Broker – New California Regulations FAQ

Effective 1/1/2017- AB 1305, AB 339, SB 999 and AB 1954

California Indiv, SG, LG and NAT - *UPDATED as of January 1, 2017*

AB 1305 – Limitations on Cost Sharing: Family Coverage (embedding deductibles and out-of-pocket limits)

Who is impacted?

- Individual ACA, Small Group, Large Group & National Fully Insured
- CalChoice (SG Only)
- Minimum Premium (LG Only)
- PEX (LG Only)
- Non-Grandfathered

Who is excluded?

- ASO, JAA, MCS, ACS (LG Only)
- Anthem Balance Funding
- All Grandfathered

What is changing?

- Plan Benefits have been updated to comply where needed
- No additional action was required

Who will be notified and when?

- Brokers will receive an e-blast in January 2017
- Impacted Employers have been and will be notified as part of their 2017 renewals
- Impacted Enrolled Members will be notified through Open Enrollment activities
- Electronic Evidence of Coverage Booklets will be made available upon renewal during 2017

Summary:

Assembly Bill (AB) 1305 amended both the Health and Safety Code (Department of Managed Healthcare, or DMHC, regulated business) and the Insurance Code (California Department of Insurance, or CDI, regulated business). The bill requires, for family coverage, that an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

Pursuant to this bill, if a health care service plan contract or health insurance policy for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

AB 1305 includes a different requirement for high deductible health plans and policies. A plan contract or policy for family coverage that includes a deductible and is a high deductible health plan, as defined in federal law, must include a deductible for each individual covered by the plan contract or policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract or policy, whichever is greater.

Pursuant to the bill and a regulatory exemption, the above requirements apply to plans/policies issued, amended or renewed on or after January 1, 2017.

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AB 1305 also specifies new index requirements for deductibles under a small group employer health care service plan contract or small employer health insurance policy. These requirements were effective for plans/policies issued, amended or renewed on or after January 1, 2016.

Q: What is changing?
A: AB 1305 requires that an individual within a family shall not have a Maximum Out-of-Pocket limit that is greater than the Maximum Out-of-Pocket limit for individual coverage for that product. It also requires the same for the Deductible.

Q: Which plans were updated?

Individual: Individual ACA plans are already compliant.

Small Group: The following plans were updated.

- **EmployeeElect** plans : Anthem Silver Select PPO 2000/20%/5400 w/HSA – RxC ***AND*** Anthem Silver PPO 2000/20%/5400 w/HSA – RxC
- **CalChoice** plan: Anthem Silver EPO 2000/20%/5750 w/HSA

Large Group: Standard PPO Plans were already compliant. CDHP Plans were either updated or discontinued (with forced migration to a compliant plan) for new sales and renewals starting 1/1/2017. And all custom plans in scope were reviewed and updated for renewals starting 1/1/2017.

National: All custom plans in scope were reviewed and updated for renewals starting 1/1/17.

Q: What about CA Fully Insured and Minimum Premium Payment plan enrolled members living out-of-state? Do their plans have to comply with AB 1305?
A: Yes, even members living out-of-state. As long as their group policy is issued here in California, the Fully Insured and Minimum Premium plan must comply.

Q: Does the Federal Maximum Out-of-Pocket requirement still apply?
A: Yes, the individual Maximum Out-Of-Pocket (MOOP) for 2017 must be less than or equal to $7,150 for self-only coverage and $14,300 for other than self-only coverage. Additionally, all HSA plans must comply with the IRS MOOP for 2017 of $6,550.

Q: The law states something about applying to plans starting 1/1/2015. What did that mean?
A: AB 1305 updated existing sections of the California Health and Safety and Insurance codes. However, the effective dates provided for the Maximum Out-Of-Pocket (MOOP) and deductible changes are provided above.

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California Indiv, SG, LG and NAT - *UPDATED as of January 1, 2017*

AB 339 – Health Care Coverage: Outpatient Prescription Drugs (maximum copayment, standard tier definitions, and other requirements related to prescription drugs)

Who is impacted?

