DEPARTMENT OF MANAGED HEALTH CARE

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

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

In Health and Safety Code section 1342, the legislature has expressly instructed the Department Director to ensure the continued role of the professional as the determiner of the patient's health needs; ensure that enrollees are educated and informed of the benefits and services available in order to increase consumer choice in the healthcare market; and promote effective representation of the interests of enrollees, including ensuring the best possible health care at the

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

The Director of DMHC is appointed by and serves at the pleasure of the Governor. The Department's staff of attorneys, financial examiners, health plan analysts, physicians, health care professionals, consumer service representatives, and support staff assist the DMHC Director in licensing and regulating 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 such as 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 that are independent of the health plans and certified by an accrediting organization. An IMR determination is binding on the health plan, and the Department will enforce it.

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). Comprised of the DMHC Director and seven members appointed by the Director, FSSB periodically monitors and reports

on the implementation and results of those requirements and standards, and reviews proposed regulatory changes. FSSB advises the DMHC Director on matters of financial solvency affecting the delivery of health care services. FSSB develops and recommends financial solvency requirements and standards relating to plan operations.

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.

Following the retirement of previous DMHC Director Shelley Rouillard in mid-July 2020, Mary Watanabe is Acting Director of the Department. Additionally, Ms. Watanabe is the current Acting Chief Deputy Director for the Department. At this writing, there are no plans set by the Governor's Office in terms of appointing a permanent Director.

At this writing, the Department is seeking five (5) healthcare professionals to serve on the DMHC Financial Solvency Standards Board (FSSB).

HIGHLIGHTS

DMHC Orders Aetna to Pay Fine for Improper Denial of Emergency Room Claims

On August 25, 2020, the Department issued a cease and desist order to Aetna Health of California, Inc. with respect to its continued failure to comply with California standards for emergency room coverage and fined the health care provider $500,000. As alleged in DMHC's

accusation against Aetna, Aetna repeatedly failed to apply California law and implement corrective action plans agreed to in 2015 and 2016. DMHC also ordered Aetna to correctly reprocess all of its emergency room denials dating back to February 1, 2017. In a press release announcing the order and fine, Acting Director Mary Watanabe stated, "The plan's failure to follow California law for reimbursing emergency room claims is unacceptable. This has resulted in Aetna wrongfully denying emergency room claims. Aetna must follow the state's health care laws to ensure enrollees have access to the care they need."

According to the August cease and desist order, in 2010, Aetna applied its national "prudent layperson" standard set forth in the federal Balanced Budget Act of 1997, and applicable state law standards, to deny coverage for 23 separate emergency medical services. The national "prudent layperson" standard allows Aetna to deny payment for an emergency room visit unless the medical record shows that a prudent layperson with an average knowledge of health and medicine would have known that his or her condition was truly an emergency. The California standard, under the Health and Safety Code sections 1371.4(b) and 1371.4(c), requires a plan to pay for an emergency room visit unless it has evidence to show that emergency services were not performed, or the enrollee did not require emergency health care services and reasonably should have known that an emergency did not exist.

In the accusation, DMHC alleges that Aetna agreed with DMHC to implement an informal corrective action plan (CAP) to reform its procedures for adjudicating claims, agreeing they had not applied the California standard. In 2015, DMHC ordered a second corrective action plan asking Aetna to pay a $10,000 administrative penalty and enter into a CAP that required Aetna to train employees adjudicating claims to apply the California standard. Again in 2016, Aetna denied coverage for eight claims for medical services and was ordered by DMHC to pay a $125,000

administrative penalty and implement a CAP to reimburse emergency medical services based on the California standard. In four instances between 2017 and 2018, Aetna continued to apply the national "prudent layperson" standard to California cases. In 2019, DMHC's survey report of Aetna-denied cases found 93 percent of the sampled emergency claims were wrongfully denied.

