From: DMHC Licensing eFiling
Subject: APL 20-001 (OPL) – Newly Enacted Statutes Impacting Health Plans
Date: Wednesday, January 15, 2020 2:28:00 PM
Attachments: APL 20-001 (OPL) – Newly Enacted Statutes Impacting Health Plans (1.15.20). pdf

Dear Health Plan Representative,

Please find the attached All Plan Letter regarding newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (Department or DMHC).

Thank you.

Gavin Newsom, Governor
State of California
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ALL PLAN LETTER

DATE: January 15, 2020

TO: All Health Care Service Plans

FROM: Phuc Nguyen
Acting Deputy Director
Office of Plan Licensing

SUBJECT: APL 20-001 (OPL) Newly Enacted Statutes Impacting Health Plans

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This All Plan Letter (APL) outlines newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).[1]

In this APL, the Office of Plan Licensing (OPL) identifies and discusses fourteen bills enacted this session that may require plans to update EOCs, disclosure forms, provider contracts and/or other plan documents.[2] Plans must review relevant plan documents to ensure those documents comply with newly enacted legislation. The DMHC expects plans to comply with all applicable statutes upon the statutes' effective dates.

This APL does not identify or address every newly enacted statutory requirement that may apply to plans. Plans should consult with their legal counsel to ensure compliance with all newly enacted statutes that may impact the plan. Discussion of each bill may be found in the APL on the pages identified below.

AB 577 – page 2	AB 1309 – page 6	SB 260 – page 10	SB 600 – page 14
AB 651 – page 3	AB 1802 – page 7	SB 343 – page 12	SB 784 – page 15
AB 744 – page 4	SB 129 – page 8	SB 407 – page 12	
AB 954 – page 5	SB 159 – page 8	SB 583 – page 13	

[1] Unless specifically indicated below, the newly enacted legislation does not apply to Medicare Advantage plans or EAP plans and therefore these plans are not required to make the Compliance with 2019 Legislation Amendment filing.
[2] Guidance regarding AB 731 (Kalra, Ch. 807, Stats. 2019) is being considered and may be forthcoming.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by March 6**, 2020**, one filing to demonstrate or affirm compliance with all of the newly enacted statutory requirements discussed in this APL.

- Submit the filing via eFiling as an **Amendment** titled "**Compliance with 2019 Legislation.**"

- In the Compliance with 2019 Legislation Amendment filing, please include an Exhibit E-1 (the "Compliance E-1") that addresses how the plan is complying with the newly enacted legislation discussed below.

- Going forward, plan documents (EOCs, provider contracts, notices, etc.) must be in compliance with newly enacted legislation and should be filed pursuant to the timelines and requirements of the Knox Keene Health Care Service Plan Act of 1975, as amended, (Health and Safety Code Section 1340, *et seq.*) (Act)[3] and other applicable laws. For example, plans on Covered California must file their 2021 plan year documents according to timeframes set forth by Covered California and the DMHC. Plans do not need to refile previously filed and approved documents, unless otherwise directed by the DMHC.

- If you have questions regarding the applicable timelines for filing or other questions about the requirements of this APL, please contact your plan's assigned reviewer in the OPL.

1. AB 577 (Eggman, Ch. 776, Stats. 2019)—Maternal Mental Health Continuity of Care

Codified in Health and Safety Code § 1373.96.

a. Overview of the bill:

- Applies to full-service commercial plans, Medi-Cal plans, and behavioral health plans except EAP plans.

- Adds "a maternal mental health condition" to the list of conditions for which a plan shall provide completion of covered services by a terminated or nonparticipating provider if the enrollee is undergoing a course of treatment

[3] References to California Code of Regulations sections will be designated as "Rule," e.g., Rule 1300.67.1, and references to California Health and Safety Code sections will be designated as "Section," e.g., Section 1367.016.

for one of the specified conditions at the time of the contract or policy termination or at the time the coverage became effective.

- Defines "a maternal mental health condition" as "a mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery."

