From: DMHC Licensing eFiling

Subject: APL 23-025 (OPL) Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) - REVISED

Date: Wednesday, February 7, 2024 4:36 PM

Attachments: APL 23-025 - Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) – REVISED (2.7.24)

Dear Health Plan Representative:

Please find the attached REVISED APL 23-025 in regard to newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC). Please note the revised APL now includes compliance requirements for AB 352 (Bauer-Kahan, Ch. 255, Stats. 2023).Due to the addition of AB 352 in APL 23-025, the Department is extending the filing deadline to submit the plan's filing demonstrating compliance with all of the newly enacted statutory requirements discussed in the APL from March 11, 2024 to March 29, 2024.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Sacramento, CA 95814
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ALL PLAN LETTER

DATE: February 7, 2024

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 23-025 (OPL) Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) - REVISED

This All Plan Letter (APL) outlines the 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 16 bills enacted this session that may require plans to update Evidences of Coverage (EOCs), disclosure forms, provider contracts and/or other plan documents. 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 impact the plan. Discussion of each bill may be found in the APL on the pages identified below.

[1] Unless specifically indicated below, the newly enacted legislation does not apply to Medicare Advantage plans or Employee Assistance Program (EAP) plans and therefore these plans are not required to submit the Compliance with 2023 Legislation Amendment filing.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by March 29, 2024, one filing to demonstrate or affirm compliance with all newly enacted statutory requirements discussed in this APL.

- Submit the filing[2] via eFiling as an **Amendment** titled "**Compliance with 2023 Legislation.**"

- In the Compliance with 2023 Legislation Amendment filing, include an Exhibit E-1 (the "Compliance E-1") that addresses how the plan intends to comply with the newly enacted legislation discussed below.

- Plan documents (EOCs, provider contracts, notices, etc.) must be consistent with the 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[4]. For example, plans in Covered California must file 2025 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 118 (Committee On Budget, Ch. 42, Stats. 2023)—Budget Act of 2023: Health

Codified in Health and Safety Code §§ 1352.1, 1363, 1363.3, 1367.041, 1367.24 and 1374.724.

a. Overview of the bill:

- Health and Safety Code §§ 1352.1, 1363, 1363.3, 1367.041, 1367.24.
    - Applies to all plans. Excludes Medi-Cal products.

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[2] Under each bill discussed in this APL, the types of plans that the specific bill impacts are listed. If the plan determines that a specific bill does not apply to it, please respond accordingly in the plan's filing and provide the reasoning as to why the specific bill does not apply to the plan.

[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.

[4] Nothing in this APL shall be construed to require the plan to cover services beyond what is required pursuant to the Act and Rules.

- On or after January 1, 2025, AB 118 requires plans to utilize the standard templates developed by the DMHC for any disclosure form, EOC, schedule of benefits, explanation of benefits, and cost-sharing summaries.

- Health and Safety Code § 1374.724.
  - This bill made changes to AB 988 (Bauer-Kahan, Ch. 747, Stats. 2022) with respect to terminology, utilization management for poststabilization care and reimbursement procedures. Further guidance regarding AB 988 will be forthcoming and issued under a separate communication to the plans.
  - Applies to all plans that cover mental health and substance use disorder treatment. Excludes dental, vision, acupuncture/chiropractic and/or Medi-Cal products.
  - Please note that all references to poststabilization care in this section of the APL are for services listed in Section 1374.724 and as defined in Section 1374.724(e)(3).
  - Effective immediately, requires plans' coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 to include behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility. With respect to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team, requires plans to cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.
  - Prohibits plans from requiring prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to an enrollee.
  - Prohibits plans from denying payment for behavioral health crisis stabilization services and care pursuant to AB 118 unless the plan, or its contracting medical provider, reasonably determines that the services were never performed.
  - Allows plans, if the plan's prior authorization requirements comply with Section 1374.721, to require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system.

- Requires plans, if there is a disagreement between the plan and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, to assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721.

- Prohibits plans from requiring, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.

- Requires plans that are contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to, within 30 minutes of the time the provider makes the initial telephone call requesting information, either authorize poststabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider.

- Requires plans that are contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to reimburse the provider for poststabilization care rendered to the enrollee if any of the following occur: (1) the plan authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care; (2) the plan did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee's care within 30 minutes of the time the provider makes the initial telephone call requesting information; or (3) there is an unreasonable delay in the transfer of the enrollee's care to another provider, and the provider determines that the enrollee requires poststabilization care.