- Individual, Small Group, Large Group & National Fully Insured
- CalChoice (SG Only)
- Minimum Premium (LG Only)
- PEX (LG Only)
- Non-Grandfathered

Who is excluded?

- ASO, JAA, MCS, ACS (LG Only)
- Anthem Balance Funding
- All Grandfathered

What is changing?

- Plan Benefits have been updated to comply where needed
- No additional action was required

Who will be notified and when?

- Brokers will receive an e-blast in January 2017
- Impacted Employers have been and will be notified as part of their 2017 renewals
- Impacted Enrolled Members will be notified through Open Enrollment activities
- Electronic Evidence of Coverage Booklets will be made available upon renewal during 2017

Summary:

Effective **January 1, 2017**, Assembly Bill (AB) 339 prohibits the formulary or formularies for outpatient prescription drugs maintained by a health care service plan or health insurer from discouraging the enrollment of individuals with health conditions and from reducing the generosity of the benefit for enrollees with a particular condition. The bill until January 1, 2020, would provide that the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription shall not exceed $250 for a supply of up to 30 days, and would prohibit, for a non-grandfathered individual or small group plan contract or policy, the annual deductible for outpatient drugs from exceeding a specified amount.

AB 339 makes these cost sharing limits applicable only to covered outpatient prescription drugs that constitute essential health benefits. The bill also requires a plan contract or policy to cover a single-tablet prescription drug regimen for combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV, as specified. The bill, until January 1, 2020, would require a non-grandfathered individual or small group plan contract or policy to use specified definitions for each tier of a drug formulary.

AB 339 requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to provide coverage for medically necessary prescription drugs, including non-formulary drugs determined to be medically necessary, and, for an insurer, would

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require copayments, coinsurance and other cost sharing for outpatient prescription drugs to be reasonable.

In addition, the bill authorizes an insurer to require step therapy, as defined, when more than one drugs is appropriate for the treatment of a medical condition. The bill, with regard to an insured changing a policy, would prohibit a new insurer from requiring the insured to repeat step therapy when that person is already being treated for a medical condition by a prescription drug, as specified.

On or after January 1, 2017, the bill, except as specified, would require a plan or insurer that provides essential health benefits to allow an enrollee or insured to access his or her prescription drug benefits at an in-network retail pharmacy, and would authorize a non-grandfathered individual or small group plan or insurer to charge an enrollee a different cost sharing for obtaining a covered drug at retail pharmacy, and would that cost-sharing amount to count towards the plan's or insurer's annual out-of-pocket limitation, as specified.

Q: What is changing?
A**: Individual:** Bronze and Silver OFF exchange non-standard plans will reflect cost share caps as required to comply with this regulation.

Small Group: Small Group plans were already in compliance with AB 339 so no benefit changes will be needed. There will, however, will be EOC language changes.

Large Group: These benefit changes were rolled out starting with 1/1/2017 renewals and new plans.

National: These benefit changes were reflected in the 2017 renewal CIP submission for each impacted plans.

Q: What about CA Fully Insured and Minimum Premium Payment plan enrolled members living out-of-state? Do their plans have to comply?
A: Yes, even members living out-of-state. As long as their group policy is issued here in California and filed with the DMHC or CDI, the Fully Insured and Minimum Premium plan must comply.

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SB 999 – Health Care Coverage: Contraceptives (12 month supply of FDA-approved, self-administered hormonal contraceptives)

Senate Bill (SB) 999 requires a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed for an enrollee or insured at one time by a provider, pharmacist, or at a location licensed or authorized to dispense drugs or supplies.

The bill specifically provides that a health care service plan contract or an insurance policy is not required to cover contraceptives provided by an out-of-network provider, pharmacy, or other location, except as authorized by state or federal law or by the plan or insurer's policies governing out-of-network coverage.

SB 999 prohibits a health care service plan or health insurer, in the absence of clinical contraindications, from imposing utilization controls limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply.

Who is impacted?