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan has revised its template block transfer/enrollee transfer notices (ETNs) to add "a maternal mental health condition" to the list of conditions for which a plan shall provide completion of covered services by a terminated or nonparticipating provider, per § 1373.96, or affirm the plan's ETN shall explain to the affected enrollee that his or her eligibility is conditioned upon certain factors as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form, **AND**

- State either:

  - The plan reviewed current continuity of care policies, EOCs, disclosure forms, provider contracts with behavioral health providers, and plan to plan contracts with behavioral health plans/entities, and those documents were either amended to include or already included "a maternal mental health condition" in the list of conditions for which a plan will provide completion of covered services by a terminated or nonparticipating provider, per AB 577.

OR

  - The plan reviewed current continuity of care policies, EOCs, disclosure forms, provider contracts with behavioral health providers, and plan to plan contracts with behavioral health plans/entities, and those documents are not consistent with AB 577. The plan will amend these documents to comply with AB 577, including the addition of "a maternal mental health condition" in the list of qualifying conditions and file the documents per the Act's applicable timeframes.

2. AB 651 (Grayson, Ch. 537, Stats. 2019)—Air Ambulance Balance Billing Prohibition

Codified in Health and Safety Code § 1371.55.

a. Overview of the bill:

- Applies to all plans that cover emergency services.

- Establishes that an enrollee shall not pay more than the in-network cost-sharing amount for out-of-network air ambulance services. The cost-sharing amount paid by the enrollee shall count toward the out-of-pocket maximum and deductible in the same manner attributed to a contracted provider.

- Establishes that at the time the plan pays the non-contracting air ambulance provider, the plan must inform both the enrollee and the air ambulance provider of the in-network cost-sharing amount owed by the enrollee.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm an enrollee shall not pay more than the in-network cost-sharing amount for out-of-network air ambulance services, and that the cost-sharing amount paid by the enrollee shall count toward the out-of-pocket maximum and deductible in the same manner attributed to a contracted provider.

- State either:

  - The plan reviewed its current EOCs, SOBs, SBCs, administrative service agreements for claims payments, and provider contracts involving claims payments, and those documents are consistent with the requirements of AB 651.

OR

  - The plan reviewed its current EOCs, SOBs, SBCs, administrative service agreements for claims payments, and provider contracts involving claims payments, and those documents are not consistent with the requirements of AB 651. The plan will amend these documents to comply with AB 651 and file the documents per the Act's applicable timeframes.

3. AB 744 (Aguiar-Curry, Ch. 867, Stats. 2019)—Telehealth Reimbursement Parity

Codified in Health and Safety Code § 1374.14.

a. Overview of the bill:

- Applies to all plans.

- Requires all contracts between a plan and provider, and between a plan and enrollee, issued, amended, or renewed on or after January 1, 2021, to specify that the plan will reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of an enrollee via telehealth on the same basis and to the same extent that the plan would reimburse the same covered in-person service.

- Requires that if the plan chooses to charge a copayment or coinsurance for telehealth services, that cost share shall not exceed the cost share charged for the same services delivered in-person.

- Requires that telehealth services be subject to the same deductible and annual or lifetime dollar maximum as equivalent in-person services.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm all plan contracts with providers, EOCs, disclosure forms, and other subscriber documents issued, amended, or renewed on or after January 1, 2021, will specify the plan will reimburse telehealth services on the same basis and to the same extent the plan reimburses the same covered services delivered in-person.

- State either:

    - The plan reviewed its current provider contracts, administrative services agreements, contracts with plans, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are consistent with the requirements of AB 744.

OR

    - The plan reviewed its current provider contracts, administrative services agreements, contracts with providers, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are not consistent with the requirements of AB 744. The plan will amend these documents to comply with AB 744 and file the documents per the Act's applicable timeframes.

4. AB 954 (Wood, Ch. 540, Stats. 2019)—Dental Provider Network Provisions

Codified in Health and Safety Code § 1374.193.

a. Overview of the bill:

- Applies to all plans that offer contracts covering dental services, excluding Medi-Cal plans and plans that operate under the same brand licensee program.