- Requires plans to (1) prominently display on the plan’s internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another provider or authorization to provide poststabilization care; (2) ensure the telephone number published on the plan’s internet website is the correct telephone number for such purposes; (3) update the telephone number on the plan's internet website within one business day if the telephone number changes; and (4) provide the telephone number to the DMHC, and the DMHC to post the telephone number on the DMHC’s internet website.

- Prohibits plans from requiring a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one telephone call to the number provided in advance by the plan, to the extent permissible under federal law. The representative of the 988

center, mobile crisis team, or other provider of behavioral health crisis services that makes the telephone call may be, but is not required to be, a physician or surgeon.

- Prohibits a 988 center, mobile crisis team, or other provider of behavioral health crisis services from billing a patient who is a plan enrollee for poststabilization care, except for the in-network cost-sharing amount. An enrollee who is billed in violation of AB 118 may report receipt of the bill to the plan and the DMHC. The DMHC shall forward that report to the California Department of Public Health.

- Requires plans to reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care pursuant to AB 118, consistent with the requirements of Section 1371.4 and any other applicable requirements.

- Requires plans, if services and care pursuant to AB 118 are received from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside of the plan's network, to ensure the enrollee pays no more than the same cost sharing that the enrollee would pay for the same services received from an in-network provider.

- Prohibits an out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services from billing or collecting an amount from the enrollee for services subject to Section AB 118 except for the in-network cost-sharing amount.

b. Compliance and filing requirements:

- Health and Safety Code §§ 1352.1, 1363, 1363.3, 1367.041, 1367.24.

  - The DMHC will engage stakeholders for input and feedback. Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

- Health and Safety Code § 1374.724.

  - Affirm the plan's coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 will include behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility.

  - Affirm the plan's coverage with respect to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team,

will cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.

- Affirm the plan can deliver behavioral health crisis services through its network(s) pursuant to Sections 1367 and 1367.03 and Rule 1300.67.2.2(b)(5).

- Affirm the plan will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.

- Affirm the plan will not deny payment for behavioral health crisis stabilization services and care pursuant to AB 118 unless the plan, or its contracting medical provider, reasonably determines that the services were never performed.

- Affirm the plan will require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system only if the plan's prior authorization requirements comply with Section 1374.721.

- Affirm, if there is a disagreement between the plan and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721.

- Affirm the plan will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.

- Affirm, if contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, the plan will either authorize poststabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for poststabilization care.

- Affirm, if contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, the plan will reimburse the provider for poststabilization care rendered to the enrollee if any of the following occur: (1) the plan authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care; (2) the plan did not respond to the provider's

initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee's care within 30 minutes of the time the provider makes the initial telephone call requesting information; or (3) there is an unreasonable delay in the transfer of the enrollee's care to another provider, and the provider determines the enrollee requires poststabilization care.

- Affirm the plan will (1) prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another provider or authorization to provide poststabilization care; (2) ensure the telephone number published on its internet website is the correct telephone number for such purposes; and (3) update the telephone number on its internet website within one business day if the telephone number changes.

- Affirm, to the extent permissible under federal law, the plan will not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one poststabilization telephone call to the number provided in advance by the plan.

- Affirm the plan will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the poststabilization telephone call to the plan to be a physician or surgeon.

- Affirm the plan will ensure that if an enrollee receives a bill or other demand for payment, except for the in-network cost-sharing amount from a 988 center, mobile crisis team, or other provider of behavioral health crisis services for poststabilization care, the plan will take appropriate action to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Affirm the plan will ensure that an enrollee who is billed in violation of AB 118 can report receipt of the bill to the plan and the DMHC.

- Affirm the plan will reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care pursuant to AB 118, consistent with the requirements of Section 1371.4 and any other applicable requirements.

- Affirm that if services and care pursuant to AB 118 are received from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside of the plan’s network, the plan will ensure the

enrollee pays no more than the same cost sharing that the enrollee would pay for the same services received from an in-network provider.

- Affirm the plan will ensure that if an enrollee receives a bill or other demand for payment, except for the in-network cost-sharing amount from an out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services or services subject to AB 118, the plan will take appropriate action to assist the enrollee in resolving demands for payment excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Provide, via an Exhibit J-22, the plan's specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another provider or authorization to provide poststabilization care. The DMHC will post the telephone number on the DMHC's internet website. Exhibit J-22 is an exhibit type the DMHC created for this purpose.

- Provide the steps the plan will take to ensure the following: (1) how an enrollee who is billed in violation of AB 118 can report receipt of the bill to the plan and to the DMHC through the DMHC's complaint process; and (2) if services and care pursuant to AB 118 are received from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside of the plan's network, the enrollee will pay no more than the same cost sharing that the enrollee would pay for the same services received from an in-network provider.

