DEPARTMENT OF MANAGED HEALTH CARE

Director: Shelley Rouillard ♦ (916) 324-8176 ♦ Help Center: (888) 466-2219 or www.HealthHelp.ca.gov ♦ Internet: www.dmhc.ca.gov

Created on July 1, 2000, the Department of Managed Health Care (DMHC) 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), one component of a 21-bill package signed by the Governor in 1999 to reform the regulation of managed care in the state. The Department 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 or subscribe to 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 members, 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 the enrollees or members. In Health and Safety Code section 1342, the legislature has expressly instructed the Department Director to ensure the continued role of the professional as the determiner of the patient's health needs; ensure that enrollees and members are educated and informed

of the benefits and services available in order to make a rational consumer choice in the marketplace; prosecute malefactors who make fraudulent solicitations or who use misrepresentations or other deceptive methods or practices; help to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers; promote effective representation of the interests of enrollees and members; ensure the financial stability of health plans by means of proper regulatory procedures; ensure that enrollees and members receive available and accessible health and medical services rendered in a manner providing continuity of health care; and ensure that subscribers and enrollees have their grievances expeditiously 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 and other health care professionals, consumer service representatives, and support staff assist the DMHC Director in licensing and regulating more than 130 health plans in California. Licensed health plans include HMOs and other full-service health plans, as well as several categories of specialized health plans (including prepaid dental, vision, mental health, chiropractic, and pharmacy plans). DMHC-licensed health plans provide health care services to approximately 26 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

independent of plans and certified by an accrediting organization, pursuant to conflict of interest provisions. An IMR determination is binding on the plan, and the Department will enforce it.

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). FSSB advises the DMHC Director on matters of financial solvency affecting the delivery of health care services, and develops and recommends financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions. Comprised of the DMHC Director and seven members appointed by the Director, FSSB also periodically monitors and reports on the implementation and results of those requirements and standards, and reviews proposed regulation changes.

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 HMO. 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. DMHC is funded by assessments on its regulated health plans.

MAJOR PROJECTS

Trump Administration Actions Roil Health Insurance Markets

On October 12, 2017, President Trump—having been defeated in two earlier attempts to repeal or significantly undermine the Affordable Care Act (ACA)—issued Executive Order 13813, which encourages the expansion and use of "short-term limited duration" individual health insurance policies. Originally designed to fill temporary gaps in health coverage, these so-called "skimpy" policies are typically purchased by healthy consumers who have few preexisting health conditions. According to experts, these policies will be cheaper because they will provide fewer benefits, and insurers do not have to cover preexisting conditions. Health care advocates across the country have voiced concern that these limited health plans will entice younger, healthier consumers to opt for short-term health plans, driving up the cost for those (usually older and sicker consumers) insured through the ACA health care exchanges or existing health care plans in the individual market. On February 20, 2018, the U.S. Department of Health and Human Services proposed federal regulatory changes to permit the sale of "skimpy" health insurance policies. Senator Ed Hernandez has already introduced legislation to ban the sale of these policies in California (see LEGISLATION).

The President's executive order additionally allows for the use of association health plans, which allow small businesses or self-employed individuals to band together by geography or industry and buy coverage as if they were a single large employer. Although lower in cost than ACA-compliant policies, they have been poorly managed and are not obligated to provide the ten "essential health benefits" that ACA-compliant policies must provide and that have been incorporated into California law and DMHC regulations. *[23:1*

CRLR 13] On January 4, 2018, the U.S. Department of Labor announced proposed regulatory changes to expand the opportunity to offer employment-based health insurance to small businesses through association health plans.

On December 22, 2017, Congress passed the "Tax Cuts and Jobs Act," Trump administration legislation that provides massive tax cuts to the wealth and dramatically changes the health care landscape. Effective in 2019, this bill eliminates the ACA's so-called "individual mandate" that all Americans have some form of health insurance or be required to pay a penalty. The nonpartisan Congressional Budget Office has estimated that the repeal of the individual mandate will cause 13 million fewer Americans to be insured by 2027. Healthier and wealthier people may choose to forego coverage, and even poorer, medically needy people may not sign up for insurance because they do not know which options are available and there may not be the same sense of urgency to enroll without the mandate.