- Requires all plans offering dental services to include specific notification language in its dental provider network contracts if the plan grants third-party access to the provider network contract, a provider's dental services or contractual discounts. Dental provider network contracts that grant access to a third-party must also allow the provider to opt out of third-party access.

- Plans that grant third-party access must give a provider a list of all of the third-parties it grants access and maintain the list on the plan's website. This list must be updated every 90 days.

b. Compliance and filing requirements:

In the Compliance E-1, state either:

- The plan, either directly through its license or via its contracted specialized (dental) health care service plan, [name of dental plan], does not grant third-party access to its dental provider network contract, or a provider's dental services or contractual discounts.

OR

- The plan, either directly through its license or via its contracted specialized (dental) health care service plan [name of dental plan], grants third-party access to its dental provider network contracts, or a provider's dental services or contractual discounts. The plan [or its contracted dental plan] has updated or is in the process of updating its dental provider network contracts and developing a list on the plan's website that identifies all of its third-party entities to ensure compliance with AB 954 and will file those changes per the Act's applicable timeframes. Either: [The plan affirms it will update the list of all third-party entities every 90 days as required by statute.] or [The plan's contracted dental plan has confirmed it will update the list of all third-party entities every 90 days as required by statute.].

5. AB 1309 (Bauer-Kahan, Ch. 828, Stats. 2019)—Open/Special Enrollment Periods

Codified in Health and Safety Code § 1399.848.

a. Overview of the bill:

- Applies to full service plans offering individual coverage.

- Shifts the annual open enrollment dates for off-exchange plans by two weeks, with the open enrollment period from November 1 of the preceding calendar year, to January 31 of the benefit year.

- Adjusts the special enrollment periods for on-exchange plans from December 16 of the preceding calendar year, to January 31 of the benefit year.

- Makes coverage effective February 1, for individuals that select a plan between December 16 and January 31.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan will adhere to revised open and special enrollment periods, per AB 1309.

- State either:

  - The plan reviewed its current EOCs and enrollee notices regarding termination or renewal, and those documents are consistent with the requirements of AB 1309.

OR

  - The plan reviewed its current EOCs and enrollee notices regarding termination or renewal, and those documents are not consistent with the requirements of AB 1309. The plan will amend these documents to comply with AB 1309 and file the documents per the Act's applicable timeframes.

6. AB 1802 (Committee on Health, Ch. 113, Stats. 2019)—DMHC Contact

Codified in Health and Safety Code §§ 1358.20, 1368.015, 1368.02, 1371, and 1373.65.

a. Overview of the bill:

- Applies to all plans.

- Changes the term "Internet Web site" to "internet website," in all plan documents required under Sections 1358.20, 1368.015, 1368.02, and 1373.65.

- Changes the Department's internet website from http://www.hmohelp.ca.gov to http://www.dmhc.ca.gov, and toll-free telephone number from 1-888-HMO-2219 to 1-888-466-2219, in all plan documents required under Sections 1358.20, 1368.015, 1368.02, and 1373.65.

b. Compliance and filing requirements:

In the Compliance E-1, affirm:

- The plan will revise all applicable documents to contain the Department's updated contact information, and update any references to "internet website"; and

- At the next required submission, the plan will file applicable revised documents, as the appropriate exhibit type, with the changes highlighted in redline form.

7. SB 129 (Pan, Ch. 241, Stats. 2019)—Enrollment Data Reporting

Codified in Health and Safety Code § 1348.95.

a. Overview of the bill:

- Applies to all plans except specialized plans.

- Amends existing plan enrollment reporting requirements to include individual and small group products sold inside and outside Covered California, and multiple employer welfare arrangements (MEWAs), in addition to large group products, administrative services only business lines, and any other business lines.

- Requires the DMHC to publicly report annual enrollment data no later than April 15 of each year.

b. Compliance and filing requirements:

- In the Compliance E-1, affirm the Plan will include in its annual enrollment data reporting the required information for individual and small group products sold inside and outside Covered California, and MEWAs, per SB 129.