DMHC Notices Amendment to Conflict-of-Interest Code

On June 26, 2020, the Department published notice of its intent to amend Article 1, section 1000 of its Conflict-of-Interest Code pursuant to its obligations under the Political Reform Act, Government Code Section 81000, et seq. Specifically, section 87302 of the Government Code requires DMHC to periodically update its Conflict-of-Interest Code to identify specific employee positions at the Department that are involved in the making, or participation in the making, of decisions that may foreseeably have a material effect on any financial interest. DMHC's proposed amendment updates the list of positions, specifies that the Director of DMHC will file his or her statement of economic interest electronically with the Fair Political Practices Commission, while all other individuals identified will file their statements with the Office of Legal Services at the Department, and will be made available for public inspection upon request. Finally, the Department proposes to make technical changes to reflect the current organizational structure of DMHC and to remove obsolete classifications.

On September 11, 2020, DMHC released a Notice of 2nd Comment Period of 15 Days for Amendments to the Conflict-of-Interest Code. According to its Notice of 2nd Comment Period, the DMHC proposes to add "Research Data Supervisor in the DMHC Help Center" to the list of

employees who are involved in the making, or participation in the making, of decisions that may foreseeably have a material effect on any financial interest.

The deadline to submit written statements, arguments, or comments relating to the proposed amendment was September 26, 2020.

DMHC Financial Solvency Standards Board Quarterly Update – August 2020

On August 19, 2020, the Financial Solvency Standards Board (FSSB) held its quarterly meeting via Zoom. DMHC staff provided a number of updates to FSSB, namely the Department of Health Care Services Update, DMHC's Response to COVID-19, 2020–21 Budget, Provider Solvency Quarterly Update, and a Health Plan Quarterly Update.

Of note, DMHC Acting Director Mary Watanabe provided an update to the Board with respect to the Department's response to COVID-19. Specifically, she reported that DMHC has launched a COVID-19 resource website where the public can find important information about the virus, including DMHC's various All-Plan Letters (APLs), directing health plans to provide certain essential services to patients in light of the pandemic, and a fact sheet advising individuals as to how to obtain health care coverage if they lost their employer-sponsored health care as a result of the economic crisis. The Department has been consistently issuing APLs since the beginning of the pandemic, include DMHC's direction that plans reduce cost-sharing to zero for all emergency COVID-related testing and screening, and telehealth instructions to allow providers to provide the same level of care with the same reimbursement to patients despite closure of in-person office visits. Additionally, an APL was issued with Covered California to extend coverage for people who lost their healthcare coverage. DMHC asked health plans to notify DMHC on how they are

reaching their vulnerable, high-risk populations (people with chronic illness, elder, disabled). [*25:2 CRLR 17–20*] Additional and updated APLs can be found on the DMHC website.

Ms. Watanabe also updated the Board on the Department's Emergency Regulations, effective July 17, 2020, to ensure appropriate coverage and payment for diagnostic testing for COVID-19. These regulations provide that, in working with plans and providers, cost-sharing for COVID relief is split into three categories. Under Category One (positive symptoms, or COVID exposure), no cost-sharing is allowed per federal statutes. Categories Two and Three (no symptoms, COVID exposure) allow cost-sharing per existing Knox-Keene Act provisions. Plans may not pass financial risk of COVID-19 testing to providers unless the providers and plan negotiated and agreed that the provider will assume risk. Additionally, plans may not delay payment based on a claim the plan delegated financial risk to the provider or demand "proof" that an enrollee is an essential worker. Under the Families First Coronavirus Response Act (FFRCA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES), Category One enrollees (symptomatic or exposed) have a negotiated rate or follow the provider's cash price if no negotiated rate. Categories Two and Three require a negotiated rate if in-network, or no negotiated rate if out-of-network. The Emergency Regulations will remain in effect through May 14, 2021.

FSSB also received a budget update from the Department. DMHC's Fiscal Year (FY) 2019–20 budget consisted of $91,093,000 in spending authority and 482 authorized positions. DMHC's FY 2020–21 budget is $96,034,000 in spending authority and 505 authorized positions.

The next FSSB meeting is scheduled via videoconference on Wednesday, November 18, 2020.

