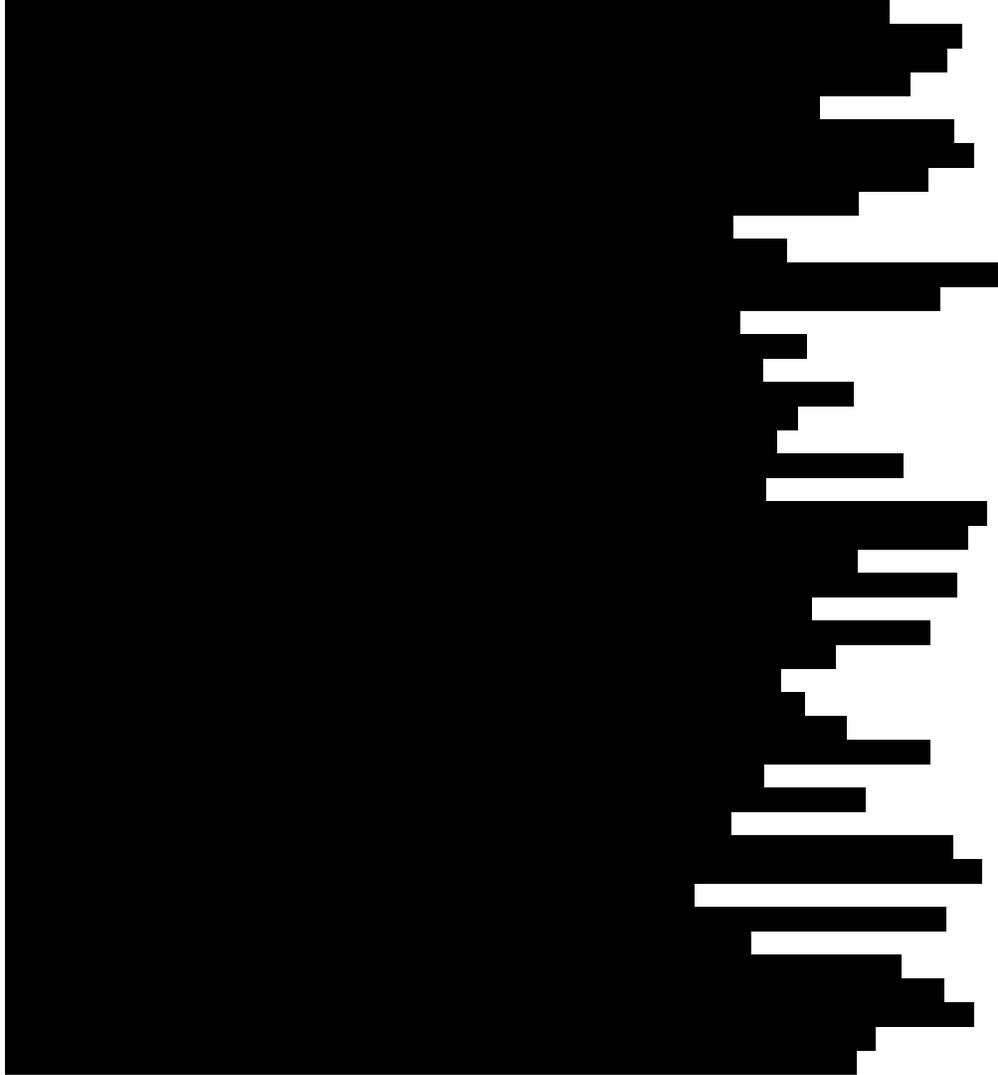


From: [DMHC Licensing eFiling](#)
Bcc:



Subject: APL 18 - 001 (OPL) - Newly Enacted Statutes Impacting Health Plan License Filings
Date: Friday, January 05, 2018 8:50:00 AM
Attachments: [APL18-001 \(OPL\) - New Legislation.pdf](#)

Dear Health Plan Representative,

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

If you have questions about this APL, please contact the Office of Plan Licensing through your assigned reviewer.

Thank you



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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ALL PLAN LETTER

DATE: January 5, 2018

TO: All Health Plans

FROM: Sarah Ream, Deputy Director
Office of Plan Licensing

SUBJECT: APL 18-001 (OPL) Newly Enacted Statutes Impacting Health Plan License Filings

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

This APL identifies and discusses those statutes that may require plans to update EOCs, disclosure forms, provider contracts, etc. 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 identify every newly enacted statute that may apply to a plan. You should consult with your plan's legal counsel to ensure compliance with all newly enacted statutes that may impact your plan.