- Provide the steps the plan will take to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting 988 center, mobile crisis team, or other provider of behavioral health crisis services of its obligations under the Act and Rules for any services provided pursuant to AB 118, including poststabilization care.

- Provide any policies and procedures, as an Exhibit II-4, regarding the steps the plan will take to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Provide any notices, as an Exhibit I-7, that the plan will send to a noncontracting provider to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Provide updated utilization management policies and procedures, as an Exhibit J-9, to demonstrate compliance with Section 1374.721 and AB 118.

- Provide updated claims policies and procedures, as an Exhibit II-4, to demonstrate the plan's reimbursement of a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care pursuant to AB 118, is consistent with the requirements of AB 118, Section 1371.4, and any other applicable requirements.
- State either:

    - The plan reviewed its policies and procedures, provider contracts, administrative service agreements (ASAs), plan-to-plan contracts, Summaries of Benefits, or other detailed cost sharing documents (collectively referred to as "SOBs"), Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 118.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 118. The plan will amend these documents to comply with AB 118 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

2. AB 254 (Bauer-Kahan, Ch. 254, Stats. 2023)—Confidentiality of Medical Information Act: reproductive or sexual health application information

Codified in Civil Code §§ 56.05 and 56.06.

a. Overview of the bill:

- Applies to all plans, including EAPs, that provide reproductive or sexual health care or mental health care. Excludes dental, vision or acupuncture/chiropractic products.

- Requires plans, on or after January 1, 2024, to include "reproductive or sexual health application information"[5] in the definition of "medical information" as set forth in the Confidentiality of Medical Information Act.

- Requires plans to deem any business that offers a "reproductive or sexual health digital service"[6] to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the Confidentiality of Medical Information Act.

b. Compliance and filing requirements:

- Affirm the plan will revise its definition of "medical information" as set forth in the Confidentiality of Medical Information Act to include "reproductive or sexual health application information".

- Affirm the plan will deem any business that offers a "reproductive or sexual health digital service" to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the Confidentiality of Medical Information Act.

- Provide the plan's revised policies and procedures required by Section 1364.5, as an Exhibit J-18, to demonstrate compliance with AB 254.

- State either:

    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 254.

OR

    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 254. The plan will amend these documents to comply with AB 254 and file the documents per the Act's applicable timeframes.

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[5] *See* Civil Code § 56.05(p) for the definition of "reproductive or sexual health application information".
[6] *See* Civil Code § 56.05(q) for the definition of "reproductive sexual health digital service".

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

3. AB 317 (Weber, Ch. 322, Stats. 2023)—Pharmacist Service Coverage

Codified in Health and Safety Code § 1368.5.

a. Overview of the bill:

- Applies to all plans that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist.

- Requires plans, on or after January 1, 2024, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the plan has an out-of-network benefit.

b. Compliance and filing requirements:

- If the plan offers coverage for a service that is within the scope of practice of a duly licensed pharmacist, affirm the plan will pay or reimburse the cost of the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the plan has an out-of-network benefit.

- State either:

  - The plan reviewed its claims policies and procedures, Pharmacy Benefit Manager (PBM) contracts, ASAs and plan-to-plan contracts, and those documents are consistent with the requirements of AB 317.

OR

  - The plan reviewed its claims policies and procedures, PBM contracts, ASAs, and plan-to-plan contracts, and those documents are not consistent with the requirements of AB 317. The plan will amend these documents to comply with AB 317 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

4. AB 352 (Bauer-Kahan, Ch. 255, Stats. 2023)—Health Information

Codified in Civil Code §§ 56.101, 56.108, 56.110 and Health and Safety Code § 130290.

a. Overview of the bill:

- Applies to all plans, including EAPs, that provide reproductive or sexual health care or mental health care. Excludes dental, vision or acupuncture/chiropractic products.

- Civil Code Section 56.101.

    - Requires businesses, as described in AB 254, on or before July 1, 2024, that electronically store or maintain medical information for the provision of sensitive services, including but not limited to an electronic health record system on behalf of a plan to develop capabilities, policies and procedures to enable all of the following: (a) limit user access privileges to information systems that contain medical information related to sensitive services only to those persons who are authorized to access specified medical information, (b) prevent the disclosure, access, transfer, transmission, or processing of medical information related to sensitive services to persons and entities outside of California, (c) segregate medical information related to sensitive services from the rest of the patient's record, and (d) provide the ability to automatically disable access to segregated medical information related to sensitive services by individuals and entities in another state.

- Civil Code Section 56.108.