CVS Seeks to Acquire Aetna

On December 3, 2017, CVS Health announced its intention to purchase Aetna, Inc. If approved by the U.S. Department of Justice, the $69 billion acquisition would merge one of the nation's largest health insurers into CVS, which operates a nationwide chain of pharmacies and retail clinics. The deal, which could allow Aetna to provide care to its insureds through CVS clinics but could also concentrate what used to be separate health care-related silos to reduce choice for consumers, illustrates the various initiatives of businesses in the field to adapt to the volatile terrain of the health care industry. On March 13, 2018, CVS and Aetna shareholders approved the merger.

DMHC is scheduled to hold an open forum to discuss the merger of the two companies on May 2, 2018 in Sacramento. Similarly, the Department of Insurance (DOI) is scheduled to hold a public hearing on the proposal on June 19, 2018.

Implementation of AB 72 (Bonta)

On February 2, 2018, DMHC published notice of its intent to adopt new section 1300.71.31 ("Methodology for Determining Average Contracted Rate; Default Reimbursement Rate") and make conforming amendments to section 1300.71, Title 28 of the CCR, to implement AB 72 (Bonta) (Chapter 492, Statutes of 2016). AB 72 protects consumers from surprise medical bills when they go to in-network facilities, such as hospitals, labs, or imaging centers, and receive non-emergency services from a non-contracted provider.

These proposed regulatory changes, which follow two interested parties meetings in 2017, implement Health and Safety Code section 1371.31, which created—effective July 1, 2017—a default reimbursement rate for non-contracting providers, which is the greater of 125% of the Medicare rate or the "average contracted rate" (ACR) for health care services subject to Health and Safety Code section 1371.9. Thereafter, section 1371.31 requires DMHC—by January 1, 2019—to develop a standardized methodology for calculating the ACR paid to non-contracting providers for services most frequently subject to section 1371.9. This methodology must take into account, at minimum (1) information from the independent dispute resolution process created in AB 72, at Health and Safety Code section 1371.30, (2) the specialty of the individual health professional, (3) the geographic region in which the services are rendered, and (4) the highest and lowest contracted rates for those services. *[23:1 CRLR 17–19]*

New section 1300.71.31 addresses the four minimum statutorily-required considerations described above, as well as other necessary elements identified during the ACR methodology development stakeholder process. By providing payors with a standard way to compute the ACR for the health care services most frequently subject to Health and Safety Code section 1371.9, the methodology ensures a uniformly reasonable default reimbursement for non-contracting providers.

DMHC did not schedule a public hearing on the proposed regulatory changes, but accepted written public comments until March 19, 2018. At this writing, DMHC staff is reviewing the comments received and is preparing to release modifications to the original text for another public comment period.

General Licensure Requirements

On October 27, 2017, DMHC published notice of its intent to add section 1300.49 to Title 28 of the CCR, which would clarify the Knox-Keene Act's definition of a "health care service plan" (health plan) that requires licensure by DMHC. The proposed regulation states that a person who accepts global risk (both institutional and professional risk) for services provided to health plan subscribers and enrollees receives "advance or periodic consideration" from or on behalf of subscribers or enrollees, and shall seek health plan licensure pursuant to Health and Safety Code section 1349. The proposed regulation would also set out requirements for a restricted license for entities that do not market directly to consumers or employers but otherwise meet the statutory definition of a health plan. In addition, the regulation states specific criteria that DMHC may apply in considering a request for exemption from licensure requirements.

Following an initial public comment period ending on December 17, 2017, DMHC released modified text of proposed section 1300.49 on March 20, 2018 for an additional public comment period ending on April 5, 2018.

Among other things, the modified text changes the definition of "global risk" to "the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk," and states that "any person who assumes global risk shall obtain a license to operate a health care service plan pursuant to section 1349 of the Health and Safety Code."

DMHC did not schedule a public hearing on these proposed changes, and is currently evaluating the comments received during the second comment period.

Recent Enforcement Actions

Following is a description of recent enforcement actions taken by DMHC:

♦ ***Anthem's Systemic Grievance Process Violations Result in $5 Million Fine.*** On November 15, 2017, DMHC announced it would fine Anthem Blue Cross $5 million for systemic grievance process violations. According to DMHC's accusation, the Knox-Keene Act and DMHC regulations require health plans to have and maintain a grievance system to ensure that standard enrollee complaints are adequately considered and resolved within 30 days, expedited complaints are adequately considered and resolved within three days, and to ensure the plan timely and thoroughly responds to Department communications and requests for information regarding consumer complaints. DMHC alleges that "[r]espondent's grievance system is defective, and has been for many years. This impacts consumers by causing delays in resolving their health care disputes and consequently creating frustration, stress, and even potentially detrimental effects on their health if

appropriate care is delayed." DMHC's press release notes: "This enforcement action is the result of deficiencies identified in DMHC surveys and 245 specific grievance system violations identified by the DMHC Help Center during the investigation of consumer complaints from 2013 through 2016. Including this fine, DMHC has fined Anthem Blue Cross $11.66 million for grievance system violations since 2002." Anthem Blue Cross said it would appeal the fine.

