

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

MAJOR PROJECTS

DMHC Releases 2017 Annual Report

On May 31, 2018, DMHC issued its [2017 Annual Report](#), which includes an enrollment overview, statistics on the Help Center, and information on plan licensing, plan monitoring, financial oversight, rate review, and enforcement against health plans. Overall, DMHC assisted with over 144,000 phone inquiries, 11,000 consumer complaints, 4,500 independent medical review cases, and over 2,500 non-jurisdictional referrals.

Enrollment Overview. In 2017, within 75 DMHC-licensed full service health plans, enrollment was over 26 million Californians. In addition to full service health plans, the DMHC oversees 48 specialized health plans in which enrollment reached over 30 million. Health plan enrollment is evenly distributed between commercial and government enrollment; this includes approximately 13.2 million commercial enrollees and approximately 13.1 million government enrollees.

Help Center Statistics. In 2017, DMHC’s Help Center assisted 164,151 health care consumers, handled 11,964 complaints, and closed 4,719 independent medical review cases. In addition to providing consumer assistance, the DMHC Help Center assists providers with claims payment disputes they have with health plans. In 2017, the DMHC Help Center received 4,833 provider complaints and recovered \$8,790,517 in payments for providers. DMHC implemented [AB 72 \(Bonta\) \(Chapter 492, Statutes of 2016\)](#), which put an end to “surprise billing” of consumers by out-of-network providers (see below). On September 2, 2017, DMHC’s Help Center launched an Independent Dispute Resolution Process (IDRP), to remove consumers from the middle of billing disputes, as a mechanism for out-of-network or non-contracted providers to dispute the default reimbursement amount. In the last four months of 2017, DMHC received no requests for IDRP.

Plan Licensing. DMHC issues licenses to health plans in California and reviews health plan mergers to ensure adherence with the Knox-Keene Act’s consumer protection and financial solvency requirements. DMHC reviews all aspects of a health plan’s operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, and complaint and grievance systems. After licensure, DMHC continues to monitor health plans and any changes they

make to their operations. In 2017, DMHC participated in the California Provider Directory Collaborative Advisory Committee in support of the creation of a statewide, centralized provider directory utility. The utility will allow providers to update their information in one place, and health plans will be able to submit and receive updated provider information. Also in 2017, DMHC issued five new licenses: two restricted Medicare Advantage health plans (Medcore HP and Sequoia Health Plan Inc.); two specialized health plans (EyeMax Vision Plan and Humana EAP and Work-Life Services of California Inc.); and one Medi-Cal plan (Aetna Better Health of California Inc.).

Plan Monitoring. DMHC assesses and monitors health plan networks and accessibility of services to enrollees, provider-to-patient ratios, and compliance with its timely access to health care regulations. During 2017, DMHC conducted 24 routine surveys and 25 follow-up surveys. The surveys examine health plan practices related to access, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievances and appeals. In 2017, DMHC continued its efforts to improve the accuracy of the timely access data submitted by health plans by holding biweekly workgroups with health plans and the California Association of Health Plans to discuss data challenges and how to improve the mandatory methodology. DMHC was able, for the first time, to report some comparable timely access data across health plans for Measurement Year 2016. The [Timely Access Report](#) is available on DMHC's website.

Financial Oversight. DMHC monitors the financial status of health plans and provider groups to make sure they can meet their financial obligations to consumers and other purchasers. During 2017, DMHC conducted 70 financial examinations, reviewed 2,357 financial statements,

ensured rebates of almost \$2 million to consumers whose plans failed to comply with established medical loss ratios, remediated \$581,000 worth of disputed payments, and assessed over \$1.5 million in interest and penalties. In January 2017, DMHC required Blue Cross of California (Anthem Blue Cross) to reprocess claims that it had improperly denied and to pay interest and penalties for late payment. DMHC identified this issue during a routine financial examination of the plan, and recovered approximately \$800,000 for providers through this action.

Rate Review. In 2017, DMHC reviewed 60 individual and small group rate filings. Although DMHC is not authorized to approve or deny rate increases, its rate review efforts hold health plans accountable through transparency. During 2017, Anthem Blue Cross agreed to reduce both its proposed individual and small group rate increases, saving consumers approximately \$114 million. DMHC also enhanced the premium rate review section of its public website, which provides consumers with the capability to easily find and view premium rate filings and submit comments. On February 1, 2017, DMHC held a public meeting to discuss a summary of the filings, including reasons for changes in rates, benefits, and cost sharing in the large group rate market.

Enforcement. DMHC monitors and takes timely action against health plans that violate the law. In 2017, DMHC took numerous enforcement actions and assessed \$8,907,000 in fines and penalties against health plans. For example, DMHC imposed a penalty of \$50,000 against Anthem Blue Cross for failing to provide documents for IMRs which caused an unnecessary delay in the IMR process. DMHC also revoked the license of Avante Behavioral Health Plan to protect the public from a financially troubled plan. This is only the second time in its history that DMHC has revoked a plan's license.

In July 2017, DMHC reached a settlement agreement with Kaiser Permanente to correct issues that DMHC identified with the plan’s monitoring of timely access to behavioral health services. [[23:1 CRLR 22](#)] This settlement represents a collaboration between the Department, Kaiser Permanente, and an independent expert consultant working together to ensure the plan meets all obligations under the settlement agreement for the benefit of all Kaiser Permanente enrollees.