8. SB 159 (Wiener, Ch. 532, Stats. 2019)—HIV PrEP Prior Authorization

Codified in Business and Professions Code §§ 4052, 4052.02 and 4052.03, Health and Safety Code § 1342.74, and Welfare and Institutions Code § 14132.968.

a. Overview of the bill:

- Applies to commercial and Medi-Cal plans with prescription drug benefits.
- Authorizes a pharmacist to provide preexposure/postexposure prophylaxis (PrEP) for the prevention of AIDS/HIV, if the enrollee meets certain clinical criteria, and the pharmacist completes a training program approved by the California State Board of Pharmacy.
- Expands Medi-Cal benefits to include PrEP.
- Prohibits plans from requiring prior authorization/step therapy for antiretroviral drugs including PrEP, unless there are FDA approved therapeutic equivalents to prevent AIDS/HIV. If so, the plan must cover at least one therapeutic equivalent without prior authorization/step therapy.
- Prohibits plans and PBMs from not covering PrEP.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan does not require prior authorization/step therapy for antiretroviral drugs including PrEP, unless there are FDA approved therapeutic equivalents to prevent AIDS/HIV. If so, affirm the plan covers at least one therapeutic equivalent without prior authorization/step therapy.
- State either:
    - The plan reviewed its provider contracts and/or administrative services agreements with pharmacy providers, pharmacy provider groups and/or its PBM, and those documents do not conflict with SB 159 or include any restrictions or limitations as to compliance with SB 159 or Business and Professions Code Sections 4052, 4052.02 and 4052.03.

      The plan reviewed its policies and procedures and the policies and procedures of its PBM, and/or pharmacy provider groups. Those documents are consistent with Section 1342.74, which requires the plan provide medically necessary antiretroviral drugs for the prevention of AIDS/HIV, including PrEP, without prior authorization or step therapy, unless the plan offers one or more therapeutic equivalents approved by the FDA.

      The plan reviewed its plan formulary(ies) and determined plan formulary(ies) are consistent with Section 1342.74, which requires the

plan provide (i) medically necessary antiretroviral drugs for the prevention of AIDS/HIV, including PrEP, without prior authorization or step therapy, and (ii) coverage of preexposure prophylaxis furnished by a pharmacist up to a 60-day supply to a single patient every two years, unless otherwise directed by a prescriber. If the FDA approves one or more therapeutic equivalents, the Plan reviewed its health plan formularies to ensure they include at least one therapeutic equivalent of a drug, device, or product for the prevention of AIDs/HIV, including PrEP, without prior authorization or step therapy.

OR

- If any provider contracts, administrative services agreements with pharmacy providers, pharmacy provider groups and/or PBM or policies and procedures conflict with SB 159, the plan affirms it will amend these documents to comply with SB 159 and file the documents per the Act's applicable timeframes.

9. SB 260 (Hurtado, Ch. 845, Stats. 2019)—Covered California Automatic Enrollment

Codified in Health and Safety Code § 1366.50, Government Code § 100503.4.

a. Overview of the bill:

- Applies to individual and group commercial full service plans enrolling individuals losing eligibility for Medi-Cal or CHIP. Excludes specialized plans.

- Requires Covered California to automatically enroll individuals losing eligibility for Medi-Cal or CHIP into the lowest cost silver plan available on the Exchange, and provide a notice to the individual of the plan in which the individual is auto-enrolled and the individual's rights and obligations related to their new coverage and prior coverage. The auto-enrollment must occur before the termination date of the individual's prior coverage. If the enrollee's previous plan is also available on-Exchange, the enrollee should be enrolled into their current plan's offering.

- Adds additional requirements to enrollee notices. Enrollees must be notified of reduced cost-coverage through the Exchange.

- Requires additional notices informing enrollees eligible for the Medicare Program that delaying Medicare enrollment may result in substantial financial implications, and explaining how to find information regarding Medicare enrollment.

- Beginning January 1, 2021, plans are required to transmit the name, address, and contact information of newly disenrolled individuals to Covered California.