♦ ***Blue Shield and Care 1st Added to List of Those Fined for Grievance System Violations.*** On December 8, 2017, DMHC filed two enforcement actions against Blue Shield of California and Care 1st Health for failure to adhere to its health plan grievance and appeals process requirements. More specifically, DMHC flagged 34 cases involving 61 consumer grievance system violations for Blue Shield of California, and 18 cases involving 30 consumer grievance violations for Care 1st Health Plan. Blue Shield incurred a fine of $322,500, and Care 1st a fine of $135,000.

LEGISLATION

SB 910 (Hernandez), as amended March 5, 2018, would amend sections 1367.29 and 1368.016 of the Health and Safety Code to prohibit health plans—as of January 1, 2019—from offering "short-term limited duration health insurance," defined as health insurance coverage provided pursuant to a health insurance policy that has an expiration date that is less than 12 months after the original effective date of the coverage, including renewals. These so-called "skimpy" plans do not provide comprehensive coverage nor do they cover the "essential health benefits" required under the Affordable Care Act. This bill is a response to the Trump administration's repeated attempts to repeal the ACA and its February 20, 2018 announcement of proposed federal regulations permitting the sale of

"skimpy" health insurance that will be cheaper than ACA-compliant insurance (see MAJOR PROJECTS). *[S. Appr]*

SB 997 (Monning), as introduced February 5, 2018, would amend section 1375.9 of the Health and Safety Code, which requires—until January 1, 2019—health plans to ensure there is at least one full-time primary care physician for every 2,000 enrollees, and authorizes the assignment of up to 1,000 additional enrollees to a primary care physician for every full-time nonphysician supervised by that primary care physician. This bill would repeal the January 1, 2019 sunset date on this requirement, thus extending it indefinitely *[S. Appr]*

AB 2674 (Aguiar-Curry), as amended April 2, 2018, would add section 1386.5 to the Health and Safety Code regarding DMHC disciplinary actions against health plans. New section 1385.5 would require DMHC to investigate provider complaints that a health plan underpaid or failed to pay the provider, and outlines action required of the provider to initiate the investigative process. New section 1386.5 would additionally require the DMHC Director, upon a final determination that a health plan underpaid or failed to pay a provider, to assess an administrative penalty in an amount not less than the amount owed plus interest, and require the health plan to pay the provider an amount not less the amount owed plus interest. *[A. Appr]*

AB 595 (Wood), as amended January 22, 2018 would add Article 10.2 (commencing with section 1399.65) to the Health and Safety Code regarding mergers of health plans. New Article 10.2 would require a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by any entity, including another health plan or a licensed health insurer, to give notice to,

and secure prior approval from, the DMHC Director. The bill would require the Director to prepare an independent health care impact statement if the Director determines that a material amount of the assets of a health plan is subject to purchase, acquisition, or control; and would permit DMHC to hold a public meeting on the proposal and the impact statement in accordance with the Bagley-Keene Open Meeting Act. Under this bill, DMHC would be authorized to approve, conditionally approve, or disapprove the proposed agreement or transaction. *[S. Health]*

SB 1457 (Hernandez), as introduced February 16, 2018, would add section 1342.3 to the Health and Safety Code, to request that the National Association of Insurance Commissioners (NAIC) allow DMHC to participate in NAIC proceedings regarding Medicare supplement insurance policies (also known as "Medigap" policies); these policies provides reimbursement for certain expenses for services that are not reimbursable for payment under Medicare. In order to compile complete information with regard to California Medicare supplement insurance, the bill would amend section 1358.15 to require the DMHC Director to require Medicare supplement policy issuers to submit a completed NAIC Medicare supplement experience exhibit. *[S. Appr]*

SB 437 (Atkins), as amended April 6, 2017, would amend section 1342.4 of the Health and Safety Code, which requires DMHC and DOI to maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments. The bill would amend section 1342.4 to also require the joint working group to review and examine timely access to care and network adequacy as part of its review of the grievance and consumer complaint processes, and to review and examine the state implementation of federal health care

reforms, including any changes in federal law, rules, regulations, or guidance issued under federal law. *[A. Health]*

