DEPARTMENT OF MANAGED HEALTH CARE

Director: Mary Watanabe ◆(916) 324-8176 ◆Help Center (888)466-2219 or www.HealthHelp.ca.gov ◆Internet: www.dmhc.ca.gov

The Department of Managed Health Care (DMHC), created on July 1, 2000, regulates the managed care industry in California. The creation of DMHC resulted from Governor Gray Davis's approval of AB 78 (Gallegos) (Chapter 525, Statutes of 1999), a bill that reformed the regulation of managed care in the state. DMHC is created in Health and Safety Code section 1341; DMHC's regulations are codified in Title 28 of the California Code of Regulations (CCR).

DMHC administers the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 et seq., which is intended to promote the delivery of health and medical care to Californians who enroll in services provided by a health care service plan. A "health care service plan" (health plan)—more commonly known as a health maintenance organization (HMO) or managed care organization (MCO)—is defined broadly as any person who undertakes to arrange for the provision of health care services to enrollees, or to pay for or reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of enrollees.

In Health and Safety Code section 1342, the legislature has expressly instructed the Department Director to ensure the continued role of the profession as the determiner of the patient's health needs, ensure that enrollees are educated and informed of the benefits and services available in order to increase consumer choice in the healthcare market, and promote effective representation of the interests of enrollees, including ensuring the best possible health care at the lowest possible cost by transferring the financial risk of health care from patients to providers. The

Department Director must also prosecute individuals and/or health plans who engage in fraud or misrepresent or deceive consumers, ensure the financial stability of health plans through proper regulation, and ensure that health care be accessible to enrollees and rendered in a manner to provide continuity of care, which includes a grievance process that is expeditious and thoroughly reviewed by DMHC.

The Director of DMHC is appointed by and serves at the pleasure of the Governor. The Department's staff of attorneys, financial examiners, health plan analysts, physicians, health care professionals, consumer service representatives, and support staff assist the DMHC Director in licensing and regulating 132 health plans in California. Licensed health plans include HMOs and other full-service health plans, as well as several categories of specialized health plans such as prepaid dental, vision, mental health, chiropractic, and pharmacy plans. DMHC-licensed health plans provide health care services to 27.7 million California enrollees.

Created in Health and Safety Code section 1374.30 et seq., DMHC's independent medical review (IMR) system allows health plan enrollees to seek an independent review when medical services are denied, delayed, or otherwise limited by a plan or one of its contracting providers, based on a finding that the service is not medically necessary or appropriate. The independent reviews are conducted by expert medical organizations that are independent of the health plans and certified by an accrediting organization. An IMR determination is binding on the health plan, and the Department will enforce it. 68% of total consumer appeals (IMRs) have resulted in the consumer receiving the requested service or treatment from their health plan.

SB 260 (Speier) (Chapter 529, Statutes of 1999) added section 1347.15 to the Health and Safety Code to create the Financial Solvency Standards Board (FSSB). Composed of the DMHC Director and seven members appointed by the Director, FSSB periodically monitors and reports

on the implementation and results of those requirements and standards and reviews proposed regulatory changes. FSSB advises the DMHC Director on matters of financial solvency affecting the delivery of health care services. FSSB develops and recommends financial solvency requirements and standards relating to plan operations. Current FSSB members include Larry deGhetaldi, M.D., Paul Durr, Scott Coffin, Abbi Coursolle, Theodore Mazer, M.D., Jeff Rideout, M.D., Mary Watanabe, and Amy Yao.

AB 133 (Committee on Budget) (Chapter 143, Statutes of 2021) added section 1399.870 to the Health and Safety Code to create the Health Equity and Quality Committee (Committee). The Committee is tasked with making recommendations to the DMHC Director for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery.

DMHC houses the Help Center, which is open 24 hours a day, 365 days a year, and functions in many languages to help consumers who experience problems with their health plan. The Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to appropriate health care services. The DMHC Help Center provides direct assistance to health care consumers through a call center and online access, with 2.5 million total consumers assisted in California since its creation. DMHC is funded by assessments on its regulated health plans.

HIGHLIGHTS

Department Approves Centene Acquisition of Magellan Health

On December 30, 2021, DMHC announced that it had approved Centene Corporation's acquisition of Magellan Health, Inc. (Magellan), with certain conditions. Magellan is the parent entity for two DMHC-licensed plans: Human Affairs International of California (HAI-CA) and Magellan Health Services of California, Inc.–Employer Services (MHSC). The acquisition is contingent on Centene and Magellan's ("the plans") compliance with conditions made by DMHC "to ensure the merger does not adversely impact enrollees or the stability of California's health care delivery system." Among several other financial and competition-based conditions, the plans will be required to help to control health care costs and must keep premium rate increases to a minimum. Specifically, the plans will not be allowed to increase premiums as a result of acquisition costs. Magellan must also continue its market presence in California, and HAI-CA must continue to fulfill its existing contracts to provide behavioral health services at the same rates for at least two years. Furthermore, Centene must invest $10 million "to support the acceleration of behavioral health integration into primary care practices in California's health care delivery system." A third-party monitor will be set in place to ensure compliance with competition related conditions, including that the plans continue to operate as separate businesses. Centene must reimburse DMHC for the cost of the third-party monitor.

Magellan will continue to operate independently under Centene's Health Care Enterprises umbrella, and the Magellan leadership team will continue to lead the organization.

On January 12, 2021, Magellan filed notice with DMHC outlining the proposed acquisition. After determining the proposed acquisition met the requirements of a major

transaction Deborah Haas Wilson, PH.D., was retained by the Office of the California Attorney General on behalf of DMHC, to conduct an independent analysis of the anti-competitive impact on subscribers and enrollees as a result of the proposed acquisition. *[27:1 CRLR 27–29]* On October 27, 2021, DMHC held a public meeting to address the proposed acquisition. The public comment period for this meeting concluded on November 3, 2021.