- Individual, Small Group, Large Group & NationalFully Insured
- CalChoice (SG Only)
- Minimum Premium (LG Only)
- PEX (LG Only)
- Grandfathered & Non-Grandfathered

Who is excluded?

- ASO, JAA, MCS, ACS (LG Only)
- Anthem Balance Funding

What is changing?

- Plan Benefits have been updated to comply where needed
- No additional action was required

Who will be notified and when?

- Brokers will receive an e-blast in January 2017
- Individual Enrollees will recieve a notification letter in January - February 2017
- Individual Grandfathered Subscribers will recieve an updated 2017 Endorsement with the January - February notification Letter
- Impacted Employers will receive a notification letter in January - February 2017
- Employers will be provided with a notification to share with impacted members
- Electronic Evidence of Coverage Booklets will be made available upon renewal during 2017

<u>Q: What are self-administered hormonal contraceptives?</u>

A: The definition of Self-Administered Hormonal Contraceptives is hormonal contraception products with the following methods of administration listed below. Please refer to the impacted plan's formulary for more details.

(A) Oral;
(B) Transdermal;
(C) Vaginal;
(D) Depot Injection

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Q: What is changing?

A: **Individual:** Anthem will be making benefit changes to allow up to a 12 month supply for FDA-approved self-administered female hormonal contraceptives. Previously only 30 day or 90 day supplies were allowed.

Small Group: Anthem will be making benefit changes to allow up to a 12 month supply for FDA-approved self-administered female hormonal contraceptives. Previously only 30 day or 90 day supplies were allowed

Large Group: Anthem will be making benefit changes to allow up to a 12 month supply for FDA-approved self-administered female hormonal contraceptives. Previously only 30 day for retail or, 90 day for home delivery were allowed on standard plans. Custom plans may have allowed different day limits (i.e.100 day, etc.).

National: Anthem will be making benefit changes to allow up to a 12 month supply for FDA-approved self-administered female hormonal contraceptives. Previously only 30 day, 90 day or 100 day supplies were allowed.

Q: Are members required to obtain a 12 month supply of self-administered hormonal contraceptives if they only want a 30 or 90 day supply?

A: No. Members are allowed up to a 12 month supply but do ***NOT*** have to obtain a 12 month supply if not wanted or medically necessary.

Q: Wasn't there a recent bill requiring contraceptive coverage?

A: Yes, there was. SB 1053, effective 1/1/16, extended Female Contraceptive Coverage, voluntary sterilization procedures, and education/counseling/follow up services, to all members enrolled on CA DMHC and CDI Fully Insured and Minimum Premium, Non-Grandfathered AND Grandfathered medical plans. The coverage requirement in SB 1053 remains the same. The additional requirements under SB 999 means that Anthem must allow prescriptions for up to a 12 month supply for FDA-approved self-administered hormonal contraceptives.

Q: Will cost shares continue to be permitted for Grandfathered medical plans for SB 999?

A: Yes. Cost sharing for contraceptive coverage was permitted on CA DMHC and CDI Fully Insured and Minimum Premium Grandfathered plans per SB 1053 and that will remain in place. The copays and cost share amounts will remain the same but will be applied for up to a 12 month supply.

Example: Copay is $5 for birth control pills at a retail pharmacy for a 30 day supply. If the member wants a 12 month supply of birth control pills, the total copay the member will pay will be $60 ($5 copay X 12 months).

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Q: Can I continue to obtain my self-administered hormonal contraceptives via retail pharmacy or mail order for SB 999?
A: Yes. If you currently obtain your FDA-approved self-administered hormonal contraceptives via these methods, this will remain in place.

Q: What about CA Fully Insured and Minimum Premium Payment plan enrolled members living out-of-state? Do their plans have to comply under SB 999?
A: Yes, even members living out-of-state. As long as their group policy is issued here in California and filed with the DMHC and CDI, the Fully Insured and Minimum Premium plan must comply.

Q: What if my client wants to opt out due to religious reasons?
A: A religious employer can continue to request a policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets.

