full deductible and/or out-of-pocket amount. The bill further requires plans to establish and maintain a system that allows an enrollee to request their most up-to-date accrual balance toward their annual deductible and/or out-of-pocket maximum from the plan at any time. If the plan contract includes more than one annual deductible for an enrollee, these requirements apply for each deductible.

Accrual updates must be mailed to the enrollee, unless the enrollee has elected to opt out of mailed and instead has elected to receive accrual information electronically, or unless the enrollee previously opted out of mailed notices. However, enrollees who have opted out of receiving mailed notices may opt-in at any time. Accrual notices may be included with evidence of benefit statements.

Health plans subject to the provisions of SB 368 must also notify enrollees of their rights pursuant to SB 368, including but not limited to:

- How to request information; and
- How to opt-out of mailed notices and to instead elect electronic accrual notifications.

The Department may issue guidance regarding the required notice. Such guidance is not subject to the Administrative Procedure Act[2] until January 1, 2027. The Department must consult with stakeholders in developing such guidance.

If a plan delegates claims payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity must comply with the requirements of SB 368. Plans with delegated entities must specify by contract the delegated entity's responsibilities and must monitor the delegated entity to ensure compliance with the provisions of SB 368.

II. Compliance and Filing Requirements

Please submit by **May 18, 2022**, one filing to demonstrate compliance with SB 368 requirements discussed in this APL. Submit the filing via eFiling as an Amendment titled "Compliance with SB 368."

- In the "Compliance with SB 368" Amendment filing, include an Exhibit E-1 (the "Compliance E-1") that addresses how the plan intends to comply with SB 368. The Compliance E -1 should include the following information:
    - Explain in detail how the plan will track deductible and out-of-pocket accrual balance information. Describe any systems used to track annual

[2] Chapter 3.5 (commencing with Section 1340) of Part 1 of Divisions 3 of Title 2 of the Government Code.

deductible and out-of-pocket maximum accrual balance information to ensure the enrollees can access this information at any time.

- Demonstrate how the plan is providing the availability and accuracy of the accrual balance information to ensure the enrollee can obtain up-to-date balances.

- If the plan contracts with an affiliate or third-party vendor either to assist with the tracking or delegates the tracking of accrual balance information for annual deductible and/or out-of-pocket maximum information, list the name(s) of the affiliate and/or third party vendor(s) providing such services.

- Explain the processes and systems the plan uses to obtain claims information from providers to track the up-to-date accrual balance of annual deductibles and out-of-pocket maximums.

- If the plan delegates claims payment services to a contracted entity, explain how the plan will ensure compliance with Section 1367.0061, including, but not limited to, how the plan will ensure compliance when more than one delegated entity may be responsible for claims payment where cost-sharing that accrues to the annual deductible and out-of-pocket maximum are collected. For example, if the plan delegates claims payment to a medical group as well as a specialized health care service plan(s), explain how the plan will ensure that up-to-date annual deductibles and cost-sharing amounts that accrue to the out-of-pocket maximum are accounted for from each of the contracted entities to ensure the accuracy of the information provided to the enrollees pursuant to SB 368.

- Submit any new or revised Policies and Procedures related to the accrual of annual deductible and out-of-pocket maximum amounts pursuant to ensure the most up-to date annual out-of-pocket and deductible information, as an Exhibit J-20.

- Submit template notice(s), as an Exhibit I-9, the health plan will send to enrollees informing them of their rights pursuant to Section SB 368.

- Submit any revised Evidence of Coverage, Disclosure Form or combined Evidence of Coverage and Disclosure Form language that explains to enrollees their ability to opt-out of mailed accrual notifications as an Exhibit Q-1, S-1, T-1, or U-1, as applicable.

- Submit, as an Exhibit N-1, or provide the filing number for any previously submitted third-party vendor or affiliate contracts for the tracking of the accrual balance of annual deductibles and/or out-of-pocket maximums.

- If the plan delegates claims payment functions to a contracted entity, including a medical group and/or an independent practice association, submit template verbiage the plan intends to use to demonstrate compliance with SB 368 as an Exhibit K-1. File amended provider contracts in a separate filing in accordance with Section 1352 and Rule 1300.52 or Rule 1300.52.1, as appropriate.

- If the plan delegates claims payment functions to another licensed health plan, including a specialized health care service plan, submit an Exhibit P-5 if amended to comply with SB 368.

- In addition to the above listed information, health plans shall review the following documents to determine which documents are not consistent with the requirements of SB 368. Health plans shall make all necessary revisions to ensure these documents are consistent with SB 368 and submit the revised documents as part of this filing. If the health plan determines any of the documents listed below do not require revisions to comply with SB 368, affirm the health plan has reviewed the document and no revisions were necessary.

    - EOCs, Disclosure Forms, and/or Group Subscriber Agreements.

    - Provider Contracts, Administrative Service Agreements, and/or Plan-to Plan Agreements.

If you have questions regarding the timelines for filing or other questions about the requirements of this APL, please contact your health plan’s assigned reviewer in the Office of Plan Licensing.