SB 1021 (Wiener), as introduced February 7, 2018, would amend section 1342.71 of the Health and Safety Code to prohibit health plans from maintaining a prescription drug formulary that has more than four tiers, and require a health plan's prescription drug benefit to prohibit an enrollee from being required to pay more than the retail price if the pharmacy's retail price for a prescription drug is less than the applicable copayment or coinsurance amount. *[S. Health]*

AB 2863 (Nazarian), as amended April 11, 2018, would add section 1367.47 to the Health and Safety Code, to limit the amount a health plan may require an enrollee to pay at the point of sale for a covered prescription to the lesser of the applicable cost-sharing amount or the retail price. The bill would prohibit a health plan from requiring a pharmacy to charge or collect a copayment from an enrollee that exceeds the total submitted charges by the network pharmacy. The bill would require the amount paid for a prescription to be applied to the enrollee's deductible and out-of-pocket maximum if the enrollee pays the retail price. *[A. Health]*

AB 2985 (Arambula), as amended April 11, 2018, the "Primary Care Spending Transparency Act," would add section 1347 to the Health and Safety Code to require a health plan that reports rate information to DMHC to annually report the percentage of expenses the health plan allocated to primary care. The bill would also require DMHC and DOI to annually compile and post a report with that information on their Internet websites, beginning January 1, 2020, and would require the departments to include their reports as discussion items at specified public meetings. The bill would also require DMHC and DOI

to convene a Primary Care Payment Reform Collaborative to propose revisions to the types of primary care data collected from health plans and insurers, as well as to advise and assist in developing and sharing best practices in technical assistance and methods of payment that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care.

The bill would also add section 1385.035 to the Health and Safety Code, to require health plans—beginning October 1, 2019— to report to DMHC the following information no later than October 1 of each year: (1) for medical benefits, a separation of primary care and specialty services; (2) the percentage of expenses the health plan allocated to primary care, compared to the health plan's overall expenditures; and (3) the methods the health plan used to financially support the delivery of primary care services. DMHC must compile this information into a public report that demonstrates health plans' spending on primary care services, and must post the report on its website. *[A. Health]*

AB 2416 (Wood), as amended March 23, 2018, would add section 1360.7 to the Health and Safety Code, which would require—on and after January 1, 2020—certain health plans to negotiate with Covered California to offer individual products on the exchange, if there are two or fewer health plans operating in the county. *[A. Health]*

SB 1156 (Leyva), as amended March 22, 2018, would add section 1367.016 to the Health and Safety Code, which would require health plans that provide coverage for hospital, medical, or surgical expenses to accept premium and cost-sharing payments from specified third-party entities (including an Indian tribe or a local, state, or federal government program). The bill would also require an entity, other than those specified entities, that is making third-party premium and cost-sharing payments, to provide that

assistance in a specified manner and to perform other related duties, including annually providing a statement to the health plan and to DMHC from the recipient of the financial assistance confirming that the recipient has completed and submitted an application for Covered California or Medi-Cal and is not eligible for financial help from either program, and requiring the entity to disclose to DMHC the name of the enrollee for each plan or policy on whose behalf a third-party premium or cost-sharing payment, or both, will be made.

According to the author, "health insurance rates in California are driven up every year when providers seek profit by exploiting loopholes created by the Affordable Care Act []. Financially-interested providers who steer patients away from Medicare and Medi-Cal by directly or indirectly paying their commercial insurance premiums raise prices for Californians who purchase their own insurance, businesses purchasing insurance on behalf of their employees, and state/local governments purchasing insurance on behalf of their employees. Financially-interested providers steering patients onto commercial insurance plans can also expose patients to unnecessary coverage disruptions, higher out-of-pocket costs, and other harms. . . . SB 1156 will require financially-interested providers or provider-funded entities to disclose that relationship to regulators and comply with disclosure requirements, including showing that patients are not otherwise eligible for Medicare or Medi-Cal." *[S. Health]*

SB 538 (Monning), as amended May 26, 2017, would add section 1367.32 to the Health and Safety Code regarding contracts between a hospital and a health plan. To mitigate anticompetitive contract provisions commonly used in these contracts, new section 1367.32 would provide that a contract between a hospital and a health plan may

not, directly or indirectly, do any of the following: set payment rates or other terms for nonparticipating affiliates of the hospital; require the health plan to contract with any of the hospital's affiliates; require payors to confirm in writing that the payor is bound by the terms of the contract between the hospital and the health plan; require the health plan, as a condition to entering into or continuing the contract with the hospital, to submit to arbitration or any other alternative dispute resolution program any claims or causes of action that arise under state or federal antitrust laws; require the health plan to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital; or require the health plan to keep the contract's payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. Any contract provision that includes any of these conditions is void.