Representatives from Centene and Magellan accepted and signed the DMHC conditions on December 28, 2021.

DMHC and Department of Health Care Services Issue $55 Million in fines to L.A. Care Health Plan in Enforcement Action to Protect Consumers

On March 4, 2022, DMHC released a statement detailing its enforcement action against Local Initiative Health Authority for Los Angeles County (L.A. Care), the state's largest Medi-Cal plan. The action is the result of DMHC's joint investigation with the Department of Health Care Services (DHCS), which, according to the statement, was spurred by a 2020 *Los Angeles Times* article, and revealed numerous operational violations by L.A. Care causing harm to Los Angeles' poorest patients. DMHC's 45-page accusation details L.A. Care's repeated violations of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) including violations concerning the handling of enrollee grievances, the processing of requests for authorization (utilization review or utilization management), overseeing and adequately supervising its contracted entities regarding timely access, and the processing of claims. According to the accusation, "[t]he widespread, systemic, and unrelenting nature of these violations is unprecedented and has caused harm to Respondents' enrollees." Of note, in 2021, L.A. Care disclosed to DMHC and DHCS a systemic failure to timely issue grievance resolution letters to

enrollees dating back to 2017. The agencies' joint investigation revealed that as of December 2021, L.A. Care had failed to timely resolve 67,717 instances where the plan failed to respond in a timely manner to grievances for several lines of business. Additionally, L.A. Care disclosed that the plan had a backlog of 9,125 processing requests for authorizations of health care services for DMHC, and 8,517 requests to the DHCS for a three-month period in 2021. Upon further inquiry, DMHC and DHCS identified 92,854 further instances in which prior authorization requests were not processed in a timely manner from January 1, 2019, through October 13, 2021. DMHC and DHCS also found that L.A. Care had failed to maintain sufficient organizational and administrative capacity to provide services to members.

DMHC's statement about the action asserts that all of these operational violations had detrimental impacts on L.A. Care members, such as unnecessary delays in receiving medical treatment. Ultimately, DMHC issued a $35 million penalty, and DHCS issued a $20 million sanction on L.A. Care. According to the *Los Angeles Times*, the total $55 million fine is reportedly the largest enforcement action in California history.

AB 1400, the California Guaranteed Health Care for All Act, Pulled Before Voting Occurred in the Assembly

AB 1400 (Kalra), titled the "California Guaranteed Health Care for All Act," as amended January 24, 2022, and as it applies to DMHC, would have added Title 23 to the Government Code to establish a universal single-payer health care coverage and cost control system for all California residents.

AB 1400 would have created the CalCare program, a publicly financed healthcare system that would have provided health care coverage to all Californians, regardless of income or

immigration status. According to the bill analysis, an estimated 3.2 million Californians remain uninsured today. Supporters of the bill, including the California Nurses' Association, several California cities and counties, universal healthcare advocates, social justice in healthcare organizations, political organizations, and labor unions, believe CalCare would have saved residents money by forming a singular government program that would remove the cost of premiums, deductibles, and copays associated with private insurance. CalCare would run as an independent public entity governed by a nine-member executive board, a Public Advisory Committee, and an eleven-member Advisory Committee on Long-term Services and Supports. According to the Assembly Appropriations Committee's analysis, this program would cost an estimated $314 to $391 billion in state and federal funds, which would exceed Governor Newsom's proposed state budget of $286.4 billion.

The Author, Assemblymember Ash Kalra, proposed to pay for the costs with ACA 11, a constitutional amendment that would have raised taxes by increasing payroll and sales taxes for large businesses and increasing the payroll tax by 1% for those who earn more than $49,900; thereby providing hundreds of billions of dollars to help fund the CalCare program.

The bill drew significant opposition from powerful coalitions, such as the "Protect California Health Care Coalition," comprised of the California Life and Health Insurance Coalition, the California Chamber of Commerce, the California Hospital Association, the California Medical Association, and others, who, according to the bill analysis, cited a host of concerns including that the bill would fragment patient care, leading to increased clinical practice variation and poorer health outcomes, poorer consumer protections, increased costs, and loss of jobs.

Ultimately, Kalra pulled the bill from the Assembly floor before voting occurred on January 31, 2022, explaining in a press release, "we did not have the votes necessary for passage and I decided the best course of action is to not put AB 1400 for a vote today." Because AB 1400 was introduced in 2021, and did not meet the January 31, 2022 deadline to pass out of the Assembly, it is considered "dead" for this legislative session. ACA 11, however, is still pending; it requires a 2/3 vote in each house, and voter approval to pass.

Department Proposes Rulemaking Action on Annual, Quarterly, and Monthly Financial Reporting Requirements

On December 24, 2021, DMHC published notice of its intent to adopt Rule 1300.84.03; amend and renumber Rules 1300.84.06; amendment to Rules 1300.84.2 and 1300.84.3; and renumber Rules 1300.84.06 to 1300.84.1, of Title 28 of the CCR to clarify the annual, quarterly, and monthly financial reporting requirements for health plans, which is set forth in the proposed language. According to the initial statement of reasons, the proposed regulations are the Department's efforts to update existing reporting requirements by including new reporting forms and an instruction manual to adapt the law to new technologies, health plan operation changes, and health delivery trends in order for health plans to maintain financial viability at all times to protect against claims received on behalf of health plan enrollees. The initial statement of reasons further states that "the changes proposed in this regulatory package reflect the outcome of discussions with health plans related to best practices for health plan financial reporting."