Ninth Circuit Court of Appeals Finds Standing in Skyline Wesleyan Church's Claims Against Department of Managed Health Care, Remands Case to District Court

On May 13, 2020, as amended on rehearing on July 21, 2020, the U.S. Court of Appeals for the Ninth Circuit issued its opinion in ***Skyline Wesleyan Church v. California Department of Managed Health Care*, 968 F.3d 738 (9th Cir. 2020)**, reversing the U.S. District Court for the Southern District of California's ruling that it lacked jurisdiction over Skyline Wesleyan Church's ("Skyline") federal free exercise of religion claim against the DMHC. The Ninth Circuit also vacated the district court's ruling that it lacked jurisdiction over Skyline's other claims and remanded the case to the district court for further proceedings.

On March 9, 2018, in *Skyline Wesleyan Church v. California Department of Managed Healthcare*, No. 3:16-cv-0501-CAB (DHB), (S.D. Cal. Mar. 9, 2018), the district court dismissed Skyline's complaint against DMHC as (1) not ripe for adjudication because DMHC had not received a request for exemption from Skyline and (2) not redressable because any remedy the court could provide would only be against DMHC. Noting that DMHC is not a health plan and is "simply a regulatory body that does not have the authority to mandate that a provider give [Skyline] the plan it seeks," the district court found that Skyline lacked standing to pursue its claims. On April 9, 2018, Skyline appealed the District Court's dismissal of its complaint. *[see 23:2 CRLR 38–40; 24:1 CRLR 47–48]*

The source of the litigation was DMHC's August 22, 2014, letter to seven group health insurers who had limited or excluded coverage for abortions in their health plans. In its letter, DMHC stated that its prior practice of allowing insurers to offer health plans with some abortion-

related restrictions was inconsistent with the Knox-Keene Health Care Service Plan Act of 1975, and the California Constitution. DMHC concluded that "all health plans must treat maternity services and legal abortion neutrally." DMHC later told health plans that it would allow for certain exemptions from the requirements it had explained in its 2014 letter. The DMHC's letter had caused Skyline's insurer to amend Skyline's plan so that it covered abortion, which did not comport with Skyline's religious beliefs. Skyline, a Christian church that does not support abortion except in specific circumstances, did not request an exemption from DMHC for its health plan and filed suit against DMHC in February 2016, alleging that its right to free exercise of religion required the Department to approve a health insurance plan that accommodated Skyline's religious beliefs regarding abortion.

The Ninth Circuit's opinion explained that Skyline had successfully established all three elements of standing regarding its federal free exercise claim and thus the claim was justiciable, but the Court declined to reach the merits of the claim. The Ninth Circuit stated that its findings regarding the justiciability of Skyline's federal free exercise claim could apply to Skyline's other claims, but that it would not address this issue, as only the merits of the federal free exercise claim had been briefed on appeal. It remanded the case to the district court to determine, after deciding whether Skyline's other claims were justiciable, when it would be appropriate to address the merits of Skyline's claims. At this writing, the district court has not yet addressed the issues on remand.

Office of Administrative Law Approves DMHC's Regulation Regarding COVID-19 Diagnostic Testing

On July 15, 2020, DMHC published a notice of emergency rulemaking with respect to its intent to adopt section 1300.67.01, Title 28 of the CCR, pertaining to COVID-19 Diagnostic

Testing. DMHC's finding of emergency contains a rare "non-delay statement," citing the Director of the Department's determination that a typical five-day notice period for public comment was not feasible because "the emergency situation addressed by this proposed emergency regulation clearly poses such an immediate and serious harm that delaying action to allow public comment would be inconsistent with the public interest." DMHC also petitioned the Office of Administrative Law (OAL) to similarly waive its typical five-day notice period and expedite the effective date of the proposed regulation. According to DMHC, "Time is of the essence in this instance because the State of California is in the midst of a global pandemic due to the SARS-CoV-2 virus, which causes COVID-19." Citing the recent surge in COVID-19 cases in California, the Department went on to state:

> Testing for COVID-19 is essential to identifying people with COVID-19 and stopping the spread of the virus. The proposed emergency regulation will clarify when California health plans must cover testing, how quickly they must provide testing to their enrollees, and how health plans must reimburse providers for performing COVID-19 testing. Prompt reimbursement of providers will allow them to continue to provide testing to their patients. Any delay in the promulgation of this regulation will increase confusion as to when and how enrollees can obtain a test and intensify the spread of COVID-19 in California, resulting in more cases, more hospitalizations, and ultimately, more deaths from the virus.