According to the author, "[h]igh hospital prices are driving up health care spending by employers, consumers and taxpayers. Increasing consolidation of hospitals into mega-chains has decreased competition and that market power is a major driver of price increase and health care spending. Empirical studies demonstrate that dominant providers in California are using their market power to engage in unfair contracting practices that result in higher-than-competitive prices. This bill seeks to prohibit anti-competitive contract provisions that dominant hospital systems impose to maintain market power and to inflate prices charged to consumers, workers and employers." *[A. Health]*

AB 2499 (Arambula), as introduced February 14, 2018, would amend section 1367.003 of the Health and Safety Code to increase the minimum medical loss ratio percentages applicable to health plans from 85% to 90% for a health plan in the large group

market, and from 80% to 85% for a health plan in the individual market. The bill would also delete language in section 1367.003 relating to DMHC's authority to adopt emergency regulations and its duty to consult with DOI in adopting regulations. *[A. Health]*

SB 1008 (Skinner), as amended April 10, 2018, would amend section 1367.003 of the Health and Safety Code to establish medical loss ratios for dental health plans of 75% for large group products and 70% for small and individual market products. The bill would also add new section 1363.04, which would require a health plan that provides dental services to implement a uniform benefit disclosure form that includes the annual deductible; the annual benefit limit; coverage for preventive and diagnostic services; dental plan reimbursement levels; estimated annual out-of-pocket expenses; the applicable medical loss ratio; and limitations, exceptions and waiting periods. SB 1008 would also amend section 1367.004, which requires health plans that issue health plan contracts covering dental services to file an annual report with DMHC, to additionally require those plans to report their medical loss ratios and to file those reports by July 1 instead of September 30; additionally, DMHC must post the information on its website within 45 days of receiving it.

Finally, SB 1008 would add new section 1367.013, which would require a health plan that covers dental services and provides out-of-network dental services as a covered benefit to provide a billing and treating provider, on behalf of the enrollee, all of the following: (a) the health plan's criteria for determining eligibility for payment for coverage of dental care; (b) the dental treatment and procedures covered; and (c) the actual percentages or amounts payable as a benefit toward dental care or treatment on behalf of the enrollee for dental treatment rendered by the billing provider. *[S. Health]*

SB 1375 (Hernandez), as amended March 22, 2018, would amend sections 1357, 1357.500, and 1357.600 of the Health and Safety Code to revise the definition of "eligible employee" for purposes of all small employer health plan contracts to exclude sole proprietors. *[S. Health]*

AB 2384 (Arambula), as introduced February 14, 2018, would add section 1367.207 to the Health and Safety Code regarding medication-assisted treatment (MAT). New section 1367.207 would require health plans that provide prescription drug benefits and maintain one or more drug formularies to include, at a minimum, five specified MAT prescription drugs for substance abuse disorders. The new sections requires health plans to presume that MAT is medically necessary and not subject to prior authorization; an annual or lifetime dollar limit; a requirement that an enrollee receives coverage at a facility that exceeds allowable time and distance standards for network adequacy, a specific number of visits, days of coverage, scope or duration of treatment, or other similar limitations; financial limitations different than those for other illnesses covered under the health plan; and step therapy, fail first policies, or other similar drug utilization strategies. *[A. Health]*

SB 1285 (Stone), as introduced February 16, 2018, would add section 1367.44 to the Health and Safety Code to require a health plan contract issued or renewed after January 1, 2019 to cover services provided by an advanced practice pharmacist (as defined in Business and Professions Code section 4016.5) to include comprehensive medication management. The term "comprehensive medication management" means the process of care that ensures each beneficiary's medications, whether they are prescription drugs and biologics, over-the-counter medication, or nutritional supplements, are individually assessed to determine that each medication is appropriate for the beneficiary, effective for

the medical condition, and safe given the comorbidities and other medications being taken, and that all medications are able to be taken by the patient as intended. *[S. Health]*