The initial public comment period ended on February 7, 2022. On March 4, 2022, the Department provided notice of a second public comment period. The revised proposed language for the second public comment period contained minor amendments to the original proposed

language that did not significantly impact the rules or the reporting forms. The comment period on the modified text expired on March 21, 2022. At this writing, the Department has not taken further action on the regulations.

Department Issues Prescription Drug Cost Transparency Report for Measurement Year 2020

On December 27, 2021, DMHC released its Prescription Drug Cost Transparency Report for Measurement Year 2020. Pursuant to SB 17 (Hernandez) (Chapter 603, Statutes of 2017), Health and Safety Code section 1367.243 requires health plans that offer commercial products and file rate information with DMHC to report, for all covered prescription drugs annually, the 25 most frequently prescribed drugs, the 25 most costly drugs by total annual spending, and the 25 drugs with the highest year-over-year increase in total annual plan spending. This provision also requires DMHC to compile the data into a report for the public and the legislature that demonstrates the overall impact of drug costs on health care premiums and post its report on its website every year on January 1. *[23:1 CRLR 26–27]* The most recent report looks at the impact of the cost of prescription drugs on health plan premiums compared to data over-reporting years: 2017, 2018, 2019, and 2020.

In a press release issued by the Department, Director Mary Watanabe commented that the amount health plans paid for prescription drugs has increased by $1.5 billion since 2017, showing that "the cost of prescription drugs continued to outpace the growth of overall medical expenses in health plan premiums," and that "[t]his report provides greater transparency into prescription drug costs and provides important information about the impact prescription drug costs have on health plan premiums." Other key findings indicated that health plans paid more than $10.1 billion for prescription drugs in 2020, an increase of almost $500 million or 5% from 2019. The

Department found that prescription drugs accounted for 12.7% of total health plan premiums in 2020, a slight decrease from 12.8% in 2019. Prescription drugs accounted for 12.9% of total health plan premiums in 2017.

Health plans' prescription drug costs increased by 5% in 2020, whereas medical expenses increased by 3.7%. Overall, total health plan premiums increased by 5.9% from 2019 to 2020. Manufacturer drug rebates totaled approximately $1.437 billion, up from $1.205 billion in 2019 and $1.058 billion in 2018, representing about 14.2% of the $10.1 billion spent on prescription drugs in 2020.

According to the report, while specialty drugs accounted for only 1.6% of all prescription drugs dispensed, they accounted for 60.2% of total annual spending on prescription drugs. Generic drugs accounted for 89.1% of all prescribed drugs but only 18.1% of the total annual spending on prescription drugs. Brand name drugs accounted for 9.3% of prescriptions and constituted 21.7% of the total annual spending on prescription drugs. The 25 Most Frequently Prescribed Drugs represented 48.2% of all drugs prescribed and approximately 46.2% of the total annual spending on prescription drugs. For the 25 Most Frequently Prescribed Drugs, enrollees paid 2.9% of the cost of specialty drugs, 11.5% of the cost of brand name drugs, and 59.2% of the cost of generics. Of the 12.7% of total health plan premium spent on prescription drugs, the 25 Most Costly Drugs accounted for 7.2%. Overall, health plans paid 92.8% of the cost of the 25 Most Costly Drugs across all three categories (generic, brand name, and specialty).

DMHC's Health Equity and Quality Committee Convenes its First Meeting

On February 24, 2022, DMHC's Health Equity and Quality Committee (Committee) held its first meeting via Zoom. AB 133 (Committee on Budget) (Chapter 143, Statutes of 2021), which

became effective January 1, 2022, requires DMHC to establish the Committee to make recommendations regarding standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery. *[27:1 CRLR 38]*

According to DMHC's Committee Overview, the Committee will consider various quality measures; effective ways to measure health outcomes in the absence of quality measures; approaches to stratifying reporting of results by factors, including age, sex, geographic region, race, ethnicity, language, sexual orientation, gender identity, and income; alternative methods to measure physical and behavioral health outcomes; and measures of social determinants of health. Pursuant to section 1399.870 of the Health and Safety Code, the Committee is comprised of 17 voting members, including consumer representatives, experts, researchers, and community members who are engaged in the development of alternative approaches to measuring health equity, consumer experience, and health outcomes, and five ex officio representatives from DMHC, Covered California, California Department of Insurance, California Public Employees Retirement System, and the California Department of Healthcare Access and Information. It must submit its final recommendations to the DMHC Director by September 30, 2022.

DMHC will establish standards for health plans to comply with starting in 2023 and DMHC may assess administrative penalties relating to health plan data collection, reporting, and corrective action implementation or monitoring requirements. The standard measures and annual benchmarks shall sunset every five years at most and may be continued as long as DMHC conducts a public assessment at least one year before sunset. In 2025, DMHC will publish the first annual Health Equity Quality Compliance Report and may begin assessing administrative penalties for failure to meet the health equity and quality benchmarks. It is anticipated that the measures and benchmarks will be codified in regulation by 2026.

FSSB Quarterly Meetings

On February 23, 2022, FSSB held its first quarterly meeting of 2022 through video conference and teleconference. DMHC staff provided a number of updates to FSSB, namely: a Department of Health Care Services Update, which included budgetary, oversight, and accountability information, an update on pending and recently approved regulations, an update of recently passed federal laws, Dental Medical Loss Ratio (MLR) requirements and summary, a provider solvency quarterly update, a report providing the status of the risk bearing organizations on corrective action plans, the health plan quarterly update, and a report on health plan enrollment and tangible net equity. The next quarterly FSSB meeting is scheduled for May 19, 2022.