The newly adopted text classifies COVID-19 diagnostic testing as "a medically necessary basic health care service" for all essential workers and prevents delays in testing and claims payments specifically related to essential workers. For enrollees who are not essential workers, the new regulation permits a health plan to impose ordinary utilization management procedures allowed by the Knox-Keene Act when determining whether a COVID-19 test is medically necessary for an enrollee, unless otherwise specified by state or federal law.

According to DMHC's finding of emergency, the regulation is necessary to increase diagnostic testing to slow the spread of COVID-19 and to provide health plans, consumers,

providers, and other stakeholders with "clear direction on requirements for coverage of COVID-19 diagnostic testing and claims reimbursement."

On July 17, 2020, OAL approved the proposed emergency regulation, effective that day, and issued an amended order on August 27.

On July 23, 2020, Sarah Ream, Acting General Counsel for DMHC, issued an All Plan Letter to all full-service commercial health care service plans, detailing the emergency regulation. On September 18, 2020, Ms. Ream issued another All Plan Letter addressing common questions from stakeholders regarding the implementation of the emergency regulation. The emergency regulation is set to expire on May 15, 2021.

Governor Newsom Signs SB 855 Into Law, Requiring Health Plans Cover Medically Necessary Treatment of Mental Health and Substance Use Disorders

SB 855 (Wiener), as amended August 24, 2020, and as it applies to the DMHC, adds sections 1367.045 and 1374.721, and repeals and adds section 1374.72, to the Health and Safety Code to repeal California's Mental Health Parity Act, and replace it with a broader requirement for health plans to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. This bill also establishes new requirements for medically necessary care determinations and utilization review and bans discretionary clauses in health plan contracts. According to the bill's author, Senator Scott Wiener, by updating the Mental Health Parity Act, California can save lives by treating mental health and substance use disorders early on, which can subsequently combat death and suicide. Wiener emphasized that COVID-19 has exacerbated the already-existing need for behavioral health treatments.

Specifically, section 1367.045 removes discretionary clauses in health plan contracts, and states that if a health care service plan contract that is offered, issued, delivered, amended, or renewed on or after January 1, 2021, contains a provision that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

Section 13474.72 was repealed, and in its new form, adds a requirement to the Health and Safety Code that every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage, must provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions.

SB 855 also adds section 1374.721 to the Health and Safety Code, which states that a health care service plan that provides hospital, medical, or surgical coverage must base any medical necessity determination or utilization review criteria that the plan applies to determine the medical necessity of health care services and benefits for the prevention and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. It also authorizes DMHC's Director to assess administrative penalties on health plans that do not comply with this requirement.

According to the Assembly Health Committee's Analysis, DMHC requested multiple amendments to SB 855, including removing the prohibition on discretionary clauses and changing the definition of "medically necessary treatment of mental health substance use disorder," but the amendments were not adopted.

Governor Newsom signed SB 855 on September 25, 2020 (Chapter 151, Statutes of 2020).

MAJOR PUBLICATIONS

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

- ***DMHC 2019 Annual Report***, Department of Managed Health Care, 2020 (Annual Report summarizing 2019 DMHC accomplishments, plan licensing, plan monitoring, financial oversight, rate review, and enforcement. Reports $256 million saved on health plan premiums, 2.4 million consumers assisted, $80 million assessed against health plans that violated the law, and $34 million recovered from health plans on behalf of consumers. Discloses that 60% of consumer appeals through DMHC's Independent Medical Review process resulted in the consumer receiving the requested service or treatment from their health plan.)