DMHC Rulemaking

The following is a status update on recent rulemaking proceedings that DMHC has initiated, some of which were covered in more detail in Volume 23, Number 2 of the *California Regulatory Law Reporter*:

◆ **General Licensure Requirements.** On October 8, 2018, the Office of Administrative Law (OAL) [disapproved](#) DMHC’s adoption of new section 1300.49, Title 28 of the CCR, which attempted to clarify the Knox-Keene Act’s definition of a “health care service plan” that requires licensure by DMHC. The new regulation would have defined “health care service plan” to include an entity that takes on global risk (both institutional and professional risk) for services provided to health plan subscribers and enrollees. The new section would also have defined relevant terms and set forth requirements for a restricted health plan license as well as standards for obtaining an exemption from health plan licensing requirements. [[23:2 CRLR 20](#)]

OAL disapproved the proposed regulation partially on grounds that it failed to comply with the “clarity” requirement of Government Code section 11349.1. Specifically, OAL found that the exemption provisions in section 1300.49(b) are inconsistent with similar provisions in section 1300.49(b)(2), and that the language used is “subject to more than one interpretation.” OAL

additionally found that DMHC failed to fully comply with the procedural requirements in the Administrative Procedure Act in that the rulemaking package was inconsistent concerning the fiscal impact of the new regulation.

DMHC has 120 days from the date of the disapproval decision to address the deficiencies identified by OAL and resubmit the proposed regulation to OAL.

◆ *Standard Prescription Drug Formulary Template.* On September 28, 2018, DMHC published [notice](#) of its intent to add section 1300.67.205 to Title 28 of the CCR. According to the [initial statement of reasons](#), the proposed regulation implements [SB 1052 \(Torres\) \(Chapter 575, Statutes of 2014\)](#). Of import, SB 1052 added new section 1367.205 to the Health and Safety Code, which requires DMHC to collaborate with the Department of Insurance (DOI) to develop—by January 1, 2017—a standard formulary template to be used by health plans and health insurers that provide prescription drug benefits and maintain one or more drug formularies.

Under new section 1367.205, such a health plan must do all of the following: (1) post the formulary or formularies for each product offered by the health plan on the plan’s Internet website in a manner that is accessible and searchable by potential enrollees, enrollees, and providers; (2) update the formularies on a monthly basis; and (3) no later than six months after the date that a standard formulary template is developed by DMHC and DOI, a health plan must use that template to display the formulary or formularies for each product offered by the health plan. The statute required DMHC and DOI to hold at least one public meeting to receive input on the standard template; DMHC conducted its public meeting on August 25, 2017. [[23:1 CRLR 14](#)]

Proposed new section 1300.67.205(a) defines key terms utilized throughout the regulation. Proposed section 1300.67.205(b) would establish the structure and content of the template. The

formulary must include (1) a title page, (2) a table of contents, (3) an informational section, (4) a categorical list of prescription drugs, (5) an alphabetical list of prescription drugs, and (6) an index. Each of these components is described in detail in the proposed regulation.

The initial statement of reasons further explains, “In 2014, the Legislature enacted SB 1052 to promote accessibility and transparency in prescription drug coverage by requiring the Department to create a formulary template for easy access to clear and comparable prescription drug information for health plan enrollees.” In addition, as explained in the initial statement of reasons, “this regulation sets forth the requirements of Health and Safety Code section 1367.205 and implements the goals of SB 1052 by providing a standard prescription drug formulary template for use by health plans and enrollees.”

At this writing, DMHC is accepting written comments on its proposed regulation until November 13, 2018, and has scheduled a public hearing on the proposed rule for November 13 in Sacramento.

◆ ***Cancellations, Rescissions, and Nonrenewals of Health Plan Enrollment, Subscription, or Contract.*** On June 22, 2018, DMHC published [notice](#) of its intent to delete old sections 1300.65, 1300.65.1, and 1300.65.2, Title 28 of the CCR, and to add new sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, and 1300.65.5 to Title 28 of the CCR, to clarify and interpret the rights and responsibilities of plans, providers, and enrollees prior to, during, and following cancellations, rescissions, or nonrenewals of an enrollee’s health care coverage.

Health and Safety Code sections 1365 and 1389.21 prohibit a health plan from cancelling, rescinding, or nonrenewing an enrollee’s health care enrollment, subscription, or contract except for seven specified reasons. This regulation package seeks to amend and clarify current regulations

in order to address identified ambiguities and inconsistencies existing in current regulations (especially with regard to the notice and grace period that must be afforded to an enrollee after the enrollee fails to promptly renew a plan), as well as updating regulations to address changes in federal law. This rulemaking also seeks to clarify and streamline the grievance process for cancellations, rescissions, and nonrenewals.

DMHC did not schedule a public hearing on these proposed regulatory changes, but accepted written comments until August 6, 2018. DMHC is currently reviewing the comments received during the comment period, and is preparing modified text of the proposed changes.

◆ ***Financial Solvency of Risk-Bearing Organizations.*** On May 25, 2018, DMHC published [notice](#) of its intent to amend sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76, of Title 28 of the CCR, regarding the financial solvency of risk-bearing organizations. Under Health and Safety Code section 1375.4(g)(1), a “risk-bearing organization” (RBO) is defined as a professional medical corporation, other form of corporation controlled by physicians, or another lawfully organized group of physicians that delivers or provides health care services by contracting directly with a health plan or arranges for health care services for the health plan’s enrollees, receiving compensation for these services on a capitated or fixed periodic payment basis, and is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health plan that are covered under the capitation or fixed periodic payment made by the plan to the RBO. DMHC does not directly regulate RBOs; however, it is authorized to regulate health plan contracts with RBOs. According to the [initial statement of reasons](#), the proposed amendments regarding the clarification of cash-to-claims ratio, sub-delegates, and sponsoring organizations are DMHC’s efforts towards

increasing efficiency in the financial reporting process, expanding clarity on known points of ambiguity, and updating obsolete regulations.

The proposed amendment to section 1300.75.4 would clarify the accounting procedures that are used to determine the “cash-to-claims ratio” (defined as “an organization’s cash, readily available marketable securities and plan receivables due with 30 days, divided by the organization’s unpaid claims (claims payable and incurred but not reported [IBNR]) liability”). The amended regulation provides clearer direction to organizations on how to calculate the cash-to-claims ratio.

Amended section 1300.75.4 would also state that the term “sponsoring organization” has “the same meaning as Health and Safety Code section 1375.4(b)(1)(B),” and it would define the term “sub-delegating organization” as “an organization that delegates any portion of the responsibility for providing or arranging for the health care services of a plan’s enrollees to another organization on a capitated or fixed period payment basis.”