Compliance With Newly Enacted Statutes

Unless otherwise indicated below, please submit by **March 1, 2018**, one filing to demonstrate compliance with the newly enacted statutes discussed in this APL.

- Submit the filing via eFiling as an Amendment titled "Compliance with 2017 Legislation";
- In that amendment filing include an Exhibit E-1 (the "Compliance E-1") that addresses how the plan is complying with the newly enacted legislation discussed below. For your convenience attached to this APL is a template Compliance E-1 plans may use in drafting their Compliance E-1s.

- Unless otherwise indicated below or directed by your OPL reviewer, at this time plans do not need to submit to the DMHC the actual notices and document revisions they are sending and/or posting as directed in this APL. 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 2019 plan year documents according to Covered California and DMHC timeframes.

1. AB 156 (Hernandez, ch. 468, Stats. 2017)—Individual Market: Enrollment Periods

Codified in Health and Safety Code §§ 1357.503, 1385.03, 1399.849 and 1399.859; Insurance Code §§ 10181.3, 10753.05, 10965.3 and 10965.13.

a. Overview of the bill:

- Sets the dates of the annual open enrollment period for individual, commercial full-service health benefit plans sold on or off exchange for policy years beginning on or after January 1, 2019, as follows:

On Exchange	Enrollment Window
Special Enrollment	Oct. 15, 2018 to Oct. 31, 2018
Open Enrollment	Nov. 1, 2018 to Dec. 15, 2018
Special Enrollment	Dec. 16, 2018 to Jan. 15, 2019
Off Exchange	Enrollment Window
Open Enrollment	Oct. 15, 2018 to Jan. 15, 2019

- Requires plans to supplement the annual open enrollment period with two special enrollment periods for individual coverage offered through the Exchange.
- Aligns the annual open enrollment period for coverage obtained outside the Exchange with the combined annual open and special enrollment periods for the Exchange.

b. Compliance and filing requirements:

- Beginning for plan year 2019, ensure open and special enrollment periods comply with AB 156’s requirements.
- This bill does not require a filing with the Department at this time.

2. **AB 1048 (Arambula, Ch. 616, Stats. 2017)—Pain Management and Schedule II Drug Prescriptions**

Codified in Business and Professions Code § 4052.10; Health and Safety Code §§ 1254.7, 1371.1 and 1367.43; Insurance Code §§ 10123.145 and 10123.203.

a. *Overview of the bill:*

- Applies to plans that cover prescription drugs, including Medi-Cal plans.
- Beginning July 1, 2018, authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber.
- Authorizes a pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.
- Beginning January 1, 2019, requires a plan to prorate an enrollee's cost sharing for a partial fill of a prescription of an oral, solid dosage form of the drug.
- Prohibits a plan from considering a prorated cost sharing payment made to a pharmacist for dispensing a partial fill as an overpayment.
- Removes the health facility licensure requirement that a patient's pain be assessed at the same time as vital signs.

b. *Compliance and filing requirements:*

- Plans have indicated concern that some pharmacy systems do not allow partial fills. The Department encourages plans to work closely with their pharmacy partners to ensure compliance with AB 1048.
- Plans must review their current EOCs and other disclosure forms to confirm they do not conflict with AB 1048's requirements.
- In the Compliance E-1, state *either*:
 - the plan has reviewed its current EOCs and disclosure forms and those documents do not conflict with AB 1048; or,
 - the EOCs and/or disclosure forms conflict with AB 1048 and the plan has contacted its OPL assigned reviewer to discuss next steps to ensure timely compliance.
- Going forward, plans must update EOCs (including amended and new EOCs), other disclosure forms, contracts (e.g., pharmacy benefit manager contracts), and any other applicable documents to include information relevant to AB 1048, such as the availability of partial refills and that the plan will prorate enrollee cost sharing.

3. **AB 1074 (Maienschein, ch. 385, Stats. 2017)—Pervasive Developmental Disorder or Autism**

Codified in Health and Safety Code § 1374.73; Insurance Code § 10144.51; Welfare and Institutions Code § 14132.56.

a. Overview of the bill:

- Applies to individual, small group, and large group commercial plans that provide behavioral health treatment (BHT). The bill does not apply to:
 - specialized plans that do not provide mental health or behavioral health services to enrollees;
 - a health plan contract in the Medi-Cal program; or,
 - EAP products.
- Modifies and revises employment status, qualification requirements, and scope of permissible duties for qualified autism service (QAS) providers, professionals, and paraprofessionals that provide BHT to patients with pervasive developmental disorders or autism through plan or health insurer coverage.
- Allows for QAS professionals and paraprofessionals to be employed by a qualified entity or group, deletes the requirement that QAS professionals be approved as a vendor by a Regional Center, and allows certain QAS professionals to supervise QAS paraprofessionals.
- Deletes outdated exemptions for the Healthy Families program and CalPERS and defines BHT separately for Medi-Cal plans.