AB 2342 (Burke and Waldron), as introduced February 13, 2018, would add section 1367.615 to the Health and Safety Code to require health plan contracts issued or renewed after January 1, 2019 to cover screening, genetic counseling, and testing for breast cancer susceptibility (BRCA) gene mutations in women who have not been diagnosed or who do not show symptoms but may have increased risk of breast cancer based on familial history. *[A. Health]*

AB 2193 (Maienschein), as introduced February 12, 2018, would add section 1367.625 to the Health and Safety Code, to require health plans, by July 1, 2019, to develop a case management program that is available for an enrollee when her treating provider determines that she may have a maternal mental health (MMH) condition. The case management program must offer all of the following: (a) provide the provider and enrollee direct support in accessing treatment, and, if available, managing care in accordance with the provider's treatment plan; (b) provide direct access to a clinician assigned to both the provider and the patient; (c) support the provider and enrollee in accessing care in a timely manner, pursuant to existing timely access standards, to provide direct access for the enrollee to a therapist trained in MMH and direct access for both the provider and enrollee to a provider-to-provider psychiatric consultation with a psychiatrist familiar with the latest research in MMH; and (d) require, when a treatment plan is available, clinical case managers in the program to extend the capacity of the enrollee's provider by following the enrollee's treatment access, symptoms, and symptom severity and by recommending potential changes to the treatment plan when clinically indicated. Commencing July 1,

2019 and annually thereafter, health plans must notify providers in writing of the availability of the MMH case management program and the process by which a provider can access that program. *[A. Health]*

AB 1860 (Limón and Cervantes), as introduced January 10, 2018, would amend section 1367.656 of the Health and Safety Code to delete the January 1, 2019 sunset date and to extend permanently that section's prohibition on an individual or group health care plan that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells from requiring an enrollee to pay, notwithstanding any deductible, a total amount of copayments and coinsurance that exceeds $200 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication. *[A. Appr]*

AB 1534 (Nazarian), as amended June 26, 2017, would add section 1367.693 to the Health and Safety Code to require health plans to permit an HIV specialist to be an eligible primary care provider, so long as the provider adheres to health plan criteria and requests primary care provider status. *[S. Floor]*

AB 2643 (Irwin), as introduced February 15, 2018, would amend section 1367.71 of the Health and Safety Code to require health plan contracts covering hospital, surgical, or medical expenses to cover general anesthesia and associated facility charges for dental procedures when the clinical status or underlying medical condition of the enrollee requires dental procedures that ordinarily would not require general anesthesia. *[A. Health]*

AB 2941 (Berman), as introduced February 16, 2018, would add section 1368.7 to the Health and Safety Code to require health plans to provide enrollees who have been displaced due to a state of emergency access to medically necessary health care services,

including possible relaxed time limits for prior authorization, precertification, or referrals; extended filing deadlines for claims; suspension of prescription refill limitations; prescription refills from an out-of-network pharmacy; replacement of medical equipment or supplies; access to an out-of-network provider should their in-network provider become unavailable due to the state of emergency; and a toll-free number an enrollee may access for inquiries related to health care. *[A. Appr]*

SB 1023 (Hernandez), as amended March 12, 2018, would amend section 1374.13 of the Health and Safety Code to clarify that health plans are permitted to cover sexual and reproductive health services that are provided appropriately through telehealth according to clinical guidelines; and to require services provided by a Family PACT provider through direct video and telephonic communications with a provider, or direct or asynchronous care provided through a smart phone application, that are appropriate to be delivered remotely based on current clinical guidelines, to be covered services under the Family PACT Program (which is administered by the Department of Health Care Services). *[S. Appr]*

SB 399 (Portantino), as amended January 22, 2018, would amend section 1374.73 of the Health and Safety Code, which requires health plans that offer hospital, surgical, and medical coverage to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. This bill would broaden the eligibility criteria to become a "qualified autism service professional" and a "qualified autism service paraprofessional" by allowing specified education, work experience, and training qualifications to meet the requirements of a qualified autism service professional or paraprofessional. *[A. Health]*

AB 3087 (Kalra), as amended April 9, 2018, would add Title 23 (commencing with section 100600) to the Government Code, which would create the nine-member California Health Care Cost, Quality, and Equity Commission, described as an independent state agency with the purpose of imposing a limit on California health care costs. Under section 100603, the purposes of the Commission are to (1) set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers; (2) determine methods for state government to reduce the cost of prescription drugs and medical devices paid for by private purchasers in the commercial market; (3) control in-state health care costs in a manner intended to improve health care quality, improve health outcomes, and reduce health disparities for all Californians; (4) reduce price discrimination by health care providers among health care purchasers and the variation in prices paid to providers by private purchasers in the commercial market; (5) ensure payments to health care providers will permit them to provide medically necessary, effective, and efficient health care services in a manner that improves health outcomes, reduces health disparities, ensures there are an adequate number of providers to provide timely access to health care services for all Californians with commercial health coverage, and ensures a fair and reasonable return on investment to providers; and (6) measure and reduce total health care expenditures per capita in the state.