DMHC proposes to amend section 1300.75.4.1 to revise an organization’s financial reporting requirements to provide greater clarity to the type of risk arrangements that shall be disclosed by the health plan to the RBO, and to incorporate the current payment models used by Medicare for consistency.

The proposed amendment to section 1300.75.4.2 would remove the quarterly reporting distinction between RBOs that serve at least 10,000 covered lives under all risk arrangements and those that service less than 10,000 covered lives. The proposed amendments allow for a one-year phase-in period for RBOs to comply with the revised cash-to-claims definition proposed in section 1300.75.4. The proposal also incorporates by reference the “DMHC Quarterly Financial Survey

Report Form” and the “DMHC Annual Financial Survey Report,” which implement the financial reporting requirements pursuant to Health and Safety Code section 1375.4 and amended section 1300.75.4.2.

DMHC proposes to amend section 1300.75.4.5 to clarify that any financial information a health plan or sub-delegating organization contracts to receive from an RBO shall be reviewed as a part of the health plan’s and RBO’s duty to ensure their risk-sharing arrangements are financially viable. Amended section 1300.75.4.8 would streamline the corrective action plan process by requiring a shorter turnaround by health plans and sub-delegating organizations raising objections and allowing DMHC to assist in resolving objections at an earlier stage of the process. Finally, the amendments to section 1300.76 would clarify what “positive tangible net equity” (TNE) is for purposes of calculating the TNE that an RBO must have in order to be compliance with DMHC’s solvency regulations.

On September 13, following an initial public comment period ending on July 9, 2018, DMHC released [modified text](#) of the proposed regulations for an additional 15-day public comment period ending on September 28, 2018. At this writing, DMHC is reviewing the comments received during the second comment period.

◆ **Implementation of AB 72 (Bonta).** On September 13, 2018, OAL [approved](#) DMHC’s adoption of new section 1300.71.31 (“Methodology for Determining Average Contracted Rate; Default Reimbursement Rate”) and 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 noncontracting provider. [\[23:2 CRLR 19\]](#)

DMHC originally posted notice of its intent to adopt new section 1300.71.31 on February 2, 2018, and held a public comment period ending March 19, 2018. Thereafter, on May 3, 2018, DMHC released [modified text](#) of the regulation in response to comments made during the initial comment period; DMHC received comments on the modifications until May 18, 2018.

To comply with AB 72, the regulatory [changes](#) in section 1300.71.31 provide a standardized methodology that health plans and their delegated entities are required to use to compute the average contracted rate for reimbursement of health care services that are most frequently subject to Health and Safety Code section 1371.9. Section 1300.71.31 defines the term “average contracted rate” as “the claims-volume weighted average of the contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year, for services most frequently subject to section 1371.9 of the Knox-Keene Act. The applicable calendar year is two years prior to the year in which the health care service was rendered.” Section 1300.71.31(c) sets forth the methodology for calculation the ACR as “the sum of [the allowed amount for the health service code under a contract times the number of claims paid at that allowed amount] divided by the [total number of claims paid for that code across all commercial contracts].” The new regulation also fleshes out reporting requirements from health plans to DMHC concerning use of the ACR, as established by AB 72 in Health and Safety Code section 1371.31.

As explained in the [final statement of reason](#), the regulation further clarifies key terms and concepts relevant to proper reimbursement of noncontracting individual health professionals and makes conforming changes to an existing DMHC regulation on claims settlement practices. These regulatory changes become effective on January 1, 2019.

U.S. Justice Department Approves CVS-Aetna Merger

On May 2, 2018, DMHC held a [public meeting](#) regarding CVS Health's proposal to purchase Aetna, Inc. in what would be a \$69 billion acquisition merging one of the nation's largest health insurers into CVS, which operates a nationwide chain of pharmacies and retail clinics. [\[23:2 CRLR 18\]](#) The meeting provided an opportunity for the public to comment and for representatives of CVS and Aetna to publicly explain the transaction and argue in for the merger. The meeting covered DMHC's jurisdiction and authority to oversee the transaction. CVS and Aetna argued that the merger would be an important step in "bringing together the strengths and capabilities of our two companies to improve the consumer health care experience." Public concerns surround previous mergers that did not succeed and the consolidation of businesses in the health care industry which would ultimately reduce competition and consumer choice.

On October 10, 2018, the U.S. Justice Department (DOJ) conditionally [approved](#) the \$69 billion-dollar merger between CVS and Aetna. Consumers have continuously opposed the CVS-Aetna merger, arguing that people enrolled in Aetna health plans could be forced to seek care at CVS Health retail clinics. Furthermore, those patients who are not insured by Aetna could be required to pay higher prices for drugs at CVS than those who are insured through Aetna. DOJ granted conditional approval of the CVS-Aetna merger so long as Aetna sells off its private Medicare drug plans.

On August 1, 2018, California Insurance Commissioner Dave Jones, whose Department of Insurance (DOI) held a public hearing on the proposed merger on June 19, 2018, issued a detailed 15-page [letter](#) finding that the proposed merger of CVS and Aetna would have significant anticompetitive impacts on American consumers and health care and health insurance markets;

Jones recommended that DOJ sue to block the merger (see agency report on DOI). At this writing, DMHC has not yet published its decision as to whether it approves of the CVS-Aetna merger.

U.S. Justice Department Approves Cigna-Express Scripts Merger

On September 17, 2018, the U.S. Department of Justice [approved](#) the \$67 billion merger between Cigna and Express Scripts. DOJ approved the merger on the condition that Cigna and Express Scripts receive state regulatory approvals before completing the deal. The decision allows Cigna to buy Express Scripts as a “vertical merger.” The companies’ merger qualifies as a vertical merger because Cigna is one of the nation’s largest health insurers and Express Scripts is a major pharmacy benefit manager (PBM); so, although within the same broad line of business, the companies do not directly compete with each other. When approving the Cigna-Express Scripts merger, DOJ officials emphasized that they did not believe the merger would hinder any competition within the pharmacy sector of the medical industry.