A religious employer is one who:

(A) The inculcation of religious values is the purpose of the entity.
(B) The entity primarily employs persons who share the religious tenets of the entity.
(C) The entity serves primarily persons who share the religious tenets of the entity.
(D) The entity is a nonprofit organization pursuant to Section 6033(a)(2)(A)(i) 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Any religious employer that requests exemption must provide written notice to any prospective employee once an offer of employment has been made, and prior to that person commencing that employment, listing the contraceptive health care services the employer refuses to cover for religious reasons.

Q: What if my client previously opted out of offering contraceptive coverage per PPACA Women Preventative Care mandate or SB 1053? Is it required for them to inform us they wish to opt out of SB 999?

A: No, if the employer has already provided a signed opt-out form for Patient Protection and Affordable Care Act (PPACA) or SB 1053, it is not necessary for the client to fill out another form.

The existing religious exemption process will be followed for SB 999. If a new client comes on board, the client can fill out the religious employer form to obtain the exemption. This form may be obtained from the Sales Representative or AME Account Representative.

Q: What if my client doesn't offer prescription coverage through ESI (i.e. carve out)?
A: If pharmacy benefits are carved out, the plan should be reviewed with your client to ensure those services are covered. Additionally, every effort should be made to confirm with the client that their pharmacy vendor allows up to a 12 month prescription for FDA-approved self-administered female hormonal contraceptives as required by SB 999 effective January 1, 2017.

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AB 1954 – Health Care Coverage: Reproductive Health Care Services (no referrals)

Assembly Bill (AB) 1954 prohibits every health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after **January 1, 2017**, with exceptions, from requiring an enrollee or insured to receive a referral in order to receive covered reproductive or sexual health care services, as provided.

The bill also permits a health plan or health insurer to establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services from health care providers participating in, or contracting with, the plan network, medical group, or independent practice association, provided that these provisions are consistent with the intent of this bill and those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the enrollee has direct access, and not more restrictive for the provision of reproductive and sexual health care services.

The bill also prohibits an enrollee or insured from being required to obtain prior approval from another physician, another provider, the health plan or health insurer prior to obtaining direct access to reproductive and sexual health care services and prohibits a health plan or health insurer from imposing utilization protocols related to contraceptive drugs, supplies, and devices, as specified.

Who is impacted?

- Individual, Small Group, Large Group & National Fully Insured
- CalChoice (SG Only)
- Minimum Premium (LG Only)
- PEX (LG Only)
- Grandfathered & Non-Grandfathered

Who is excluded?

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What is changing?

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- Employers will be provided with a notification to share with impacted members.
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<u>Q: What are the reproductive and sexual health services in scope for the bill?</u>
A: Services such as HIV testing, pregnancy prevention, STD (sexual transmitted disease) treatment and treatment after rape or sexual assault are in scope for AB 1954.

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Q: Does AB 1954 apply to minors?

A: Yes, this bill applies to adults and minors age 12-18 years of age.

Q: What is changing?

A: **Individual:** No benefit changes will be done as members should already have direct access to reproductive and sexual health services. However, EOC language changes will be made and grievances will be tracked to assure there are no access issues that need to be addressed.

Small Group: No benefit changes will be done as members should already have direct access to reproductive and sexual health services. However, EOC language changes will be made and grievances will be tracked to assure there are no access issues that need to be addressed.

Large Group: No benefit changes will be done as members should already have direct access to reproductive and sexual health services. However, EOC language changes will be made and grievances will be tracked to assure there are no access issues that need to be addressed.

National: No benefit changes will be done as members should already have direct access to reproductive and sexual health services. However, EOC language changes will be done and grievances will be tracked to assure there are no access issues that need to be addressed.

Q: What about CA Fully Insured and Minimum Premium Payment plan enrolled members living out-of-state? Do their plans have to comply with AB 1954?

A: Yes, even members living out-of-state. As long as their group policy is issued here in California and filed with the DMHC and CDI, the Fully Insured and Minimum Premium plan must comply.

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