On November 17, 2021, FSSB held its final quarterly of 2021 meeting through video conference and teleconference. DMHC staff provided a number of updates to FSSB, namely: a report providing the financial summary of Medi-Cal managed care health plans for the quarter, a legislative update providing an overview of bills recently signed Governor Newsom that affect DMHC, a 2020 risk adjustment transfers report that provided a summary of risk adjustment transfers and high-cost risk pool payments or plans regulated by DMHC and the California Department of Insurance, a report that gave an overview of the 2022 rates for the individual market (noting that the average rate increase for 2022 was 1.8 percent across all health plans), an update on the financial solvency of risk bearing organizations for the quarter and a report providing the status of the risk bearing organizations on corrective action plans, and a report on health plan enrollment and tangible net equity.

At this meeting, Mary Watanabe announced three new FSSB members who would began their duties in January 2022: Dr. Larry deGhetaldi from the Palo Alto Medical Foundation, Scott

Coffin, the CEO of Alameda Alliance for Health, and Abbi Coursolle, the senior attorney at the National Health Law Program.

MAJOR PUBLICATIONS

The following reports or studies have been conducted by or about DMHC during this reporting period:

All Plan Letters

- ***APL 22-013*** – Senate Bill 368 - Deductible and Out-of-Pocket Accrual Balances Guidance – April 6, 2022 (Issued to all commercial health plans, provides guidance regarding how plans shall demonstrate compliance with SB 368 (Limón) (Chapter 602, Statutes of 2021), which requires individual or group health care service plan contracts that are issued, amended, or renewed on or after July 1, 2022, to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month that benefits were used until the accrual balances are met. SB 386 also requires plans to notify enrollees of their rights to receive such accrual information and the ability to receive the information electronically instead of regular mail).

- ***APL 22-012*** – Section 1357.503 Compliance and MEWA Registration – March 24, 2022 (Issued to all health care service plans, provides guidance regarding how plans shall demonstrate compliance with SB 255 (Bradford) (Chapter 407, Statutes of 2019), SB 718 (Bates) (Chapter 746, Statutes of 2021), and California Health and Safety Code section 1357.503. To demonstrate compliance, plans offering fully insured benefits to multiple employer welfare arrangements (MEWA) through a large group health care service plan contract must provide a compliance filing on or before April 15, 2022, using the provided information and exhibits of the

APL. MEWAs are also required to register with DMHC on or before June 1, 2022, by submitting the Application Form for MEWA Registration (DMHC 10-283).

- ***APL 22-011*** – No Surprise Act (NSA) Guidance – March 21, 2022 (Issued to All Full-Service Commercial Health Care Service Plans, provides guidance on the federal No Surprises Act, included in the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions), which prohibits surprise balance billing in specified nonemergency, emergency, and air ambulance circumstances, and establishes other consumer protections, including limiting enrollee cost sharing and setting parameters for disputes between plans and providers regarding reimbursement amounts).

- ***APL 22-010*** – Guidance Regarding AB 1184 – March 17, 2022 (Issued to all health care service plans, provides guidance on the confidential requirements needed to comply with AB 1184 (Chiu) (Chapter 190, Statutes of 2021), which requires health plans to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or situations in which disclosure would endanger the individual).

- ***APL 22-009*** – Provider Directory Annual Filing Requirements – March 16, 2022 (Issued to all health care service plans, reminding health plans of their obligations pursuant to section 1367.27(m) of the Health and Safety Code relating to the annual submittals of provider directory policies and procedures to DMHC).

- ***APL 22-008*** – 2022 Annual Assessments – March 9, 2022 (Issued to all health care service plans, reminding health plans of their obligations pursuant to 1300.84.6(a), Title 28 of the CCR, which directs plans to file the Report of Enrollment Plan on or before May 15, 2022).

- ***APL 22-007*** – DPN [Division of Plan Networks] Monitoring and Annual Reporting Changes – March 4, 2022 (Issued to all health care service plans, provides guidance to health plans on the monitoring and submitting requirements for the Timely Access Compliance Report and Annual Network Report needed to comply with SB 221 (Wiener) (Chapter 724, Statutes of 2021), AB 457 (Santiago) (Chapter 439, Statutes of 2021), and section 1300.67.2.2, Title 28 of the CCR).

- ***APL 22-006*** – Plan Year 2023 QHP [Qualified Health Plans] and QDP [Qualified Dental Plans] Filing Requirements – February 1, 2022 (Issued to all health care service plans, provides guidance to health plans in preparation of Plan Year 2023 regulatory submissions, in compliance with the Knox-Keene Act and regulations promulgated by the Department under Title 28 of the CCR).

- ***APL 22-005*** – Federal Requirement to Cover At-Home COVID-19 Tests Purchased Over-the-Counter – January 25, 2022 (Issued to All Full-Service Commercial Health Care Service Plans, provides guidance on the requirements needed to comply with SB 510 (Pan) (Chapter 729, Statutes of 2021), which requires health service plans cover the costs for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19, or a future disease declared as a public health emergency by the Governor of the State of California, and prohibits cost sharing or prior authorization requirements for that coverage).

- ***APL 22-004*** – Assembly Bill 347 Step Therapy Exception Coverage Guidance – January 21, 2022 (Issued to All Full-Service Commercial and Medi-Cal Health Care Service Plans, provides guidance on requirements needed to comply with AB 347 (Arambula) (Chapter 742, Statutes of 2021), which requires plans to expeditiously grant step therapy exceptions within specified time periods when use of the prescription drug required under step therapy is inconsistent with good professional practice and permits providers to appeal a health plan's denial of an

exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request).