    - Prohibits plans from cooperating with any inquiry or investigation by or providing medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California, unless the request for medical information is authorized under Civil Code Section 56.110.

- Civil Code Section 56.110.

    - Prohibits plans from knowingly disclosing, transmitting, transferring, sharing or granting access to medical information in an electronic health records system or through a health information exchange that would identify an individual and that is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful under the laws of California to any individual or entity from another state, unless the disclosure, transmittal, transfer,

sharing, or granting is authorized under any of the conditions listed in Civil Code Sections 56.110(a)(1), (2), (3) and (4).

- Allows plans to disclose the content of health records containing medical information specified in Civil Code Section 56.110(a) to any of the following: (a) a patient, or their personal representative, consistent with the Patient Access to Health Records Act, (b) in response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543, if applicable, and only if all information about the patient's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record, and (c) when expressly required by federal law that preempts California law, but only to the extent expressly required.

- Does not prohibit plans from cooperating or complying with the investigation of activity that is punishable as a crime under the laws of California, and that took place in California.

b. Compliance and filing requirements:

- Civil Code Section 56.101.

  - If the plan utilizes a business, as described in AB 254, on or after July 1, 2024, to electronically store or maintain medical information for the provision of sensitive services, including but not limited to an electronic health record system on behalf of the plan to develop capabilities, policies and procedures, the plan affirms that it will require that business to enable all of the following: (a) limit user access privileges to information systems that contain medical information related to sensitive services only to those persons who are authorized to access specified medical information, (b) prevent the disclosure, access, transfer, transmission, or processing of medical information related to sensitive services to persons and entities outside of California, (c) segregate medical information related to sensitive services from the rest of the patient's record, and (d) provide the ability to automatically disable access to segregated medical information related to sensitive services by individuals and entities in another state.

- Civil Code Section 56.108.

  - Affirm the plan will not cooperate with any inquiry or investigation by or provide medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California,

unless the request for medical information is authorized under Civil Code Section 56.110.

- Civil Code Section 56.110.
    - Affirm the plan will not knowingly disclose, transmit, transfer, share or grant access to medical information in an electronic health records system or through a health information exchange that would identify an individual and that is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful under the laws of California to any individual from another state, unless the disclosure, transmittal, transfer, sharing, or granting is authorized under any of the conditions listed in Civil Code Sections 56.110(a)(1), (2), (3) and (4).
    - Affirm the plan will disclose the content of health records containing medical information specified in Civil Code Section 56.110(a) to any of the following: (a) a patient, or their personal representative, consistent with the Patient Access to Health Records Act, (b) in response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543, if applicable, and only if all information about the patient's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record, and (c) when expressly required by federal law that preempts California law, but only to the extent expressly required.
- Provide the plan's revised policies and procedures required by Section 1364.5, as an Exhibit J-18, to demonstrate compliance with AB 352.
- State either:
    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 352.

OR

    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 352. The plan will amend these documents to comply with AB 352 and file the documents per the Act's applicable timeframes.
- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2)

whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

5. AB 659 (Aguiar-Curry, Ch. 809, Stats. 2023)—Cancer Prevention Act

Codified in Health and Safety Code § 1367.66.

a. Overview of the bill:

- Applies to all plans. Excludes specialized plans.
- Requires plans, on or after January 1, 2024, to provide coverage for the human papillomavirus vaccine for enrollees for whom the vaccine is approved by the FDA.
- Prohibits plans from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage for the human papillomavirus vaccine.

b. Compliance and filing requirements:

- Affirm the plan will provide coverage for the human papillomavirus vaccine for enrollees for whom the vaccine is approved by the FDA.
- Affirm the plan will not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage for the human papillomavirus vaccine.
- State either:
    - The plan reviewed its provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 659.

OR

    - The plan reviewed its provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 659. The plan will amend these documents to comply with AB 659 and file the documents per the Act's applicable timeframes.
- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

6. AB 716 (Boerner, Ch. 454, Stats. 2023)—Ground Medical Transportation

Codified in Health and Safety Code § 1371.56.

a. Overview of the bill:

- Applies to all plans that provide coverage for ground ambulance providers. Excludes Medi-Cal products.
- Repeals Section 1367.11 and supersedes APL 22-022 and guidance regarding noncontracting nonemergency ground ambulance providers.
- On or after January 1, 2024, plans shall require an enrollee who receives covered services from a noncontracting ground ambulance provider (including both emergency and nonemergency services) to pay no more than the same cost-sharing amount the enrollee would pay for the same covered services received from a contracting ground ambulance provider (this amount is referred to as the "in-network cost-sharing amount").
- An enrollee will not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services provided pursuant to AB 716.
- Requires plans, at the time of payment by the plan to the noncontracting provider, to inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee and to disclose whether or not the enrollee's coverage is regulated by the DMHC or if the coverage is not state-regulated.
- Requires plans to apply the in-network cost-sharing amount the enrollee pays towards the annual out-of-pocket maximum and towards any deductible in the same manner as cost sharing would be attributed to a contracting provider.
- The in-network amount paid by the enrollee pursuant to AB 716 will satisfy the enrollee's obligation to pay cost sharing for the health service.
- Requires that a noncontracting ground ambulance provider (1) only advance to collections the in-network cost sharing amount, as determined by the plan, that the enrollee failed to pay, (2) not report adverse information to a consumer credit reporting agency or commence a civil action against the enrollee from a minimum of 12 months after the initial billing regarding amounts owed by the enrollee pursuant to AB 716, and (3) not use any wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to AB 716.

- Requires plans, unless otherwise agreed to by the noncontracting ground ambulance provider and the plan, to directly reimburse a noncontracting ground ambulance provider the difference between the in-network cost-sharing amount and an amount described as follows:
    - If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85.
    - If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the amount established by Rule 1300.71(a)(3)(B).
- Payment made by the plan to the noncontracting ground ambulance provider for services pursuant to AB 716 plus the applicable cost share paid by the enrollee constitutes payment in full for the services rendered.
- Allows plans or providers to seek relief in any appropriate court for the purpose of resolving a payment dispute.
- Allows ground ambulance providers to use plans' existing dispute resolution process.

b. Compliance and filing requirements:

- Affirm the plan will ensure that if an enrollee receives a bill or other demand for payment from a noncontracting ground ambulance provider that is greater than the in-network cost-sharing amount for services provided pursuant to AB 716, the plan will take appropriate action to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting ground ambulance provider of its obligations under the Act and Rules.
- Affirm the plan, at the time of payment by the plan to the noncontracting provider, will inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee and will disclose whether or not the enrollee's coverage is regulated by the DMHC or if the coverage is not state-regulated.
- Affirm the plan will apply the in-network cost-sharing amount the enrollee pays for a noncontracting ground ambulance provider towards the annual out-of-pocket maximum and towards any deductible in the same manner as cost sharing would be attributed to a contracting provider.
- Affirm the plan will ensure that if the enrollee receives a notification from a noncontracting ground ambulance provider that the in-network cost-sharing

amount paid by the enrollee pursuant to AB 716 will not satisfy the enrollee's obligation to pay cost sharing for the health service, the plan will take appropriate action to assist the enrollee in resolving demands for payment in excess of the in-network cost sharing and to inform the offending noncontracting ground ambulance provider of its obligation under the Act and Rules.

- In the event that a noncontracting ground ambulance provider (1) advances to collections an amount greater than the in-network cost sharing amount, as determined by the plan, that the enrollee failed to pay, (2) reports adverse information to a consumer credit reporting agency or commence a civil action against the enrollee from a minimum of 12 months after the initial billing regarding amounts owed by the enrollee pursuant to AB 716, and (3) uses any wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to AB 716, the plan affirms it will take appropriate action to assist the enrollee and to inform the offending noncontracting ground ambulance provider of its obligation under the Act and Rules.

- Affirm the plan, unless otherwise agreed to by the noncontracting ground ambulance provider and the plan, will directly reimburse a noncontracting ground ambulance provider the difference between the in-network cost-sharing amount and an amount described as follows:

    - If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85.

    - If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the amount established by Rule 1300.71(a)(3)(B).

- Affirm the plan will ensure that if the enrollee receives a notification from a noncontracting ground ambulance provider that payment made by the plan for services pursuant to AB 716 plus the applicable cost share paid by the enrollee will not constitute payment in full for the services rendered, the plan will take appropriate action to assist the enrollee with any such notification and to inform the offending noncontracting ground ambulance provider of its obligation under the Act and Rules.

- Affirm the plan will allow noncontracting ground ambulance providers to use the plan's existing dispute resolution process.

- Provide the steps the plan will take to assist enrollees with balance bills from noncontracting ground ambulance providers for any charges for covered services beyond the enrollee's in-network cost-sharing amount.

- Provide the template notices, as an Exhibit I-9 (enrollee) and Exhibit I-7 (noncontracting provider), where the plan, at the time of payment by the plan to the noncontracting provider, will inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee and will disclose whether or not the enrollee's coverage is regulated by the DMHC or if the coverage is not state-regulated.