- Adds an annual notice requirement by which plans must notify enrollees and subscribers that if they cease to continue coverage, the plan will provide the enrollee's or subscriber's contact information to Covered California so the enrollee/subscriber may obtain other coverage. Enrollees may opt out of the transfer of information to the Exchange. Beginning January 1, 2021, Covered California may use the enrollee's or subscriber's contact information to contact potential enrollees. This notice may be incorporated into or sent simultaneously with other notices sent by the health care service plan.

- On July 1, 2021, Covered California's automatic enrollment process must be implemented.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm that beginning January 1, 2021, the Plan will transmit the name, address, and contact information of newly disenrolled individuals to Covered California. The plan will only provide Covered California with the contact information of individuals who have not opted-out of the disclosure.

- Affirm that when the plan issues enrollee notices pursuant to Director's Letter No. 14, the plan will also include in the notice information that individuals eligible for the Medicare Program should examine their options carefully, as delaying Medicare enrollment may result in substantial financial implications, as well as information on how to find enrollment advice or assistance.

- State either:

    - The plan reviewed its enrollee notices regarding renewal/termination, and those documents are consistent with the requirements of SB 260.

OR

    - The plan reviewed its enrollee notices regarding renewal/termination, and those documents are not consistent with the requirements of SB 260. The plan will amend these documents to comply with SB 260 and file the documents per the Act's applicable timeframes.

10. SB 343 (Pan, Ch. 247, Stats. 2019)—Financial Disclosure Requirements

Codified in Health and Safety Code §§ 1385.03, 1385.045, 1385.07, 128735, 128740, and 128760.

a. Overview of the bill:

- Applies to all full-service individual and small group plans.
- Eliminates alternative rate reporting requirements for a plan that exclusively contracts with no more than two medical groups. Such plans are now required to report rate information consistent with any other plan.

b. Compliance and filing requirements:

- This bill does not require a filing with the DMHC at this time.

11. SB 407 (Monning, Ch. 549, Stats. 2019)—Medicare Supplement

Codified in Health and Safety Code §§ 1358.91 and 1358.11.

a. Overview of the bill:

- Applies to all plans offering Medicare Supplement products.
- Conforms California Medicare supplement law to the federal Medicare Access and CHIP Reauthorization Act.
- Extends the annual open enrollment period provided to individuals enrolled in Medicare Supplement coverage to a minimum of 60 days.
- Prohibits issuers of Medicare Supplement contracts from selling Medicare supplement plans that provide coverage of the Medicare Part B deductible to individuals who become eligible for Medicare on or after January 1, 2020.
- Establishes various requirements related to Medicare Supplement coverage, including requirements related to new or innovative benefits that may be offered with a Medicare Supplement contract and the annual open enrollment period provided to Medicare Supplement enrollees.
- Excludes outpatient prescription drug benefits as a new or innovative benefit.
- Effective July 1, 2020, requires the portion of the premium attributed to the new or innovative benefits to be identified as a separate line item on the payment invoice or bill.

- Requires the DMHC to collaborate with the CDI and other stakeholders to develop and implement policies and procedures, as necessary, to ensure the availability of information about Medicare Supplement coverage to current and potential enrollees.

b. Compliance and filing requirements:

In the Compliance E-1, state either:

- The plan reviewed its current provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are consistent with the requirements of SB 407.

OR

- The plan has reviewed its provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are not consistent with the requirements of SB 407. The plan will amend these documents to comply with SB 407 and file the documents per the Act's applicable timeframes.

12. SB 583 (Jackson, Ch. 482, Stats. 2019)—Clinical Trial Coverage Requirements

Codified in Health and Safety Code § 1370.6.

a. Overview of the bill:

- Applies to all individual and group plans, except specialized plan contracts.

- Repeals the previous iteration of Section 1370.6 and adds a new Section 1370.6 to the Act.

- Prohibits plans from denying a qualified enrollee's participation in an approved clinical trial.