As of September 17, 2018, Cigna and Express Scripts have received approval from 16 state insurance departments and are working with regulators in other states to get the additional necessary approvals. Shareholders of both companies have voted and approved the merger. The companies expect to close the merger by the end of 2018.

On September 26, 2018, DMHC held a [public meeting](#) on the acquisition of Express Scripts by Cigna. The purpose of the meeting was to discuss DMHC’s jurisdiction and authority to oversee the transaction and to solicit public comment for DMHC’s consideration as it reviews the transaction. DMHC [recorded](#) the comments of Cigna, Express Scripts, and members of the public at the September meeting. Cigna and Express Scripts communicated their arguments for why

DMHC should approve the merger, explaining that “by working together and providing incentives for high quality care, medical cost trends have consistently performed better.” Cigna argued that the enhanced pharmacy data that it will provide within the merger will accelerate affordability of health care. Express Scripts contended that the merger would expand the portfolio and value of health care services available to customers, employers, health plans, and government agencies. Additionally, both companies contended that the merger would provide patient-provider alignments, ultimately providing a “more coordinated approach to an individual’s health care journey, and reducing complexity, and creating better outcomes.” DMHC and public comments revealed concern surrounding sharing patient data and alterations of current plans. Both companies assured DMHC and meeting attendees that “absolutely no” data sharing or changing of current plans would take place. Furthermore, public comment expressed concern that the merger would decrease patient choice and reduce competition in the pharmacy business.

At this writing, DMHC has not yet issued a ruling on whether it has approved the Cigna-Express Scripts merger.

Update on Federal Government’s Actions Concerning Health Care Coverage

The following is a status update on several Trump administration actions that have the effect of undermining the Affordable Care Act (ACA), covered previously in Volume 23, No. 2 (Spring 2018) of the *California Regulatory Law Reporter*:

◆ **“Skimpy” Health Care Coverage.** On August 3, 2018, the U.S. Department of Health and Human Services and two other federal agencies published the [final rule](#) permitting the sale of short-term, limited duration health policies in response to President Trump’s [Executive Order](#)

[13813](#). The rule, which will lengthen the maximum duration of short-term, limited-duration insurance policies, was scheduled to become effective on October 2, 2018. The final rule: (1) allows short-term plans to be sold with initial terms of up to 364 days; (2) allows short-term plans to be renewed as long as the total duration of the plan does not exceed 36 months; and (3) requires short-term plan information to include a disclosure to help people understand how short-term plans differ from individual health insurance.

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. Under the previous rule, short-term insurance could not last for more than three months, as it was meant to be a stopgap. 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. Additionally, while “skimpy” coverage may be cheaper than coverage that complies with the ACA, such policies need not cover the ten essential health benefits required by the ACA. [[23:2 CRLR 17](#)]

The short-term policies are subject to state regulation. Governor Brown recently signed [SB 910 \(Hernandez\) \(Chapter 687, Statutes of 2018\)](#), which prohibits the sale of these short-term, limited duration plans in California [see LEGISLATION]. Also, a coalition of patient advocates and health care groups filed a federal court lawsuit challenging the federal rule on September 14, 2018, in Washington, D.C., and succeeded in securing a preliminary injunction to postpone the effective date of the rule [see LITIGATION].

◆ *Association Health Plans*. Effective August 20, 2018, the U.S. Department of Labor (DOL)—pursuant to President Trump’s Executive Order 13813—issued a [final rule](#) allowing the use of association health plans (AHPs), 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. According to DOL’s [press release](#), the use of AHPs will “expand affordable health coverage options for America’s small businesses. ... AHPs are about more choice, more access, and more coverage.”

Critics of the Trump Administration’s efforts to undermine the ACA disagree. Although lower in cost than ACA-compliant policies, AHPs 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. [[23:2 CRLR 17](#)] On July 26, 2018, a group of twelve state attorneys general filed a federal challenge to the rule, arguing that the final rule is an arbitrary and capricious attempt to undermine the market structure underpinning the ACA [see LITIGATION].

The final rule does not diminish state oversight. California Governor Jerry Brown recently signed [SB 1375 \(Hernandez\) \(Chapter 700, Statutes of 2018\)](#), which prohibits sole proprietors from joining AHPs [see LEGISLATION].

LEGISLATION

[SB 910 \(Hernandez\)](#), as amended August 9, 2018, amends sections 1367.29 and 1368.016 of the Health and Safety Code to eliminate the term “short-term limited duration health insurance” from those sections. Commencing January 1, 2019, SB 910 prohibits a health plan from issuing,

selling, renewing, or offering short-term limited duration health insurance in this state [see MAJOR PROJECTS].

Governor Brown signed SB 910 on September 22, 2018 (Chapter 687, Statutes of 2018).

[SB 1375 \(Hernandez\)](#), as amended August 23, 2018, amends sections 1357, 1357.500, 1357.503, 1357.600, 1399.802 of, and adds section 1399.846 to the Health and Safety Code. The bill prohibits sole proprietors from joining association health plans [see MAJOR PROJECTS]. For plan years commencing on or after January 1, 2019, SB 1375 prohibits health plans from issuing, marketing, or selling small group products to a sole proprietorship or partnership that consists only of the sole proprietor and their spouse. New section 1399.846 states,

[f]or the purposes of determining eligibility for small employer coverage, a sole proprietor and the sole proprietor’s spouse are not employees with respect to a sole proprietorship that consists only of the sole proprietor and the sole proprietor’s spouse. A partner and a partner’s spouse are not employees of a partnership that consists solely of partners and their spouses. Employer group health care service plans shall not be issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement. Only individual health care service plans shall be sold to any entity without employees.

The conforming amendments to sections 1357, 1357.500, and 1357.600 revise the definition of “eligible employee” for the purposes of all small employer health plan contracts to exclude sole proprietors or their spouses, and partners of a partnership or their spouses.