- Provide any policies and procedures, as an Exhibit II-4, regarding the steps the plan will take to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Provide any notices, as an Exhibit I-7, that the plan will send to a noncontracting provider to assist the enrollee in resolving demands for payment in excess of the in-network cost-sharing amount and to inform the offending noncontracting provider of its obligations under the Act and Rules.

- Provide the plan's revised claims policies and procedures, as an Exhibit II-4, to demonstrate compliance with AB 716, including the methodology the plan proposes to use to establish the amount under Rule 1300.71(a)(3)(B).

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 716.

    OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 716. The plan will amend these documents to comply with AB 716 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

7. AB 904 (Calderon, Ch. 349, Stats. 2023)—Health Care Coverage: Doulas

Codified in Health and Safety Code § 1367.626.

a. Overview of the bill:

- Applies to all plans that cover maternity services.

- Requires plans, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. This may be achieved by integrating the program into existing maternal mental health programs, including those encouraging the coverage of doula care, or by expanding existing doula programs.

- Provides that a Medi-Cal managed care plan shall be considered compliant with the above requirements by providing coverage of doula services so long as doula services are a Medi-Cal covered benefit.

- Requires the DMHC, in consultation with the Department of Insurance, to collect data and submit a report describing the doula coverage and programs established pursuant to AB 904 to the Legislature by January 1, 2027. The report may do both of the following:

    - Include the DMHC's Healthcare Effectiveness Data and Information Set (HEDIS) measures or the Center for Data Insights and Innovation's quality of care report card; and

    - Assess quality of care, increased access, ongoing barriers to access, and more.

b. Compliance and filing requirements:

- Medi-Cal products.

    - Affirm the plan will provide coverage of doula services if doula services are a Medi-Cal covered benefit.

- Commercial/Non Medi-Cal products.

    - Affirm the plan, on or before January 1, 2025, will develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas.

    - Describe how the plan will develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. Explain whether the plan will be integrating the program into existing maternal mental health programs, including those encouraging the coverage of doula care, or by expanding existing doula programs. Explain how the Plan will ensure access to doulas if the Plan is delivering care through doula services. Provide any updated policies and procedures, as an Exhibit J-9, needed to demonstrate compliance with AB 904.

- Explain how the plan will make its maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas available to providers and enrollees.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 904.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 904. The plan will amend these documents to comply with AB 904 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

- Further guidance regarding the reporting requirements for this new law will be forthcoming and issued under a separate communication to the plans.

8. AB 948 (Berman, Ch. 820, Stats. 2023)—Prescription Drugs

Codified in Health and Safety Code § 1342.73.

a. Overview of the bill:

- Deletes the January 1, 2024 sunset date for Section 1342.73. Accordingly, among other provisions set forth in Section 1342.73, continues the requirements that cost-sharing for covered outpatient prescription drugs will not exceed $250 for up to a 30-day supply (unless for a bronze-level product, in which the maximum cost-sharing is $500) and the annual deductible for non-grandfathered individual or small group products will not exceed $500 (this applies to HDHP products once the annual deductible has been met).

- Health and Safety Code § 1342.73(a)

  - Applies to all plans that provide outpatient prescription drug coverage. Excludes Medi-Cal products.

- Provides that, for covered outpatient prescription drugs, a copayment or percentage coinsurance shall not exceed 50 percent of the cost to the plan, as described in Rule 1300.67.24.

- Provides that, if there is a generic equivalent to a brand name drug, a plan shall ensure that the enrollee is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. This shall not be construed to require both the generic equivalent and the brand name drug to be on the formulary.

- Health and Safety Code § 1342.73(b)

  - Applies to non-grandfathered individual or small group plan contracts that provide prescription drug coverage and maintain a 4-tier drug formulary. Excludes Medi-Cal products.

  - Removes the specific reference to biologics from the definition of Tier 4 drugs.

b. Compliance and filing requirements:

- Affirm the plan will continue to comply with all the requirements set forth in Section 1342.73, including but not limited to the requirement that cost-sharing for covered outpatient prescription drugs will not exceed $250 for up to a 30-day supply (unless for a bronze-level product, in which the maximum cost-sharing is $500) and the requirement that the annual deductible for non-grandfathered individual or small group products will not exceed $500 (this applies to HDHP products once the annual deductible has been met).

- Health and Safety Code § 1342.73(a)

  - Affirm the plan will not impose a copayment or percentage coinsurance for covered outpatient prescription drugs that exceeds 50 percent of the cost to the plan, as described in Rule 1300.67.24.

  - Affirm the plan, if there is a generic equivalent to a brand name drug, will ensure that the enrollee is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary.