b. Compliance and filings requirements:

- Plans must review their current EOCs, other disclosure forms, provider contracts, and credentialing exhibits to confirm they do not conflict with AB 1074.
- In the Compliance E-1, state *either*:
 - the plan has reviewed its current EOCs and disclosure forms and those documents do not conflict with AB 1074; *or*
 - the current EOCs and/or disclosure forms conflict with AB 1074, and the plan has contacted its assigned OPL reviewer to discuss next steps to ensure timely compliance.

4. SB 133 (Hernandez, ch. 481, Stats. 2017)—Continuity of Care

Codified in Health and Safety Code § 1373.96; Insurance Code § 10133.56.

a. Overview of the bill:

- Revises the continuity of care provisions to extend the applicability of continuity of care benefits to enrollees in the individual market when an enrollee loses coverage because his/her health plan either withdrew from the market in the enrollee's service area or ceased offering the applicable product in the enrollee's service area.
- Requires plans to:
 - include in every disclosure form required by Section 1363 and any EOC issued after January 1, 2018, notice as to the process by which an enrollee may request completion of covered services pursuant to Section 1373.96.
 - provide the plan's contracting providers and provider groups with a written copy of the process by which an enrollee may request completion of covered services pursuant to Section 1373.96.
 - provide notice of the availability of the right to request completion of covered services with any termination of coverage notice sent to an enrollee who is losing coverage under the plan because the plan is withdrawing from any portion of the market.
- SB 133 does not expressly limit its applicability to particular types of health plan products (e.g., commercial, full-service). However, the requirement to arrange for competition of covered services for a "newly covered" enrollee is triggered only if the enrollee's prior cover was terminated pursuant to paragraph (5) or (6) of Health and Safety Code section 1365, subdivision (a). Section 1365, by its terms, does not apply to Medicare, Medicare supplement, dental, or vision coverage.¹ Accordingly, SB 133's requirement for continuity of care for individual market enrollees will not be triggered if the enrollee's prior coverage was a Medicare, Medicare supplement, dental, or vision product.

b. Compliance and filing requirements:

- Plans must do *one* of the following:
 1. Send a notice to new plan enrollees in individual market products and update EOCs and disclosure forms as required by SB 133. Specifically:

¹ Health and Safety Code section 1365, subdivision (d). The DMHC will issue further, supplemental guidance regarding SB 133's applicability to behavioral health plans, including EAP products.

- a. For those new individual market enrollees that the plan has not already notified of their right to continuity of care, by March 1, 2018, send a notice to those enrollees informing them of their continuity of care rights under SB 133;
- b. by March 1, 2018, update EOCs and disclosure forms that the plan maintains electronically on the plan's website(s) to include notice of the process by which an enrollee may request completion of covered services pursuant to Health and Safety Code section 1373.96²;
- c. going forward, ensure EOCs and disclosure forms contain the information required by SB 133 and submit revised EOCs and disclosure forms to the Department pursuant to normal filing timelines and requirements; and,
- d. by March 1, 2018, confirm in the Compliance E-1 that the plan has taken steps 1.a.-1.c. above.

OR

2. Send all plan enrollees a revised EOC and disclosure form that contain the notice language required by SB 133. Specifically,
 - a. revise all individual market plan EOCs and disclosure forms that will be in effect on or after January 1, 2018;
 - b. submit those revised EOCs and disclosure forms to the Department for review;
 - c. send all individual market enrollees and/or subscribers the revised EOCs and disclosure forms; and
 - d. by March 1, 2018, confirm in the Compliance E-1 that the plan has or is in the process of completing steps 2.a.-2.c. above.

5. SB 223 (Atkins, ch. 771, Stats. 2017)—Health Care Language Assistance Services

Codified in Health and Safety Code §§ 1367.04 and 1367.042; Insurance Code §§ 10133.8 and 10133.11; Welfare and Institutions Code §§ 14029.91, 14029.92, and 14727.

a. Overview of the bill:

- Applies to all plans (although the bill applies somewhat differently to Medi-Cal plans). Specialized plans (excluding plans that arrange for mental health benefits in other than an employee assistance program), may request from the DMHC an exemption from compliance with SB 223. A specialized plan that wishes to request an exemption should

² If the plan's 2018 EOCs and disclosure forms included the notice required by SB 133, and the Department has approved the notice language, please indicate this in the Compliance E-1.

submit the request as a material modification filing via the eFiling system.