Licensure and Guidance All Plan Letters

- ***APL 21-024*** – Risk Bearing Arrangement Disclosures – November 17, 2021 (Issued to all health care service plans, reminding health plans that they must comply with contract and disclosure requirements applicable to risk-bearing arrangements between plans and risk-bearing organizations (RBOs), and ensure that, pursuant to section 1300.75.4.1, Title 28 of the CCR, and section 1375.4 of the Health and Safety Code, provisions regarding the RBO's administrative and financial capacity, and information regarding the financial risk assumed by the RBO for each risk arrangement, are included in the contract to ensure RBOs are informed of their financial risk under the contract).

- ***APL 21-025*** – Newly Enacted Statutes Impacting Health Plans (2021 Legislative Session) – December 20, 2021 (Issued to all health care service plans, informing health plans of newly enacted statutory requirements under 15 enacted bills that may require plans to update plan documents including Evidences of Coverage, disclosure forms, and provider documents, and requiring health plans to submit one filing to demonstrate or affirm the plans compliance with the new statutory requirements addressed in the APL by February 22, 2022).

- ***APL 22-001*** – Large Group Renewal Notice Requirements – January 4, 2022 (Issued to full-service health care service plans, providing guidance on the timing and contact requirements for large group contract holder renewal notices pursuant to sections 1374.21 and 1385.046 of the Health and Safety Code, which must include: a statement on whether the proposed rate change in the contract is greater than the average rate increase for individual market products negotiated by Covered California, the average rate increase negotiated by

CalPERS, and the average rate increase for coverage offered in the large group market, as confirmed and posted by DMHC on its website; and information on how the large group contract holder can apply to DMHC to review the rate change beginning July 1, 2021).

- ***APL 22-002*** – Hospital Block Transfer Filings for PPO Enrollees – January 19, 2022 (Issued to all full-service health care service plans, reminding health plans to comply with Block Transfer filing and notice requirements applicable to hospital contract terminations affecting Preferred Provider Organization enrollees in the APL by April 1, 2022, which includes a reminder to plans that Block Transfer filings must be filed when hospital contract terminations transfer or redirect 2,000 or more enrollees, that plans must provide notice to all PPO enrollees living within 15 miles of the terminating hospital, and that plans must file any updated Block Transfer policies and procedures outlined in the APL with DMHC).

- ***APL 22-003*** – Assembly Bill 457 Protection of Patient Choice in Telehealth Provider Act – January 21, 2022 (Issued to All Full-Service Commercial and Specialized Care Service Plans, providing guidance for plans to comply with AB 457 (Santiago) (Chapter 439, Statutes of 2021), which requires plans to meet certain conditions if they offer telehealth services to enrollees through third-party corporate telehealth providers, including making disclosures about the availability of the receiving service, informing enrollees of other options for receiving the service, and notifying enrollees of medical records access policies; and requires plans to submit a filing demonstrating compliance with the requirements discussed in this APL by March 21, 2022). *[see 27:1 CRLR 40]*

RULEMAKING

The following is a status update on recent rulemaking proceedings that DMHC has initiated:

- **Transfer of Enrollees Pursuant to a Public Health Order:** On January 26, 2022, the Office of Administrative Law (OAL) approved the permanent adoption of DMHC's proposed amendments to section 1300.67.02, Title 28 of the CCR, which requires health plans to transfer enrollees from hospitals that are highly impacted by patients with COVID-19 to those with available capacity. On September 17, 2021, DMHC initially published notice of its intent to adopt section 1300.67.02, Title 28 of the CCR in order to permanently adopt the emergency regulation that became effective on January 15, 2021. *[see 27:1 CRLR 25]* The amended regulations became effective on January 26, 2022.

- **Summary of Dental Benefits and Disclosure Matrix:** On November 16, 2021, DMHC published its Notice of Second Proposed Readoption of Emergency Rulemaking to readopt section 1300.63.4, Title 28 of the CCR, pertaining to dental benefits. DMHC initially noticed its intent to amend these sections via emergency rulemaking on December 30, 2020, which was approved by OAL on January 25, 2021. *[27:1 CRLR 23]* The emergency regulation, effective December 14, 2021, is exempt from OAL review pursuant to section 1363.04(f)(2) of the Health and Safety Code.

On November 18, 2021, DMHC published notice of the second comment period of rulemaking action pertaining to the formal adoption of section 1300.63.4, Title 28 of the CCR, "Summary of Dental Benefits and Coverage Disclosure Matrix." The second written public comment period ended on December 3, 2021. At this writing, no further action has been taken on the rulemaking package.

LEGISLATION

- **AB 2205 (Carrillo)**, as amended on March 24, 2022, and as it applies to DMHC, would add section 1347.8 to the Health and Safety Code to require, beginning July 1, 2023, that

health care service plans annually report the total amount of funds in the segregated accounts these plans maintain pursuant to subdivision (a) of section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). AB-2205 would require the annual report to include the ending balance of the account and the total dollar amount of claims paid during a reporting year. *[A. Health]*

- **SB 1033 (Pan)**, as introduced February 15, 2022, and as it applies to DMHC, would amend sections 1367.04 and 1367.07 of the Health and Safety Code regarding standards and requirements of health care service plans as related to enrollees. This bill would require health plans to assess, and annually update the assessment of, the cultural, linguistic, and health related social needs of enrollees to identify health disparities, improve healthcare quality, and address population health. SB 1033 would also require DMHC to: obtain accreditation, establish standardized reporting techniques for such assessments, provide support to health plans in conducting the assessments, and require health plans to report the results of the assessments conducted. According to the author, SB 1033 would "ensure data collected from people is used to help them." *[S. Health]*