Governor Brown signed SB 1375 on September 22, 2018 (Chapter 700, Statutes of 2018).

[SB 997 \(Monning\)](#), as introduced February 5, 2018, amends section 1375.9 of the Health and Safety Code, which requires—until January 1, 2019—health plans to ensure that 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 repeals the January 1, 2019 sunset date on this

requirement, thus extending it indefinitely. According to the author, this bill was introduced to make California law consistent with the ACA’s definitions of primary care provider, assist with California’s primary care provider workforce shortage, and help meet the needs of the newly insured Californians seeking services as a result of the ACA.

Governor Brown signed SB 997 on July 20, 2018 (Chapter 152, Statutes of 2018).

[AB 2674 \(Aguiar-Curry\)](#), as amended August 17, 2018, amends section 1371.39 of the Health and Safety Code to require DMHC to investigate provider complaints that a health plan is engaging in an unfair billing pattern (defined in the bill as “engaging in a demonstrable and unjust pattern of unbundling of claims, upcoding of claims, or other demonstrable and unjustified billing patterns”). The amendments to section 1371.39 would additionally require DMHC—on or before July 1, 2019 and at least annually thereafter—to review provider complaints; if the review of the complaint data indicates a possible unfair billing pattern, DMHC may conduct an audit or take an enforcement action.

Governor Brown signed AB 2674 on September 7, 2018 (Chapter 303, Statutes of 2018).

[AB 595 \(Wood\)](#), as amended August 17, 2018, adds Article 10.2 (commencing with section 1399.65) to the Health and Safety Code regarding mergers of health plans. New Article 10.2 requires 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 also requires DMHC—prior to approval, conditional approval, or denial of the proposed agreement or transaction—to hold a public meeting on the proposal in accordance with the Bagley-Keene Open Meeting Act. Under this bill, the Director is required to prepare a statement if the

Director determines that a material amount of the health plan's assets are subject to merger, consolidation, acquisition, purchase or control, and make the statement available prior to the public meeting. The bill authorizes the Director to approve, conditionally approve, or disapprove the proposed agreement or transaction.

According to an [opinion](#) piece written by former DMHC Director Daniel Zingale, AB 595

gives the Department stronger oversight over health plan mergers and authority to approve, deny, or impose conditions on these deals. This is important because consumers have very little say in health plan mergers that often upend their health care. ... At a time when the top five health giants already control 90 percent of our health care market, I can think of nothing more worthy than finally giving voice to the millions of consumers whose health would otherwise be at the mercy of these huge companies.

Governor Brown signed AB 595 on September 7, 2018 (Chapter 292, Statutes of 2018).

[SB 1021 \(Wiener\)](#), as amended August 23, 2018, adds section 1342.73 to the Health and Safety Code, which prohibits a health plan contract from maintaining a prescription drug formulary with more than four tiers, and extends—until January 1, 2024—a requirement that puts a cap on the cost sharing of a covered outpatient prescription drug at \$250 or \$500 per 30-day supply, as specified. The bill also adds new section 1342.72 to the Health and Safety Code, which provides that—for combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV—a health plan shall not have utilization management policies or procedures, including a standard of care, which rely on a multitablet drug regimen instead of a single-tablet drug regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and equally or more likely to result in adherence to a drug regimen.

Governor Brown signed SB 1021 on September 26, 2018 (Chapter 787, Statutes of 2018).

[AB 2863 \(Nazarian\)](#), as amended August 13, 2018, adds section 1367.47 to the Health and Safety Code, which provides that the maximum amount a health plan may require an enrollee to pay at the point of sale for a covered prescription drug is the lesser of the applicable cost-sharing amount or the retail price. New section 1367.47 also prohibits a health plan from requiring a pharmacist or pharmacy to charge or collect a copayment from an enrollee that exceeds the total retail price for the prescription drug. Finally, the new section provides that the payment rendered for a prescription drug shall apply to the enrollee's deductible, if any, and to the maximum out-of-pocket limit if the enrollee pays the retail price.

Governor Brown signed AB 2863 on September 26, 2018 (Chapter 770, Statutes of 2018).

[AB 2499 \(Arambula\)](#), as amended August 9, 2018, amends section 1367.003 of the Health and Safety Code, which sets minimum medical loss ratios (MLRs) that guarantee that at least 80% or 85% of premiums go towards actual medical care and quality improvement activities, and requires health plans to provide an annual rebate to enrollees if the MLR does not meet established standards. AB 2499 deletes the requirements that MLRs be implemented to the extent required by, in compliance with, and not to exceed federal law, and instead requires MLRs to be implemented as described in federal law and any rules or regulations issued as in effect on January 1, 2017. This bill exempts specialized health plan contracts that provide only dental or vision services from the annual rebate requirement; changes the date from August 1 of the following calendar year, to September 30, that a health plan that does not meet the MLR must pay an enrollee a rebate; and repeals section 1367.003's authorization to the DMHC Director to implement it by way of emergency regulation, and its requirement that DMHC consult with DOI in adopting regulations.

Governor Brown signed AB 2499 on September 22, 2018 (Chapter 678, Statutes of 2018).

[SB 1008 \(Skinner\)](#), as amended August 23, 2018, amends sections 1363 and 1367.004 and adds section 1363.04 to the Health and Safety Code regarding health plans that cover dental services. New section 1363.04 requires a health plan—for plan years on and after January 1, 2021, or 12 months after DMHC adopts regulations, whichever occurs later (as described below)—to utilize a uniform benefits and coverage (UBC) disclosure matrix, with specified contents. The new section requires plans to utilize the UBC matrix to make available, at minimum, all of the following information relating to covered dental services, together with the corresponding copayments or coinsurance and limitations: (1) the annual overall plan deductible; (2) the annual benefit limit; (3) coverage for the following categories: preventive and diagnostic services, basic services, major services, and orthodontia services; (4) dental plan reimbursement levels and estimated enrollee cost share for services; (5) waiting periods; and (6) examples to illustrate coverage and estimated enrollee costs of commonly used benefits. The new section requires DMHC to adopt emergency regulations to implement it, and DMHC must do so in consultation with DOI. The bill amends section 1363 to conform it with new section 1363.04.