ALL PLAN LETTERS

COVID-19 All Plan Letters

- ***APL 20-018***, COVID-19 Modification of Timely Access PAAS Timeframes–April 29, 2020 (Issued to all full service and behavior health plans required to submit annual timely access compliance reports, informing them that measurement year provider appointment availability surveys are not to be administered earlier than August 1, 2020, in light of COVID-19.)
- ***APL 20-023***, Extension of Special Enrollment Period in APL 20-010–June 23, 2020 (Issued to all commercial full-service health plans offering individual market products, extending the special enrollment period for individual market products through July 31, 2020 due to COVID-19) (Deadline extended to August 31, 2020 per *APL 20-029*.)
- ***APL 20-028***, Emergency Regulation Regarding COVID-19 Diagnostic Testing–July 23, 2020 (Issued to all commercial full-service health plans offering individual market

products and detailing DMHC's emergency regulation regarding health plan coverage of COVID-19 testing; APL 20-33, issued on September 18, 2020, provides FAQs regarding implementation of the emergency regulations (*see* HIGHLIGHTS).)

- ***APL 20-032***, Continuation of DMHC's All Plan Letters Regarding Telehealth–September 4, 2020 (Issued to all Health Care Service Plans, extends duration of APL 20-009 and APL 20-013 regarding the provision and coding of telehealth services throughout California's declared state of emergency, or until further notice from the Department, whichever is earlier; permits Health Plans to list a provider's practice address as of March 3, 2020 (the day before the Governor declared a state of emergency in California) in provider directories even though many providers are providing services from their homes during the pandemic, and prohibits plans from listing providers' home address unless the provider expressly authorizes the plan to do so; clarifies that the provisions of all telehealth APLs are applicable to all plans' delegated entities.)

- ***APL 20-034***, Updated COVID-19 Screening & Testing–September 23, 2020 (Issued to all Full-Service Commercial and Medi-Cal Health Care Service Plans, supersedes and replaces APL 20-006, issued on March 5, 2020; advises that the Department's emergency regulations, effective July 17, supersede APL 20-006's provisions regarding waiver of cost-sharing amounts for COVID-19 testing (see HIGHLIGHTS), but the remainder of the APL remains in effect regarding ensuring timely access to care and taking proactive measures to screen and test enrollees for COVID-19.)

Other All Plan Letters Regarding Emergency

- ***APL 20-021***, Governor's State of Emergency in Los Angeles County–June 1, 2020 (Issued to all health care service plans, requiring counties included in the Governor's proclamation

to file a notice with the DMHC describing whether the plan expects to experience any disruption to plan operations, how the plan is communicating with potentially-impacted enrollees, and actions taken to ensure needs of enrollees are met.)

- ***APL 20-030***, State of Emergency Due to Extreme Weather & Wildfires–August 19, 2020 (Issued to All Health Care Service Plans, advises that the Governor issued an emergency proclamation for California on August 18 pertaining to extreme heat and several wildfires; reminds plans of their obligations pursuant to section 1368.7 of the Health & Safety Code to provide displaced enrollees with continued access to medically necessary health care services, and that each plan operating in the counties included in the proclamation must file a notice with DMHC within 48 hours describing any actual or potential disruption to plan operations, explaining its communication plans with affected enrollees, and summarizing actions to ensure continued coverage.)

Licensure and Guidance All Plan Letters

- ***APL 20-017***, General Licensure Regulation–April 16, 2020 (Issued to all health care service plans and risk bearing organizations, informing plans and organizations that the DMHC was extending the "phase-in" period during which entities could seek an exemption from the licensure requirements through an expedited exemption request process.)

- ***APL 20-019***, Association Health Plans Extension of Phase-Out Period–May 5, 2020 (Issued to all full-service health care service plans, extending the end of the "phase-out" period of large group plans in place for small employers and individuals pursuant to APL 19-024 through October 31, 2020; APL 20-31, issued on August 21, 2020, further extended the phase out period through February 28, 2021.)

- ***APL 20-022***, Compliance with California Nondiscrimination Requirements –June 15, 2020 (Issued to all California licensed health plans, reminding them of consumers' health care rights, such as the right to be protected from discrimination based on categories such as gender identity and sexual orientation, and that plans must continue to comply with California's requirements to provide notice of availability of free language assistance.)