- **SB 923 (Wiener)**, as amended March 1, 2022, and as it applies to DMHC, would amend section 1367.27 and add section 1367.043 to the Health and Safety Code regarding the provision of gender-affirming care. This bill would require certain health plans to include search engines on their website of in-network providers who offer gender-affirming services to transgender, gender-nonconforming, or intersex people (TGI) by July 31, 2023, and to require all staff who are in direct contact with enrollees in the delivery of care to complete cultural competency training and refresher courses as determined by the health plan or DMHC. This bill would also require DMHC to approve the training curricula used by the health plans, develop and

implement procedures to impose sanctions on noncompliant plans, require plans to annually and publicly report their compliance, and adopt the new regulations under this bill by July 1, 2024. According to the author, SB 923 would create a more inclusive health care system that meets the needs of TGI people by ensuring the providers are trained in providing culturally competent healthcare. *[S. Health]*

- **AB 1880 (Arambula)**, as amended March 28, 2022, and as it applies to DMHC, would amend sections 1367.206 and 1367.241 of the Health and Safety Code regarding step therapy and prior authorization requests. This bill would require health plans to ensure the appeal of a denial of a request for coverage of a nonformulary drug, prior authorization request, or step therapy, is reviewed by a clinical peer, as defined in the bill, who was not involved in the initial coverage determination nor works for someone who made the initial determination. This bill would also require health plans that require step therapy or prior authorization for enrollees to maintain information about such requests to be made available to DMHC upon request. According to the author, AB 1880 would provide immediate access to the medication necessary for those with chronic illnesses. *[A. Health]*

- **AB 2352 (Nazarian)**, as amended April 6, 2022, and as it applies to DMHC, would add section 1367.207 to the Health and Safety Code regarding prescription drug coverage. New section 1367.207 would require health plans to provide current information about prescription drugs upon request by enrollees or their health care providers, including information about eligibility, cost, coverage, and utilization management requirements of the prescription drugs. AB 2352 would also prohibit health plans from denying or delaying responses to requests and from restricting a health provider's ability to share information or counsel patients about the coverage of prescription drugs and appropriate alternatives. According to the author, this bill would help

consumers make informed decisions about costs, increase options for consumers, and reduce the costs of prescription drugs. *[A. Health]*

- **SB 853 (Wiener)**, as amended February 28, 2022, and as it applies to DMHC, would amend sections 1367.21 and 1367.22, and add section 1367.28 to the Health and Safety Code regarding prescription drug coverage. This bill would prohibit health plans from limiting or excluding coverage for prescription drugs on the basis that the dose prescribed is different than that approved for marketing by the Food and Drug Administration. This bill would also require health plan contracts, which cover prescription drugs issued, amended, or renewed after January 1, 2023, to provide coverage for a drug for the entire duration of a drug utilization review process if the drug was previously approved for coverage, and would prohibit health plans from seeking reimbursement from an enrollee or health care provider during the review period if the final decision is to deny coverage. According to the author, SB 853 would ensure enrollees have access to medication for the duration of an appeals process of a medication coverage denial. *[S. Health]*

- **AB 2585 (McCarty)**, as introduced February 18, 2022, and as it applies to DMHC, would add section 1367.218 to the Health and Safety Code regarding coverage of nonpharmacological pain management treatment (NPMT). New section 1367.218 would permit health care service plan contracts issued, amended, or renewed on or after January 1, 2023, to provide coverage for NPMT. This bill would define NPMT as pain treatment that does not use medication and includes behavioral or instrument-based therapy approved by the Food and Drug Administration. According to the author, AB 2585 would improve access to NPMT to Californians. *[A. Health]*

- **AB 2117 (Gipson)**, as introduced February 14, 2022, and as it applies to DMHC, would add sections 1264.5 and 1371.57 to the Health and Safety Code regarding mobile stroke

units. This bill would require health care service plan contracts, which provide coverage for emergency health care services, issued, amended, or renewed on or after January 1, 2023, to include coverage for services performed by a mobile stroke unit (MSU). AB 2117 would define MSUs as mobile facilities that serve as emergency response ambulances that provide radiographic imaging, laboratory testing, and medical treatment to patients with symptoms of a stroke under the supervision of a physician and the direction of local emergency medical service agencies. According to the author, this bill would enable rapid delivery of life-saving care to patients through the use of MSUs, which currently only exist in two areas in California. *[A. Health]*

- **AB 2127 (Santiago)**, as amended March 24, 2022, and as it applies to DMHC, would amend section 1374.1 of the Health and Safety Code regarding health care coverage for dependent adults. This bill would clarify that health care service plans are required to provide the name, address, and telephone number of the local Health Insurance Counseling and Advocacy Program (HICAP) and the statewide HICAP telephone number to applicants seeking to add their parents or stepparents, who are Medicare eligible or enrolled, as dependents to their health plans. According to the author, AB 2127 would clarify and strengthen notice requirements for Medicare-eligible parents and stepparents who seek to be added to their adult child's individual health plan. *[A. Health]*

- **AB 2581 (Salas)**, as introduced February 18, 2022, would add section 1374.196 to the Health and Safety Code regarding provider credentials for mental health and substance use disorders. New section 1374.196 would require health care service plans, which provide coverage for mental health and substance use disorders, to verify the qualifications of health care providers within 45 days after receiving a complete provider credential application for provider contracts issued, amended, or renewed on and after January 1, 2023. This bill would also allow applicants

to request temporary credentials if the health plan has not approved or denied the application within 45 days and would require health plans to issue temporary credentials if the applicant has not reported a history of malpractice, substance abuse, mental health issues, or disciplinary actions on their application. According to the author, AB 2581 would set a timeline for health plans to credential providers and fix delays to no longer prevent qualified providers from treating patients. *[A. Health]*