Amended section 1367.004 requires health plans that offer dental coverage to file a MLR report with DMHC by July 31 of each year. The MLR report shall be organized by market and product type and shall contain the same information required in the 2013 federal MLR Annual Reporting Form. DMHC must post a health plan's annual MLR report on its Internet Web site within 45 days after receiving the report. Finally, the bill authorizes DMHC to issue guidance to specialized health plans subject to this section regarding compliance with these provisions until regulations are adopted.

Governor Brown signed SB 1008 on September 29, 2018 (Chapter 933, Statutes of 2018).

[SB 1156 \(Levva\)](#), as amended August 24, 2018, would have added section 1367.016 to the Health and Safety Code. The new section would have required health plans that provide coverage for hospital, medical, or surgical expenses to accept premium and cost-sharing payments from specified third-party entities.

On September 30, Governor Brown [vetoed](#) SB 1156, stating that “this bill goes too far as it would permit health plans and insurers to refuse premium assistance payments and to choose which patients they will cover.”

[AB 2193 \(Maienschein\)](#), as amended August 29, 2018, adds section 1367.625 and Article 6 (commencing with section 123640) to the Health and Safety Code, which requires health plans, by July 1, 2019, to develop a high quality, efficient maternal mental health (MMH) program whereby a prenatal or postpartum practitioner ensures that a patient who becomes a mother is offered or is appropriately screened for MMH conditions. Section 1367.625 explicitly states that it does not apply to specialized health care service plans, except for specialized behavioral health-only plans.

Governor Brown signed AB 2193 on September 26, 2018 (Chapter 755, Statutes of 2018).

[AB 1860 \(Limón and Cervantes\)](#), as amended August 20, 2018, amends section 1367.656 of the Health and Safety Code to increase the \$200 copayment and coinsurance limit to \$250 for an individual 30-day prescription of orally administered anticancer medication used to kill or slow the growth of cancerous cells, and extends the sunset date in that provision from January 1, 2019 to January 1, 2024. Section 1367.656 allows the \$250 prescription limit to be increased only once an enrollee’s deductible in a high deductible health plan has been satisfied.

Governor Brown signed AB 1860 on September 17, 2018 (Chapter 427, Statutes of 2018).

[AB 2941 \(Berman\)](#), as amended June 19, 2018, adds section 1368.7 to the Health and Safety Code, requiring health plans to provide their enrollees who have been evacuated by a state of emergency access to medically necessary health care services. Section 1368.7 requires a health plan, within 48 hours of the declaration of emergency that displaces or could displace enrollees, to file a notice with DMHC containing specified information regarding how the plan is addressing the needs of its enrollees during the state of emergency. The health plan may be required to take actions including, but not limited to, the possibility of relaxed time limits for prior authorization, precertification, or referrals; extended filing deadlines for claims; suspension of prescription refill limitations; allowing enrollees to refill prescriptions at an out-of-network pharmacy; replacement of medical equipment or supplies; access to an out-of-network provider should an 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.

Governor Brown signed AB 2941 on August 24, 2018 (Chapter 196, Statutes of 2018).

[AB 315 \(Wood\)](#), as amended August 24, 2018, adds section 1368.6 and Article 6.1 (commencing with section 1385.001) to the Health and Safety Code, relating to pharmacy benefit managers. New Article 6.1 (section 1385.001) defines a “pharmacy benefit manager” (PBM) as

a person, business, or other entity that, pursuant to a contract with a health care service plan, manages the prescription drug coverage provided by the health care service plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

According to the author, “PBMs play a major role in negotiating the prices of prescription drugs, creating and managing formularies, and several other functions key to the management of pharmacy benefits for millions of Californians. However, despite a PBM’s interaction with most major players, including drug manufacturers, health plans and insurers, and pharmacies, very little is known about those relationships.” Until the passage of AB 315, PBMs were subject to no state regulation.

Article 6.1 requires DMHC to set up a registration program for PBMs (section 1300.002), and requires PBMs to register with DMHC (section 1385.004). Additionally, it requires PBMs to exercise good faith and fair dealing (section 1385.004). The bill also adds new section 4441 to the Business and Professions Code (the Pharmacy Law), which requires—among other things—PBMs to notify a purchaser in writing of any activity, policy, or practice of the PBM that directly or indirectly presents a conflict of interest that interferes with the discharge of the PBM’s duty to the purchaser to exercise good faith and fair dealing. Additionally, new section 4441 requires PBMs to disclose, upon a purchaser’s request, specified information with respect to prescription product benefits to the purchaser for all retail, mail order, specialty, and compounded prescription products.

Under Article 6.1, DMHC—in collaboration with other agencies, departments, advocates, experts, health plan representatives, and other entities and stakeholders that it deems appropriate—must convene a Task Force on Pharmacy Benefit Management Reporting to determine what information related to pharmaceutical costs, if any, DMHC should require to be reported to it by health plans or their contracted PBMs (section 1385.007). The Task Force must consider the inclusion of specified information and submit a report to the legislature with its recommendations no later than February 1, 2020, on which date the Task Force will cease to exist.

Finally, new section 1368.6 establishes a pilot project in Riverside and Sonoma counties— from January 1, 2020 to January 1, 2023—to assess the impacts of health plans and PBM prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies. New subsection 1368.6(b) prohibits a health plan, pursuant to the pilot project, from prohibiting, or permitting any delegated PBM to prohibit, a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or PBM allows that amount to be dispensed through a pharmacy owned or controlled by the plan or PBM, unless the prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Finally, the new section requires health plans subject to the pilot project, on or before July 1, 2020, to report annually to DMHC information and data relating to changes, if any, to costs and utilization of prescription drugs attributable to the prohibition of contract terms in subsection 1368.6(b); requires DMHC to solicit and receive any additional information relevant to changes in costs or utilization attributable to the pilot project from other interested stakeholders; and requires DMHC to summarize data received and provide the summary to the Governor and health policy committees of the Legislature on or before December 31, 2022.

