CAHP IMPLEMENTATION GUIDELINE

SB 368 (Limon)
Chapter 602, Statutes of 2021

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

HEALTH COVERAGE: DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

BACKGROUND

Senate Bill 368 was authored by Senator Monique Limon (D-Santa Barbara) and was sponsored by Health Access of California. The bill was also supported by labor unions and the Pharmaceutical Research and Manufacturers of America (PhRMA). The stated purpose of the bill was to require health plans to inform consumers about how close they are to meeting their deductibles or out-of-pocket limits. According to the author and supporters, this would help people understand what they have spent on their health care by shifting the burden of tracking annual accruals to health plans.

CAHP and its partner trades took an early Oppose Unless Amended position. Our member plans had concerns that SB 368 could be unworkable because it does not take into account the delegation of medical management to contracted providers that could delay real time accumulation of information. Our members also argued that any state law should allow enrollees to opt-out of any unnecessary paper mail notifications, as health plans can make this information available electronically. Finally, new federal rules will require health plans to provide accumulation balances upon request, but those provisions do not become effective until plan years beginning on or after January 1, 2024. As a result, we also requested that the effective date be delayed to match the federal regulations.

Several amendments were added to the bill to allow CAHP to remove its opposition including the ability of enrollees to opt out of traditional paper mail. A delayed effective date was also added to the bill, albeit that is tighter than the federal rules.

SB 368 received some bipartisan support in the Legislature but in general majority Democrats voted unanimously for the bill with Republicans generally opposed, although not uniformly.

REQUIREMENTS

This bill requires health plans to monitor an enrollee's or insured's accrual toward their annual deductible and out-of-pocket (OOP) maximum and provide this information to the enrollee. Specifically this bill:

1. Requires a health plan contract issued, amended, or renewed on or after July 1, 2022, to monitor an enrollee's accrual toward their annual deductible, if any, and their annual out-of-pocket maximum, if any, for covered benefits.

2. Requires a health plan to provide an enrollee or insured with their accrual balance toward their annual deductible and annual out-of-pocket maximum during any month in which benefits were used and until the accrual balance equals the full deductible amount.

3. Requires a plan to establish and maintain a system that allows an enrollee/insured to request their most up-to-date accrual balance toward their annual deductible and their annual out-of-pocket maximum from their health plan at any time.

4. States that if the plan contract includes more than one annual deductible, then this bill applies to each deductible.

5. Requires the accrual update to be mailed unless the enrollee opts out and elects an electronic update or unless the enrollee has previously opted out of mailed notices. Permits accrual to be included in the evidence of benefits statement.

6. Requires a plan to notify enrollees of their rights pursuant to this bill, including, but not limited to, how to request information and how to opt out of mailed notices and elect to instead receive their accrual update electronically, in the manner set forth by DMHC.

7. Permits DMHC to issue guidance regarding implementation of, and compliance with, this bill, not subject to the Administrative Procedure Act, until January 1, 2027. Requires DMHC to consult with stakeholders in developing guidance.

8. Requires if a plan delegates claims payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, then the delegated entity to comply with the bill, specify by contract the delegated entity's responsibilities and monitor the delegated entity to ensure compliance. Requires health plan to remain responsible for compliance with this bill.

COMPLIANCE DATES

Applies to a health care service plan contract issued, amended, or renewed on or after July 1, 2022

IMPLEMENTATION ISSUES

Applicability:
This bill applies to all health care service plans and health insurers offering individual and large group products and policies.

Implementation Issues:
H.S.C. section 1367.0061 requires health plans to monitor an enrollee's accrual toward their annual deductible and to allow the enrollee to request their most up-to-date accrual balance at any time. Plans may need to make system updates in order to track and accurately record accrual balances for each enrollee. Plans will need to ensure administrative processes are in place to notify enrollees of

their rights and to accommodate enrollee requests for balance information, whether electronically or by mail.

Even if a plan delegates claims payment functions to a contracted entity, the plan remains responsible for compliance with this section. If applicable, plans should review delegated contracts and put processes in place to monitor delegated entity activity.

Accrual updates may also be included with evidence of benefit statements. Plans may need to review and update member handbooks/Evidence of Coverage (EOC) accordingly.

The requirements of this bill are similar to the federal transparency regulation issued in November 2020, which require plans to provide accumulated amounts at the request of a participant beginning January 1, 2024. Accumulated amounts are defined as the amount of financial responsibility an individual has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit. While the federal transparency regulation applies broadly to state and federally regulated health insurance (not Medicaid, not grandfathered plans), this bill applies only to state regulated health insurance, including grandfathered plans. Some differences between the federal rule and this bill include:

- This bill requires notification in any month benefits were used.
- The federal regulation requires notification upon request.
- The federal regulation also has requirements around the method of notification whereas this bill is silent. H.S.C. section 1367.0061(d) grants the DMHC authority to issue further guidance regarding the manner of notification. Plans may need to be prepared to review and implement such guidance.

If you have any questions regarding this document, please contact Nick Louizos at nlouizos@calhealthplans.org