- Health and Safety Code § 1342.73(b)

  - If the plan has a 4-tier formulary, affirm the plan will utilize the following definition for Tier 4 drugs: “Tier four shall consist of drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs

that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply."

- If the plan has any 4-tier formularies pursuant to Section 1342.73(b), submit the revised formulary, as an Exhibit T-3, demonstrating compliance with AB 948.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, formularies, and those documents are consistent with the requirements of AB 948.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, formularies, and those documents are not consistent with the requirements of AB 948. The plan will amend these documents to comply with AB 948 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

9. AB 952 (Wood, Ch. 125, Stats. 2023)—Dental Coverage Disclosures

Codified in Health and Safety Code § 1374.18.

a. Overview of the bill:

- Applies to all plans that cover dental services, including a specialized plan covering dental services.

- Requires plans, on or after January 1, 2025, to assist a provider in determining if an enrollee's plan coverage is regulated by the State of California by disclosing whether an enrollee's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request.

- Requires plans to include the statement "State Regulated" if the enrollee's dental coverage is subject to regulation by the DMHC on an electronic or physical identification card, or both if available, for contracts covering dental services issued on or after January 1, 2025.

b. Compliance and filing requirements:

- Affirm the plan, by January 1, 2025, will disclose whether an enrollee's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request.

- Affirm the plan, by January 1, 2025, will include the statement "State Regulated" if the enrollee's dental coverage is subject to regulation by the DMHC on an electronic or physical identification card, or both if available.

- Provide an explanation of how the plan, by January 1, 2025, will assist a provider in determining if an enrollee's health care service plan coverage is regulated by the State of California, including whether this information will be provided through the provider portal or through another method.

- Provide an amended enrollee identification card that includes the statement "State Regulated", as an Exhibit U-1, to demonstrate compliance with AB 952.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, and those documents are consistent with the requirements of AB 952.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, and those documents are not consistent with the requirements of AB 952. The plan will amend these documents to comply with AB 952 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

10. AB 1048 (Wicks, Ch. 557, Stats. 2023)— Dental benefits and rate review

Codified in Health and Safety Code §§ 1374.194, 1385.02, 1385.14.

a. Overview of the bill:

- Health and Safety Code § 1374.194

    - Applies to plans that cover dental services, including a specialized plan covering dental services. Excludes Medi-Cal products.

- Prohibits a plan, on and after January 1, 2025, from imposing a dental waiting period provision in a large group product or preexisting condition provision for any product.

- Health and Safety Code §§ 1385.02 and 1385.14

  - Applies to plans that issue, sell, renew, or offer a plan contract covering dental services, including a specialized plan covering dental services.

  - Subjects plans covering dental services to rate review, and requires plans, on or after January 1, 2025, and at least annually thereafter, to file with the DMHC specified information required by AB 1048, as applicable.

b. Compliance and filing requirements:

- Health and Safety Code §1374.194

  - Affirm that, on and after January 1, 2025, the plan shall not issue, amend, renew, or offer a plan contract that imposes a dental waiting period provision in a large group product or preexisting condition provision for any product.

  - State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are consistent with the requirements of AB 1048.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of AB 1048. The plan will amend these documents to comply with AB 1048 and file the documents per the Act's applicable timeframes.

  - If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

- Health and Safety Code §§ 1385.02, 1385.14

- Further guidance regarding how plans must demonstrate compliance and other specific filing requirements for this new law will be forthcoming and issued under a separate communication to the plans.

11. SB 421 (Limón, Ch. 607, Stats. 2023)—Health Care Coverage: Cancer Treatment

Codified in Health and Safety Code § 1367.656.

a. Overview of the bill:

- Applies to plans that provide prescription drug coverage. Excludes specialized dental, vision plans and chiropractic/acupuncture plans.

- Deletes the January 1, 2024 repeal date of the requirements that, (1) notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay shall not exceed $250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the contract and (2) an orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication. Note, the $250 cap for an individual prescription of up to a 30-day supply of prescribed orally administered anticancer medication only applies to a HDHP product once the enrollee's deductible has been satisfied for the year.

b. Compliance and filing requirements:

- Affirm the plan will continue to comply with the requirements that, (1) notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay shall not exceed $250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the contract and (2) an orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are consistent with the requirements of SB 421.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, EOCs, and those documents are not consistent with the requirements of SB 421. The plan will amend these documents to

comply with SB 421 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

12. SB 487 (Atkins, Ch. 261, Stats. 2023)—Abortion: Provider Protections

Codified under Health and Safety Code § 1375.61.

a. Overview of the bill:

- Applies to all plans.