The bill would prohibit the Commission from being regulated by DMHC or DOI. However, section 100612 would require funding for the implementation of the Commission to come—in part—from the Managed Care Fund (managed by DMHC) and the Insurance Fund (managed by DOI). *[A. Health]*

SB 562 (Lara and Atkins), as amended May 26, 2017, would add Title 22.2 to the Government Code to enact "The Healthy California Act." The Healthy California Act would require a comprehensive universal single-payer health care coverage system for all Californians. The bill is not to become effective until the Secretary of Health and Human Services establish funding for the implementation of the bill.

SB 562 would require Healthy California to be governed by an unpaid executive board comprised of nine members appointed by the Governor and legislature. It would also require the executive board members to have demonstrated knowledge, evident expertise in health care, and would require four members from a nurse labor organization, the general public, a labor organization, and the medical provider community. The bill would permit all Californians residents to be eligible and entitled to enroll. "Resident" is defined as an individual whose primary dwelling is in the state without regard to that individual's immigration status. Enrollees of Healthy California would not be required to pay any premium, co-payments, co-insurance, deductible and any other form of cost-sharing for all covered benefits.

SB 562 would require all medical care determined to be medically appropriate by the member's health care provider. This would include all services provided by Medi-Cal, essential health benefits (from the Affordable Care Act), and all health plan- or insurance-mandated benefits. Benefits shall include: chiropractic, vision, dental, ancillary health or social services (previously covered by a regional center), skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective. *[A. Desk]*

AB 315 (Wood), as amended July 11, 2017, would add Division 121 (commencing with section 152000) to the Health and Safety Code regarding pharmacy benefit management. The new division would require pharmacy benefit managers (PBM) to register with DMHC prior to conducting business within California. DMHC would be required to develop a registration form and would be authorized to charge a fee for registration and to suspend a registration of a PBM under specified circumstances. This bill would also require a PBM to exercise a duty of good faith and fair dealing in the performance of its contractual duties to a purchaser, and would require a PBM to disclose to a purchaser any conflict of interest that would interfere with the discharge of that duty.

The bill would require a PBM to periodically disclose to a purchaser, at the purchaser's request, certain information such as drug acquisition cost, rebates received from pharmaceutical manufacturers, and rates negotiated with pharmacies. The bill would require a PBM to notify a pharmacy network provider of certain material contract changes at least 30 days before those changes take effect, and would prohibit a PBM from notifying an individual receiving benefits through that PBM that a pharmacy has been terminated from its network until the required notice has been provided to the pharmacy. The bill would prohibit a PBM from including in a contract with a pharmacy network provider provisions that prohibit the provider from informing consumers of alternative medication options or from dispensing a certain amount of prescribed medication, as specified. The bill would apply these provisions to a contract or contractual relationship between a PBM and a purchaser, or between a PBM and a pharmacy network provider that is entered into, issued, amended, renewed, or delivered on or after January 1, 2018. The bill would provide that these provisions and those relating to registration described above do not apply to a

health plan, health insurer, or related entities that perform PBM services only for enrollees of the plan or insureds of the insurer. *[S. Inactive File]*

LITIGATION

On December 8, 2017, Pharmaceutical Research and Manufacturers of America ("PhRMA") filed a complaint in the U.S. District Court for the Eastern District of California in ***Pharmaceutical Research and Manufacturers of America v. Brown, et al.***, (Case No. 2:17-CV-02573), requesting declaratory relief regarding SB 17 (Hernandez) (Chapter 603, Statutes of 2017). SB 17 attempts to provide transparency in regard to prescription drug pricing, including advance information on and a justification for prescription drug price increases. In addition, SB 17 requires health plans to annually report to DMHC information regarding the 25 most frequently prescribed drugs, costliest drugs, and highest year-over-year increase in total annual spending. Starting January 1, 2019, DMHC must compile the information into a report which it must submit to the legislature and post on its website. *[23:1 CRLR 27]*