Governor Brown signed AB 315 on September 29, 2018 (Chapter 905, Statutes of 2018).

[AB 1092 \(Cooley\)](#), as amended August 21, 2018, amends section 1371 of the Health and Safety Code to authorize a specialized health plan that solely covers vision care services to use a statistically reliable method to investigate suspected fraud and to recover overpayments made as a result of fraud, if specified requirements (including DMHC approval of the method) are met. If the specialized health plan suspects fraud, the plan must provide written notice to the provider of

the suspected fraud within 60 days following the date of the latest in time payment. The bill specifies that the provider has 45 working days within which to contest the health plan's notice of suspected fraud or to request a hearing; additionally, it specifies the circumstances under which the plan may offset the amount it disclosed as overpaid.

Governor Brown signed AB 1092 on September 19, 2018 (Chapter 525, Statutes of 2018).

[SB 399 \(Portantino\)](#), as amended August 23, 2018, would have amended 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. Among other things, the bill would have changed the eligibility requirements needed to become a “qualified autism service professional” and a “qualified autism service paraprofessional.”

On September 29, Governor Brown [vetoed](#) SB 399, stating that “this bill would revise qualification standards for providers of behavioral health treatment for individuals with autism. Standards for autism providers were updated last year. I’m not inclined to revise them again.”

[AB 1534 \(Nazarian\)](#), as amended June 26, 2017, would have added section 1367.693 to the Health and Safety Code, which would have required health plans to permit an HIV specialist to be an eligible primary care provider, as long as the HIV specialist adheres to health plan criteria and requests primary care provider status.

On September 17, Governor Brown [vetoed](#) AB 1534, stating that “[t]his bill would require health plans and insurers to accept doctors who specialize in HIV as primary care providers.

Existing law allows specialists to serve as primary care providers when patients require continuing care from a particular specialist. It's not necessary to call out this particular specialty in statute.”

[AB 2384 \(Arambula\)](#), as amended August 23, 2018, would have added section 1367.207 to the Health and Safety Code regarding medication-assisted treatment (MAT). The new section would have required health plans that provide prescription drug benefits to cover at least one MAT, relapse prevention, and overdose reversal prescription drug for opioid use disorder. The health plan would have to cover the MAT regardless of whether a drug was self-administered or administered by a health care provider.

On September 23, Governor Brown [vetoed](#) AB 2384, stating that “this bill requires health plans to cover at least one version of each drug used in medication-assisted treatment for opioid disorders and restricts health plans’ ability to manage the utilization of these drugs. While the drugs specified in this bill are useful to treat opioid addiction, I’m not willing to eliminate requirements that may be in the best interest of patients.”

[AB 2342 \(Burke and Waldron\)](#), as amended August 17, 2018, would have added section 1367.615 to the Health and Safety Code, which would have required health plans issued or renewed after January 1, 2019 to follow the United States Preventive Services Task Force’s recommendation to cover screening, genetic counseling, and testing for breast cancer gene mutations and ovarian cancer susceptibility in women.

On September 27, Governor Brown vetoed SB 2342, stating that the bill requires “significant, ongoing general fund commitments. As such, I believe they should be considered as part of the budget process.”

Legislative Bills that Died

The following bills reported in Volume 23, No. 2 (Spring 2018) died in committee or otherwise failed to be enacted during 2018: [SB 1457 \(Hernandez\)](#), which would have required the DMHC Director to require an issuer of a Medicare supplement contract to annually complete and submit the National Association of Insurance Commissioners' Medicare supplement experience exhibit; [SB 437 \(Atkins\)](#), which would have required an existing senior level DMHC/DOI working group to review and examine timely access to care, network adequacy, and state implementation of federal health care reforms as part of its duties; [AB 2895 \(Arambula\)](#), which would have required a health plan that reports rate information to DMHC to annually report the percentage of expenses the health plan allocated to primary care; [AB 2416 \(Wood\)](#), which would have required on or 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 offering products on the Exchange in the county; [SB 538 \(Monning\)](#), which would have prohibited contracts between a hospital and a health plan from containing certain provisions; [SB 562 \(Lara and Atkins\)](#), which would have required the establishment of a comprehensive universal single-payer health care coverage system for all California residents; [AB 3087 \(Kalra\)](#), which would have created a commission to impose limits on health care costs; [AB 2643 \(Irwin\)](#), which would have granted health care coverage for general anesthesia required for dental procedures; [SB 1285 \(Stone\)](#), which would have required health plans to provide coverage for services provided by an advanced practice pharmacist; and [SB 1023 \(Hernandez\)](#), concerning the provision of family planning benefits via telehealth under the Medi-Cal program.

LITIGATION

◆ *Pharmaceutical Research and Manufacturers of America v. Brown*. On August 30, 2018, in *Pharmaceutical Research and Manufacturers of America v. Brown*, No. 2:17-cv-02573-MCE-KJN, U.S. District Judge Morrison C. England of the Eastern District of California [ruled](#) on PhRMA's December 2017 challenge to the constitutionality of SB 17 (Hernandez) (Chapter 603, Statutes of 2017). SB 17 attempts to provide transparency in regard to prescription drug pricing, including requiring drug manufacturers to provide 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.

In his August 30 ruling, Judge England dismissed the [complaint](#) in its entirety, but granted PhRMA leave to file an amended complaint within thirty (30) days following August 30, 2018. Judge England dismissed the Governor as a party to the action because he is immune from suit and the complaint failed to allege facts sufficient to apply an exception. The court also dismissed PhRMA's complaint in its entirety for lack of standing.

On September 28, 2018, PhRMA submitted its [first amended complaint](#). 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 the statute is unconstitutional. At this

writing, a hearing on Defendant Robert P. David’s motion to dismiss the case is set for December 13, 2018; David is the Director of the California Office of Statewide Health Planning and Development.