- **SB 1419 (Becker)**, as amended March 17, 2022, and as it applies to DMHC, would amend sections 123115 and 123418, and add section 1374.196 to the Health and Safety Code regarding access to medical information. This bill would require health plans to establish and maintain application programming interfaces (APIs), which allow the access to and the exchange of health information to enrollees and contracted providers, and permit DMHC to require health plans to maintain APIs. This bill would also expand the prohibition that the representative of a minor cannot inspect or obtain copies of the minor's patient records, to include a prohibition on the access to clinical notes, and expand the requirement that health professionals provide clinical laboratory tests to patients to include imaging scans. According to the author, SB 1419 would add new patient protections to ensure patient privacy and ensure patients receive important health information. *[S. Jud]*

- **AB 2029 (Wicks)**, as amended April 6, 2022, and as it applies to DMHC, would repeal and add section 1374.55 to the Health and Safety Code regarding infertility treatment. New section 1374.55 would require a health care service plan that covers hospital, medical, or surgical expenses issued, amended, or renewed on or after January 1, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services. AB 2029 would also prohibit a health plan from including conditions or coverage limitations on fertility medications or services or the

diagnosis or treatment of infertility and fertility services, including removing the exclusion of in vitro fertilization (IVF). According to the author, this bill would allow health plans to cover IVF, to make that and other infertility treatments available to those who would otherwise be unable to afford them. *[A. Health]*

- **SB 999 (Cortese)**, as amended April 5, 2022, and as it applies to DMHC, would amend section 1374.721 of the Health and Safety Code regarding health coverage for mental health and substance use disorders. This bill would require DMHC's director to adopt requirements for reviewers who conduct utilization reviews of the services and benefits for the treatment of mental health and substance use disorders. This bill would also deem requested services approved if a health plan does not respond to a request for coverage or to an appeal of a denial for urgent or non-urgent care within specified timeframes. According to the author, SB 999 would ensure that enrollees who require mental health and substance use disorder care are able to receive the appropriate care and treatment for the time necessary for safe addiction recovery. *[S. Health]*

- **SB 958 (Limón)**, as amended March 31, 2022, and as it applies to DMHC, would add Article 6.15 (commencing with section 1385.010) to the Health and Safety Code regarding health care coverage. This bill would create the Medication and Patient Safety Act of 2022, which would prohibit health plans from: arranging or requiring vendors to dispense infused or injected medication to patients with the intent that they will take the medication to a health care provider for administration; requiring an infused or injected medication to be administered to an enrollee's home as a condition of coverage unless it is determined to be safe or appropriate; or requiring an infused or injected medication to be supplied by a vendor specified by the plan as a condition of coverage, unless specified criteria are met. According to the author, AB 958 would ensure patients with life-threatening illnesses can receive the necessary infused or injected medication in a safe

and timely manner. *[S. Jud]*

- **AB 1130 (Wood)**, as amended February 14, 2022, and as it applies to DMHC, would add section 1385.035 and Chapter 2.6 (commencing with section 127500) to the Health and Safety Code regarding health care costs. This bill would establish the Office of Health Care Affordability, which would analyze the health market to create a data-informed state strategy for controlling and lowering the cost of health care. According to the author, AB 1130 would help lower health care costs to ensure health care affordability for consumers so that they can pay for the healthcare they need. *[S. Health]*

- **SB 858 (Wiener)**, as introduced January 19, 2022, would amend sections 1386 and 1387 of, and add section 1388.5 to the Health and Safety Code regarding discipline of health care service plans. This bill would increase the civil and administrative penalties, as specified, for violations of the Knox-Keene Act by health plans, expand the list of factors to be considered by DMHC's director when determining the appropriate penalty for each violation, and authorize DMHC to impose corrective action plans for health plan compliance. According to the author, SB 858 would improve access to quality health care by increasing penalties to serve as behavior-changing fines for noncompliant health plans. *[S. Jud]*

- **SB 1473 (Pan)**, as amended March 10, 2022, and as it applies to DMHC, would amend section 1399.848 of the Health and Safety Code regarding health care coverage enrollment periods. This bill would require health benefit plans offered through Covered California beginning on or after January 1, 2023, to provide an annual enrollment period as specified and establish the effective dates of coverage for plans purchased through and outside of Covered California as specified. According to the author, SB 1473 would clarify the open enrollment periods for Covered California enrollees, aligning them with state law and federal rules. *[S. Appr]*

- **AB 2942 (Daly)**, as introduced February 18, 2022, and as it applies to DMHC, would amend, repeal, and add section 1367.243, as well as add and repeal section 1367.52, to the Health and Safety Code. This bill would require an enrollee's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug and require a report on the impact of the provisions on drug prices and health care premium rates on or before March 1 each year. *[A. Health]*

- **SB 245 (Gonzalez)**, as amended February 14, 2022, and as it applies to DMHC, adds section 1367.251 to the Health and Safety Code to prohibit a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2023, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services. According to the author, this bill would ensure that equitable, timely access to healthcare services is attainable to all Californians regardless of an individual's bank account size. Governor Newsom signed SB 245 on March 22, 2022 (Chapter 11, Statutes of 2022). *[A. Health]*

- **AB 2134 (Weber)**, as amended March 24, 2022, and as it applies to DMHC, would add section 1367.32 to the Health and Safety Code to establish the California Reproductive Health Equity Program within the Department of Health Care Access and Information to ensure abortion and contraception services are affordable and accessible to all patients and provide financial support for safety net providers of these services. According to the author, this bill would ensure that all people in California can access abortion care regardless of their insurance type. *[A. Health]*

- **SB 473 (Bates)**, as amended January 13, 2022, and as it applies to DMHC, would amend section 1367.51 of the Health and Safety Code to prohibit a health care service plan contract

or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2023, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed $35 per month per each dosage form of insulin products. According to the author, this bill would provide certainty on the costs of insulin, allowing Californians with diabetes to focus on managing their chronic conditions, rather than rationing their insulin. *[A. Health]*