- States that the payment rate for routine patient care costs provided by a nonparticipating provider shall be the negotiated rate the plan would otherwise pay a participating provider for the same services, less applicable cost sharing.

- States that cost sharing for routine patient care costs shall be the same as that applied to the same services not delivered in a clinical trial, except that

the in-network cost sharing and out-of-pocket maximum shall apply if the clinical trial is not offered or available through a participating provider.

- Allows a plan to restrict coverage to an approved clinical trial in California, unless the clinical trial is not offered or available through a participating provider in California.

b. Compliance and filing requirements:

In the Compliance E-1:

- State either:
    - The plan reviewed its current provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, and EOCs, and those documents are consistent with the requirements of SB 583.

OR

    - The plan reviewed its current provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, and EOCs, and those documents are not consistent with the requirements of SB 583. The plan will amend these documents to comply with SB 583 and file the documents per the Act's applicable timeframes.

13. SB 600 (Portantino, Ch. 853, Stats. 2019)—Fertility Preservation Coverage

Codified in Health and Safety Code § 1374.551.

a. Overview of the bill:

- Applies to all plans except Medi-Cal Managed Care plans. Does not apply to specialized plans, unless the specialized plan's treatment causes infertility.

- Clarifies that standard fertility preservation services are basic health care services when a covered treatment may directly or indirectly cause iatrogenic infertility, and are not within the scope of coverage for treatment of infertility. SB 600 clarifies existing law, and does not change the law.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan covers standard fertility preservation services as a basic health care service when a covered treatment may directly or indirectly cause iatrogenic infertility.

- State either:

    - The plan reviewed its current EOCs, SBCs, Schedules of Benefits, Infertility Riders, Subscriber Agreements, and disclosure forms and those documents do not contain language that excludes fertility preservation services.

OR

    - The plan reviewed its current EOCs, SBCs, Schedules of Benefits, Infertility Riders, Subscriber Agreements, and disclosure forms, and those documents are not consistent with the requirements of SB 600. The plan has discussed next steps with its assigned OPL reviewer to ensure timely compliance, and the plan will amend these documents to comply with SB 600 and file the documents per the Act's applicable timeframes.

14. SB 784 (Committee on Health, Ch. 157, Stats. 2019)—Medicare Supplement Benefit Coverage

Codified in Health and Safety Code §§ 1358.91, 1358.92, and 1358.11.

a. Overview of the bill:

- Applies to plans offering Medicare Supplement policies and certificates.

- Conforms California Medicare Supplement law to the Federal Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA), which was incorporated into the Medicare Supplement Insurance Model Regulation maintained by the National Association of Insurance Commissioners (NAIC Model Regulation).

- Prohibits issuers of Medicare Supplement contracts from selling Medicare Supplement plans that provide coverage of the Medicare Part B deductible to individuals who become eligible for Medicare on or after January 1, 2020.

- Re-designates standardized Medicare Supplement benefit plans C, F, and high deductible F as plans D, G, and high deductible G, respectively, for purposes of conforming state law to federal law.

- Requires standardized Medicare Supplement benefit plans D, G, and high deductible G to provide the same coverage as required for plans C, F, and high deductible F, respectively, with the exception of coverage of 100%, or any portion, of the Medicare Part B deductible.

- Prohibit the sale of standardized Medicare Supplement benefit plans C, F, and high deductible F to newly eligible beneficiaries.

b. Compliance and filing requirements:

In the Compliance E-1:

- Affirm the plan will not sell Medicare Supplement plans that provide coverage of the Medicare Part B deductible to individuals who become eligible for Medicare on or after January 1, 2020.

- State either:

  - The plan reviewed its current provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are consistent with the requirements of SB 784.

OR

  - The plan reviewed its current provider contracts, administrative services agreements, policies and procedures, subscriber contracts, SOBs, disclosure forms, EOCs, and marketing materials, and those documents are not consistent with the requirements of SB 784. The plan will amend these documents to comply with SB 784 and file the documents per the Act's applicable timeframes.

If you have questions or concerns regarding this APL, please contact your assigned OPL reviewer.