- Aligns California law with Section 1557 of the ACA and requires health plans to provide enrollees with a notice of the health plan's non-discrimination policy, the availability of language assistance services for limited-English proficient (LEP) enrollees, and the process for filing a discrimination complaint.
- The notice must be included in the plan's EOCs effective on or after January 1, 2018, on the plan's website, and at least annually in health plan materials.
- Plans must include a notice of the availability of interpreter services in the top 15 languages spoken by LEP individuals in California as determined by the Department of Health Care Services (DHCS).
 - Per DHCS, the top 15 languages are:
 1. Arabic
 2. Armenian
 3. Cambodian
 4. Chinese
 5. Farsi
 6. Hindi
 7. Hmong
 8. Japanese
 9. Korean
 10. Punjabi
 11. Russian
 12. Spanish
 13. Tagalog
 14. Thai
 15. Vietnamese.³
- Sets requirements for interpreter qualifications.

b. Compliance and filing requirements:

1. Update EOCs and disclosure forms. Specifically:

³ In its June 30, 2017, All Plan Letter 17-011, DHCS identified the top 16 languages spoken by LEP individuals in California. DHCS confirmed to the DMHC that the 16th language is Laotian, which is not included in the top 15 languages at this time.

- a. by March 1, 2018, update EOCs and disclosure forms the plan maintains electronically on the plan's website(s) to comply with SB 223's requirements;
 - b. on a going forward basis, ensure EOCs and disclosure forms contain the information required by SB 223 and submit revised EOCs and disclosure forms to the Department pursuant to normal filing timelines and requirements; and,
 - c. by March 1, 2018, submit the Compliance E-1 confirming the plan has taken a. and b. steps above.
2. Specialized health plans may request an exemption from compliance with SB 223 by submitting an exemption request pursuant to Health and Safety Code section 1343 to the DMHC via the eFiling system. If you intend to request an exemption, please submit the request via a material modification filing by March 1, 2018; otherwise the Department will assume the plan intends to comply with SB 223.

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

Attachment 1

To assist plans with filing the Compliance E-1, the Department provides the language below for your convenience. Please chose the alternatives as appropriate and modify the language as your plan deems necessary.

Template Compliance E-1

[Name of plan] submits this Compliance E-1, as directed in the Department's APL 18-001, to demonstrate compliance with certain statutes enacted in 2017.

1. AB 1048 Compliance

[Choose one]

- A. The plan has reviewed its current EOCs and other disclosure forms and confirms they do not conflict with AB 1048.

OR

- B. The plan has reviewed its current EOCs and other disclosure forms and one or more of those documents contain language that conflicts with the provisions of AB 1048. The plan has contacted its assigned OPL reviewer to discuss what steps the plan must take to ensure timely compliance.

2. AB 1074 Compliance

[Choose one]

- A. The plan has reviewed its current EOCs, other disclosure forms, provider contracts, and credentialing exhibits and confirms they do not conflict with AB 1074.

OR

- B. The plan has reviewed its current EOCs, other disclosure forms, provider contracts, and credentialing exhibits and one or more of those documents contain language that conflicts with the provisions of AB 1074. The plan has contacted its assigned OPL reviewer to discuss what steps the plan must take to ensure timely compliance.

3. SB 133 Compliance

[Choose one]

A. The plan:

1. notified, or by March 1, 2018, will have notified, new individual market enrollees in the plan of their continuity of care rights under SB 113;
2. has, or by March 1, 2018, will have updated its online EOCs and disclosure forms to include notice of the process by which an enrollee may request completion of covered services pursuant to Health and Safety Code section 1373.96;
3. will ensure on a going forward basis that its EOCs and disclosure forms contain the information required by SB 133.

OR

B. The plan has or is in the process of:

1. revising all individual market plan EOCs and disclosure forms that will be in effect on or after January 1, 2018;
2. submitting those revised EOCs and disclosure forms to the Department for review;
3. sending all individual market enrollees and/or subscribers the revised EOCs and disclosure forms.

4. SB 223 Compliance

A. The plan has updated its online EOCs and disclosure forms to contain the information require by SB 223.

B. The plan will ensure on a going forward basis that its EOCs and disclosure forms contain the information require by SB 223.

[Alternative for specialized plans seeking an exemption from SB 223's requirements]

The plan has requested from the Department an exemption from compliance with SB 223. That request for an exemption was filed in eFiling number _____.