- ***APL 20-024***, AB 315 Reporting Requirements–June 26, 2020 (Issued to health care service plans in Riverside and Sonoma counties, providing new guidance regarding the annual filing of AB 315 (Wood) (Chapter 905, Statutes of 2018) pilot project prescription drug reporting information. *[see 24:1 CRLR 38–40]*)

- ***APL 20-025***, Medicare Supplement Guidance–July 1, 2020 (Issued to all health care service plans offering Medicare supplement plans, providing guidance and information to enrollees on new or innovative benefits that are available to consumers.)

- ***APL 20-026***, Preventive Coverage for HIV Preexposure Prophylaxis–July 8, 2020 (Issued to all health care service plans, providing guidance and filing instructions to health care service plans regarding preventive health service coverage for HIV preexposure prophylaxis.)

- ***APL 20-027***, Guidance Regarding Assembly Bill (AB) 731–July 8, 2020 (Issued to full service health care service plans, providing information on AB 731 (Kalra) (Chapter 807, Statutes of 2019) and guidance on large group rate filing and individual and small group geographic rating region trends requirements.)

- ***APL 20-020***, Network Adequacy and Unnecessary Burdens on Providers–May 20, 2020 (Issued to all health care service plans with commercial lines of business, requiring the plans

to submit an informational filing to the DMHC explaining how it has/will ensure continued network adequacy.)

- ***APL 20-035***, Medi-Cal Pharmacy Benefit Carve Out (APL 20-035)–October 6, 2020 (Issued to all Medi-Cal Health Care Service Plans, provides guidance and filing instructions regarding the transition of pharmacy services from managed care to fee for service pursuant to Governor Gavin Newsom's Executive Order N-01-19.)
- ***APL 20-036***, Large Group Renewal Notice Requirements–October 9, 2020 (Issued to all Full Service Health Plans, provides confirmation of the timing and content requirements of disclosures pursuant to section 1374.21 of the Health and Safety Code relating to large group renewal notices; reminds plans that no change in premium rates or changes in coverage stated in a large group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 120 days prior to the contract renewal effective date.)
- ***APL 20-037***, Vaccinations: Coverage and Flexibility–October 14, 2020 (Issued to all Full Service Health Care Service Plans, sets forth existing requirements for covering and reimbursing providers for vaccinations, and encourages all health plans and delegated entities to exercise maximum flexibility in covering and reimbursing for vaccines for enrollees due to the potential effects of the upcoming flu season.)

RULEMAKING

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

- **COVID-19 Diagnostic Testing Emergency Regulation**: On July 15, 2020, DMHC published a notice of emergency rulemaking action in light of COVID-19, expressing its intent to adopt section 1300.67.01, Title 28 of the CCR, pertaining to COVID-19 Diagnostic Testing. The emergency rulemaking action clarified when California health plans must cover COVID-19 testing, how quickly they must provide testing to their enrollees, and how health plans must reimburse providers for performing such testing. The emergency regulation is set to expire on May 15, 2021 (see HIGHLIGHTS).

- **Timely Access to Non-Emergency Health Care Services**: On June 12, 2020, DMHC published notice of its intent to amend section 1300.67.2.2 and to adopt section 1300.67.2.3, Title 28 of the CCR to ensure timely access to necessary health care by standardizing and codifying reporting methodologies that health plans use for the timely access report and the annual network report. According to the Initial Statement of Reasons, the proposed regulations are meant to clarify the timely access to care and annual network reporting requirements for health plans, and codifies a process set forth in 2019 for health plans to gather and interpret provider network data that plans would then report to DMHC. No public hearing was scheduled for the proposed regulations, but a written comment period was open from June 12, 2020 until July 27, 2020. At this writing, the Department has not taken further action on this proposed regulation.

- **Conflict of Interest Regulation**: On June 26, 2020, DMHC published notice of its intent to amend Article 1, section 1000 of its Conflict-of-Interest Code pursuant to its obligations under the Political Reform Act, Government Code Section 81000, et seq. (see HIGHLIGHTS).