◆ *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.* On September 14, 2018, seven patient advocate and health care groups filed a [complaint](#) in the U.S. District Court for the District of Columbia against the Departments of Labor, Treasury, and Health and Human Services (“the departments”) in *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.*, Civil Action No. 18-2133, requesting that the departments’ short-term, limited duration insurance rule (“STLDI Rule”) be set aside under the Administrative Procedure Act because it cannot be reconciled with the text, structure, or purpose of the Affordable Care Act. The STLDI Rule converts the narrow exemption for “short-term, limited duration insurance” into a loophole that permits the creation of a parallel individual insurance market consisting of plans that are not subject to the ACA’s consumer protection standards [see MAJOR PROJECTS]. According to the complaint, STLDI plans may omit essential health benefits and engage in business practices that are otherwise forbidden to ACA-compliant individual health insurance plans. The complaint also alleges that the STLDI Rule is arbitrary and capricious for multiple reasons, and that the departments failed to provide the public with reasonable notice of important aspects of the rule in their notice of proposed rulemaking. In particular, plaintiffs allege that the departments failed to disclose that they intended to permit STLDI plans to be renewable at all, or for a period of up to 36 months. Plaintiffs are seven organizations that participated in the 2018 rulemaking proceeding and/or believe strongly that the STLDI rule is incompatible with their shared purpose of ensuring access to adequate,

affordable health care for all Americans. The plaintiffs are the Association for Community Affiliated Plans, National Alliance on Mental Illness, Mental Health America, American Psychiatric Association, AIDS United, National Partnership for Women and Families, and Little Lobbyists.

On September 28, 2018, plaintiffs filed a motion for preliminary injunction blocking enforcement of the rule. On October 2, 2018, the court granted that motion and ordered defendants to file their response no later than October 22, 2018. The court also ordered a preliminary injunction hearing for October 26, 2018.

◆ ***State of New York, et al. v. U.S. Department of Labor.*** On July 26, 2018, twelve state attorneys general filed *State of New York, et al. v. U.S. Department of Labor*, Civ. Action No. 18-1747-JDB, in the U.S. District Court for the District of Columbia. This [complaint](#) challenges the Trump administration's regulation issued this year that makes it easier for individuals and small employers to band together to purchase health care coverage through association health plans (AHPs) that do not meet ACA standards [see MAJOR PROJECTS]. Plaintiffs argue that the administration is violating the ACA's purpose of establishing minimum insurance protections. Defendants argue the loosening of health plans allows for more affordable health care, and more covered Americans. On August 23, 2018, plaintiffs filed a motion for summary judgment; at this writing, all parties and numerous *amici curiae* are briefing the case; no hearing has yet been held.

◆ ***Skyline Wesleyan Church v. California Department of Managed Health Care.*** On April 9, 2018, Skyline Wesleyan Church appealed a decision of the U.S. District Court for the Southern District of California in *Skyline Wesleyan Church v. California Department of Managed Health Care*, 315 F. Supp. 1225 (March 9, 2018), which dismissed Skyline's complaint against

DMHC challenging the agency’s interpretation of California law concerning health plan coverage for voluntary termination of pregnancies on two grounds: (1) the matter is not ripe for adjudication; and (2) plaintiff lacks standing to pursue its claims. Skyline is a Christian church that believes abortion is a sin and is incompatible with the Bible’s teachings; it maintained an employee health plan that restricted abortion coverage consistent with its religious beliefs. In August 2014, DMHC sent a letter to seven group health plans (including Skyline) concluding that California law “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.” Subsequently, DMHC informed the seven health plans that it would grant them an exemption from the requirements detailed in the August 2014 letter for products offered exclusively to entities that meet the definition of “religious employers” in Health and Safety Code section 1367.25(b)(1). Rather than requesting that its health plan seek that exemption, Skyline sued DMHC. During the course of that litigation, DMHC produced a declaration from its Office of Plan Licensing, which attested that “[to] date, no plan has requested” such an exemption. Based on that declaration, the district court found that Skyline’s complaint was not ripe for adjudication. 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 seeks.” [\[23:2 CRLR 38\]](#)

In its [opening brief](#) filed in the U.S. Court of Appeals for the Ninth Circuit on September 14, 2018, Skyline argued that (1) it has standing to assert claims for prospective relief, and those claims are ripe for review; (2) the lower court failed to address its claims for retrospective relief,

which are redressable and ripe for review; and (3) DMHC’s abortion-coverage requirement violates the Free Exercise Clause of the U.S. Constitution. Also on September 14, Skyline filed a motion to supplement the record, arguing that it (as well as three other churches) had sent letters to DMHC in July 2018 requesting a religious exemption from the agency’s requirement that their employer health care plans cover all legal abortions. Skyline argued that this material fact was omitted and asked the court to exercise its authority to supplement the record. On September 21, The Jewish Coalition for Religious Liberty and The Ethics & Religious Liberty Commission filed an [amicus curiae brief](#) in support of Skyline’s arguments around ripeness and the Free Exercise Clause. On September 24, DMHC filed a [response](#) opposing the motion to supplement the record, arguing that Skyline failed to provide a basis for the court to take the “unusual and extraordinary step” of considering “purported” new evidence on appeal; and further contending that Skyline’s letter was “manufactured” after the district court entered judgment and after Skyline filed its appeal. On September 28, Skyline replied to DMHC’s response to the motion, stating that the letter should be admitted because it “confirms that there has been no change in the agency’s position. The DMHC continues to apply the abortion-coverage requirement to churches’ healthcare plans and has not adopted (and will not adopt) a religious exemption that accommodates Skyline Church.” On October 12, the Ninth Circuit referred Skyline’s motion to supplement the record to a panel for resolution. If the motion is denied, any discussion of supplemental record in either party’s brief will be stricken. The panel’s decision is expected by November 14, 2018.

DMHC is expected to file its responsive brief by December 14, 2018.