- **AB 2024 (Friedman)**, as amended March 31, 2022, and as it appliess to DMHC, would amend section 1367.65 of the Health and Safety Code to require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. According to the author, the bill would improve access to care and lead to more patients receiving early detection services and critical follow-up care. *[A. Health]*

- **SB 974 (Portantino)**, as amended April 6, 2022, and as it applies to DMHC, would amend section 1367.65 of the Health and Safety Code to require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage without imposing cost-sharing for medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer. According to the author, this bill would ensure that both initial screening mammograms and follow-up diagnostic tests are covered by California health insurance. *[S. Health]*

- **AB 2516 (Aguiar-Curry)**, as introduced February 17, 2022, and as it applies to DMHC, would amend section 1367.66 of the Health and Safety Code to require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January

1, 2023, to provide coverage without imposing cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved. According to the author, this bill would ensure that the HPV vaccine, which protects against nine variants and is expected to prevent more than 90% of HPV-related cancers, is accessible to all eligible Californians. *[A. Health]*

- **SB 912 (Limón)**, as introduced February 2, 2022, and as it applies to DMHC, would add section 1367.667 to the Health and Safety Code to require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. According to the author, this bill would improve access to biomarker testing and improve survival rates and quality of life while reducing costs by connecting all patients to the most effective treatments. *[S. Health]*

- **SB 1337 (McGuire)**, as introduced February 18, 2022, and as it applies to DMHC, would add section 1368.3 to the Health and Safety Code to require a health care service plan contract or health insurance policy issued, amended, or renewed on and after January 1, 2023, to provide coverage for coordinated specialty care (CSC) services for the treatment of first-episode psychosis, described as a team-based service delivery method composed of specified treatment modalities and affiliated activities including, but not limited to, case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities. The bill would also create a working group to establish guidelines, including, but not limited to, inclusion and exclusion criteria for individuals eligible to receive CSC services and caseload and geographic boundary parameters for the treatment team. According to the author, for

every $1 spent on care delivered in the CSC model, there is a $6.50 return on investment in improved health and productivity. *[S. Health]*

- **SB 979 (Dodd)**, as introduced February 10, 2022, and as it applies to DMHC, would amend section 1368.7 of the Health and Safety Code to authorize DMHC to require plans and insurers to take specified actions, such as relaxing or suspending certain time limits, during a state of emergency declared by the Governor or a health emergency declared by the State Public Health Officer. According to the author, this bill would allow state departments to facilitate care for patients during times of emergencies. *[S. Health]*

- **AB 2080 (Wood)**, as amended April 6, 2022, and as it applies to DMHC, would add section 1371.26 to the Health and Safety Code. The bill would prohibit a contract issued, amended, or renewed on or after January 1, 2023, between a health care service plan or health insurer and a health care provider or health facility from containing terms that restrict the plan or insurer from steering an enrollee, offer incentives to encourage enrollees to utilize or avoid specific health care providers, require the plan or insurer to contract with other affiliated providers or facilities, require the plan or insurer to agree to payment rates with other affiliated providers or facilities, restrict other plan or insurers from paying a lower rate for items or services than the rate the contracting plan pays, or prevent a plan from providing provider-specific cost or quality of care information. According to the author, health care costs are rising at an unsustainable level and action must be taken. *[A. Health]*

- **AB 2709 (Boerner Horvath)**, as introduced February 18, 2022, and as it applies to DMHC, would add section 1371.56 to the Health and Safety Code to require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2023, to require an enrollee or insured who receives covered services from a non-contracting ground

ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider and prohibit the non-contracting ground ambulance provider from billing or sending to collections a higher amount. *[A. Health]*

- **AB 1859 (Levine)**, as introduced February 8, 2022, and as it applies to DMHC, would add section 1367.014 to the Health and Safety Code. The bill would require a health care service plan issued, amended, or renewed on or after January 1, 2023, to include coverage for mental health services, including mental health services for persons who are detained for 72-hour treatment and evaluation, schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention, and prohibit a non-contracting provider of covered mental health services from billing the enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. According to the author, this bill would provide urgent support to an individual suffering from a mental health emergency and help save the lives of residents in California. *[A. Health]*

- **AB 2007 (Valladares)**, as introduced February 14, 2022, would amend section 1367.04 of the Health and Safety Code to require DMHC to report to the legislature triannually regarding plan compliance of language assistance when obtaining health care services. *[A. Health]*

LITIGATION

- ***Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, Case No. NC061310, 71 Cal. App. 5th 323 (2021)**. On November 24, 2021, the United States Court of Appeals for the Second Appellate District provided notice of a modification of opinion,

but there was no change in the judgment. The opinion originally issued on November 4, 2021, affirmed in a partially published decision, a judgment finding that Kaiser Foundation Health Plan (Kaiser) did not have an affirmative duty in tort to avoid reimbursing Long Beach Memorial Medical Center (Long Beach Memorial) less than the "reasonable and customary" value of emergency services rendered. The Court also found that the trial court had not erred by instructing the jury to consider what a "hypothetical" buyer or seller would pay to determine the "reasonable value" of medical services. In the unpublished portion of the decision, the Court held that the trial court did not abuse its discretion when it ruled that Long Beach Memorial's expert could not rely on the hospitals' "full, billed rates" as a basis for their opinion of the reasonable value of medical services. Furthermore, the Court reversed the trial court's order categorically denying Kaiser its costs, and remanded the matter for the trial court to examine the specific challenges the hospital has raised to the plan's cost bill.