LEGISLATION

- **AB 2118 (Kalra)**, as amended August 25, 2020, as it relates to DMHC, adds section 1385.043 to the Health and Safety Code to require a health care service plan and health insurer to annually report to DMHC on all grandfathered and non-grandfathered products that the plan offers and sells in the individual and small group markets. Section 1385.043 also requires that plans report to DMHC on rates such as premiums, cost sharing, and benefits effective during the 12-month period ending January 1 of the following year. According to the author, this bill provides more transparency on California's health insurance marketplace, at a time when health care costs and the need to contain them are a main concern for policymakers. Governor Newsom signed AB 2118 into law on September 29, 2020 (Chapter 277, Statutes of 2020).

- **AB 2157 (Wood)**, as introduced on February 10, 2020, and as it applies to DMHC, amends Section 1371.30 of the Health and Safety Code to require the procedures established by the Department's independent dispute resolution process (IDRP) organization to include a process for each party to submit evidence that will be kept from the other party so that the confidentiality of the source contract is preserved, conduct a *de novo* review of the claim dispute, and assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience. According to the author, this bill addresses some of the concerns raised by providers regarding the IDRP. Governor Newsom signed AB 2157 into law on September 29, 2020 (Chapter 278, Statutes of 2020).

- **AB 2450 (Grayson)**, as amended June 10, 2020, amends section 76000.10 of the Government Code to extend the length of time a county is required to collect and transfer fines imposed for convictions of a violation of the Vehicle Code, and allocate the funds collected to the

Emergency Medical Air Transportation and Children's Coverage Fund, administered by the State Department of Health Care Services and then distributed for certain purposes. According to the author, an extension of the Emergency Medical Air Transportation Act will ensure that air ambulance providers can continue to provide lifesaving services to residents throughout California, especially in light of COVID-19. Governor Newsom signed AB 2450 into law on September 9, 2020 (Chapter 52, Statutes of 2020).

- **SB 855 (Wiener)**, as amended on August 24, 2020, and as it applies to DMHC, adds sections 1367.045 and 1374.721 to, and repeals and adds section 1374.72 of, the Health and Safety Code to repeal California's Mental Health Parity Act, and replace it with a broader requirement for health plans to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. Governor Newsom signed SB 855 into law on September 25, 2020 (Chapter 151, Statutes of 2020) (see HIGHLIGHTS).

- **AB 2360 (Maienschein)**, as amended on August 5, 2020, and as it applies to DMHC, would have added section 1367.626 to the Health and Safety Code to require health care service plans and health insurers, by July 1, 2021, to provide access to a telehealth consultation program. This program would have had to meet specific criteria and would have provided providers who treat children, pregnant individuals, and certain postpartum individuals with access to a mental health consultation program.

On September 25, 2020, Governor Newsom vetoed AB 2360, stating that "[w]hile I appreciate the author's intent to expand mental health services for children and pregnant and

postpartum persons, the bill would create costs that would be more appropriately addressed through the annual budget process."

- **AB 1124 (Maienschein)**, as amended on August 25, 2020, repeals and adds section 1343.3 to the Health and Safety Code to, beginning on May 1, 2021, authorize two pilot programs that allow health care providers approved by the Department to undertake risk-bearing arrangements with a voluntary employees' beneficiary association under certain conditions. According to the author, this bill will allow self-funded plan networks to utilize value-based payment mechanisms and reduce health care costs. Governor Newsom signed AB 1124 on September 29, 2020 (Chapter 266, Statutes of 2020).

- **SB 406 (Pan)**, as amended August 24, 2020, and as it applies to DMHC, repeals and adds Sections 1367.001 and 1367.002 of the Health and Safety Code to codify existing federal Patient Protection and Affordable Care law into state law that prohibits lifetime or annual limits in health plans and requires coverage for specified preventive services without any cost-sharing requirements. Governor Newsom signed SB 406 on September 29, 2020 (Chapter 302, Statutes of 2020).