PhRMA alleges that SB 17 is unconstitutional in that it compels them to speak about potential price increases when they would prefer not to communicate that information at all (thus violating these corporations' asserted first amendment rights); additionally, plaintiff alleges that the bill interferes with interstate commerce. In its prayer for relief, PhRMA seeks an injunction to prevent California from implementing and enforcing SB 17, and a declaration that it is unconstitutional. On January 26, 2018, the State filed a motion to dismiss for lack of subject matter jurisdiction and failure to state a claim upon which relief may be granted. At this writing, the matter is being furiously briefed in the Eastern District of California.

On March 9, 2018 in ***Skyline Wesleyan Church v. California Department of Managed Health Care***, No. 3:16-cv-0501-CAB (DHB), 2018 U.S. Dist. LEXIS 39308 (S.D. Cal. Mar. 9, 2018), the U.S. District Court for the Southern District of California dismissed as not ripe for adjudication a complaint against DMHC over the agency's interpretation of California law concerning health plan coverage for voluntary termination of pregnancies.

On August 22, 2014, DMHC sent a letter to seven group health plans that had limited or excluded coverage for termination of pregnancies. The letters explained that the Department, upon review of all relevant legal authorities, concluded that the Knox-Keene Act and the California Constitution "prohibits health plans from discriminating against women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally."

Skyline Church is a Christian church that believes abortion is a sin and is incompatible with the Bible's teachings. Prior to August 22, 2014, Skyline Church had an employee health plan that restricted abortion coverage consistent with the Church's religious beliefs. Subsequently, Skyline contacted its insurance broker (but not DMHC) to discuss the possibility of obtaining a religious exemption from the abortion coverage requirement; the broker opined that all health care plans were required to provide coverage for elective abortion.

However, DMHC later informed the health plans that it would grant them an exemption from the requirements it had detailed in the August 22, 2014 letter for products offered exclusively to entities that meet the definition of "religious employers" as defined in Health and Safety Code section 1367.25(b)(1). Rather than requesting that its health plan

seek such an exemption or seeking one itself, Skyline sued DMHC in February 2016, alleging that it wished to provide health coverage to its employees in a way that "does not cause it to have to pay for abortions" and that participating in or paying for a plan that provides for abortions in circumstances not limited to endangering the mother's life, is inconsistent with its beliefs and is a grave sin. Following the district court's grant of DMHC's motion to dismiss many of the causes of action, the parties filed cross-motions for summary judgment.

During the course of the litigation, DMHC produced a November 2017 declaration from the deputy director of its Office of Plan Licensing, who attested that "[t]o date, no plan has requested an exemption that would mandate that women who become pregnant as a result of rape or incest be forced to carry to term." Based on that declaration, the district court found that Skyline's complaint was not ripe for adjudication. "If the Court were to allow Plaintiff to proceed with this case, the Court would be hypothesizing that (1) a health care insurance company will offer a plan to Plaintiff with the exemption it requires; (2) the plan will apply to the DMHC for approval, and (3) the DMHC will not approve the plan. . . . Until the DMHC receives and denies approval of a health care plan that reflects Plaintiff's religious beliefs, the Court concludes that Plaintiff's claims do not present a constitutionally ripe case or controversy."

Additionally, the court held that—inasmuch as "not a single health care plan is a party to this case"—any remedy the court could order would be against only DMHC. However, DMHC is not a health plan, "does not provide health care plans and is simply a regulatory body that does not have the authority to mandate that a provider give Plaintiff

the plan it seek." As such, "Plaintiff lacks standing to pursue its claims." The court dismissed Plaintiff's claims without prejudice.

Rather than exhausting its administrative remedies and/or seeking a religious exemption, Skyline appealed the district court's decision to the U.S. Ninth Circuit Court of Appeals on April 9, 2018.

RECENT MEETINGS

On February 7, 2018, DMHC held a public meeting on large group aggregate rates in San Francisco. SB 546 (Leno) (Chapter 801, Statutes of 2015), amended section 1374.21 and added section 1385.045 to the Health and Safety Code regarding aggregate rate information. SB 546 requires DMHC to hold annual public meetings about large group rate changes. DMHC held the February 7 meeting in compliance with SB 546. At the meeting, DMHC reviewed SB 546's requirements, presented an overview of 2017 large group rate filings, and provided an opportunity for public comment.