The following bills reported in Volume 25, No. 2 (Spring 2020) died in committee or otherwise failed to be enacted during 2020: AB 2640 (Gonzalez), relating to prior authorization for genetic biomarker testing for an enrollee with metastatic or advanced stage 3 or 4 cancer; AB 2781 (Wicks), relating to coverage for the treatment of infertility; AB 2892 (Rivas), relating to DMHC's Consumer Participation Program; SB 175 (Pan), relating to health plan lifetime or annual limits; SB 854 (Beall) relating to prescription drug benefits for the treatment of substance abuse; SB 977 (Monning), relating to additional Attorney General oversight authority with respect to

health care system consolidation; SB 1033 (Pan), relating to DMHC's authority to review a health plan's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law; SB 1452 (Morrell), regarding coverage for any biological product or biosimilar; AB 1904 (Boerner Horvath), relating to coverage for pelvic floor physical therapy after pregnancy; AB 1973 (Kamlager), relating to cost-sharing requirements on coverage for all abortion services; AB 1986 (Gipson), relating to coverage for colorectal cancer screenings and laboratory tests; AB 2144 (Arambula), relating to step therapy requirements if more than one drug that is appropriate for the treatment of a medical condition exists; AB 2204 (Arambula), relating to coverage for sexually transmitted disease testing and treatment; AB 2239 (Maienschein and Chiu), relating to the Medically Underserved Account for Physicians; AB 2242 (Levine), relating to mental health services; and AB 2625 (Boerner Horvath), relating to coverage for emergency ground medical transportation services.

LITIGATION

- ***In re Aetna Health of California*, Matter No. 19-268 (DMHC)**. On August 25, 2020, DMHC issued a cease and desist order to Aetna Health of California, Inc. with respect to its continued failure to comply with California standards for emergency room coverage and fined the health care provider $500,000 (see HIGHLIGHTS).

- ***Ben-E-Lect v. Anthem Blue Cross Life and Health Insurance Company, et al.*, 51 Cal. App. 5th 867 (2020) (Case No. SCV-256990)**. On July 22, 2020, the First District Court of Appeals affirmed the Superior Court of Sonoma County's judgment in favor of third-party insurance claim administrator Ben-E-Lect against insurers Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California ("Anthem") for violations of the Cartwright Act,

Unfair Competition Law, intentional interference with Ben-E-Lect's prospective economic relations, and negligent interference with business relations. Ben-E-Lect developed a medical expense reimbursement plan, allowing employers to buy a group policy of medical insurance with a high deductible and a self-fund to pay for employee health care costs below that deductible, also known as "wrapping." Ben-E-Lect sued Anthem in 2015, challenging its policy prohibiting wrapping with all of its health plans as anticompetitive. The court of appeal upheld the trial court's finding that Anthem and Ben-E-Lect were competitors (Ben-E-Lect clients were able to subscribe to less expensive Anthem plans because of Ben-E-Lect's wrapping services), and that the Anthem policy facilitated a vertical group boycott with Anthem brokers and agents, in essence that they "conspired" with their own agents. Accordingly, it affirmed the trial court's judgment and damages award of $2.46 million, trebled under the Cartwright Act for a total of $7.38 million. The appellate court also affirmed the trial court's judgment enjoining Anthem from implementing its prohibition against wrapping health insurance products offered to the California small group market.

- ***Skyline Wesleyan Church v. California Department of Managed Health Care,* 959 F.3d 341, 344 (2020)**. On May 13, 2020, the U.S. Court of Appeals for the Ninth Circuit issued its opinion remanding the case back to the U.S. District Court for the Southern District of California, finding that Skyline had successfully established standing and that its federal free exercise claim against DMHC was justiciable (see HIGHLIGHTS).

- ***Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, et al.,* 591 U.S. __ , 140 S. Ct. 918 (2020).** On July 8, 2020, the United States Supreme Court issued its opinion in the *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania*, holding that the federal Departments of Health and Human Services, Labor, and Treasury had the authority

under the Affordable Care Act to promulgate religious and moral exemptions to providing health care coverage for preventive health care for women, such as contraception. It also held that the Departments had done so as required by the Administrative Procedure Act. The Court reversed and remanded the case back to the Third Circuit Court of Appeals.