- Prohibits plans, on or after January 1, 2024, from including in a provider contract any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

- Prohibits plans from discriminating, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

b. Compliance and filing requirements:

- Affirm the plan will not include any terms in a provider contract that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

- Affirm the plan will not discriminate against a licensed provider solely on the basis of a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another

state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

- State either:
    - The plan reviewed its policies and procedures, provider contracts, ASAs, and plan-to-plan contracts, and those documents are consistent with the requirements of SB 487.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, and plan-to-plan contracts, and those documents are not consistent with the requirements of SB 487. The plan will amend these contracts to comply with SB 487 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

13. SB 496 (Limón, Ch. 401, Stats. 2023)—Biomarker Testing

Codified in Health and Safety Code § 1367.667.

a. Overview of the bill:

- Applies to all plans. Excludes specialized plans and Medi-Cal products.
- Clarifies the standards and coverage of biomarker testing, which plans are required to cover under Section 1367.665.
- Requires plans, on or after July 1, 2024, to cover medically necessary biomarker testing, subject to utilization review management.
- Requires plans, on or after July 1, 2024, to cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions.
- Requires plans, on or after July 1, 2024, to cover biomarker tests that meet any of the following:
    - A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug.
    - A national coverage determination made by the Centers for Medicare and Medicaid Services.

- A local coverage determination made by a Medicare Administrative Contractor for California.

- Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

- Standards set by the National Academy of Medicine.

- Requires plans, on or after July 1, 2024, to use the process described in Section 1363.5 to determine whether biomarker testing is medically necessary for the purposes of SB 496.

- Requires plans, on or after July 1, 2024, to ensure that biomarker testing is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

- Requires plans, on or after July 1, 2024, to ensure that restricted or denied use of biomarker testing for the purposes of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes.

b. Compliance and filing requirements:

- Affirm the plan will cover medically necessary biomarker testing, subject to utilization review management.

- Affirm the plan will cover medically necessary biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions.

- Affirm the plan will cover biomarker tests that meet any of the following:

  - A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug.

  - A national coverage determination made by the Centers for Medicare and Medicaid Services.

  - A local coverage determination made by a Medicare Administrative Contractor for California.

  - Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit

most of their published articles for review by experts who are not part of the editorial staff.

- Standards set by the National Academy of Medicine.

- Affirm the plan will use the process described in Section 1363.5 to determine whether biomarker testing is medically necessary for the purposes of SB 496.

- Affirm the plan will provide biomarker testing in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

- Affirm the plan will ensure that restricted or denied use of biomarker testing for the purposes of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes.

- Provide any updated utilization management policies and procedures, as an Exhibit J-9, needed to demonstrate compliance with SB 496 and Section 1363.5.

- Provide any updated grievance policies and procedures, as an Exhibit W-1, needed to demonstrate compliance with SB 496.

- Provide updated EOCs to demonstrate compliance with SB 496.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and those documents are consistent with the requirements of SB 496.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and those documents are not consistent with the requirements of SB 496. The plan will amend these documents to comply with SB 496 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

14. SB 621 (Caballero, Ch. 495, Stats. 2023)—Health Care Coverage: Biosimilar Drugs

Codified in Section 1367.206.

a. Overview of the bill:

- Applies to all plans[7] that provide prescription drug coverage.
- Allows plans to require an enrollee to try an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, before providing coverage for the equivalent branded prescription drug.
- Explains that the requirement set forth in the bullet point above does not allow the plan to prohibit or supersede a step therapy request as described in Section 1367.206(b).

b. Compliance and filing requirements:

- If the plan requires an enrollee to try an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, before providing coverage for the equivalent branded prescription drug, affirm the plan will not prohibit or supersede a step therapy exception request as described in Section 1367.206(b).
- Submit the plan's Utilization Management Policies & Procedures with respect to drugs covered under the outpatient drug benefit or the medical benefit, as an Exhibit J-9, regarding requests for a step therapy exception pursuant to Sections 1367.206 and 1367.241, to demonstrate compliance with SB 621.
- State either:
    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, Disclosure Forms, EOCs, formularies, and those documents are consistent with the requirements of SB 621.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, Disclosure Forms, EOCs, and formularies, and those documents are not consistent with

[7] Section 1367.206 neither expands nor limits the coverage of prescription drugs required under Medi-Cal Managed Care contracts.

the requirements of SB 621. The plan will amend these documents to comply with SB 621 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

15. SB 786 (Portantino, Ch. 414, Stats. 2023)—Prescription Drug Pricing

Codified in Health and Safety Code §§ 127470 and 127471.

a. Overview of the bill:

- Applies to all plans that contract with PBMs. Excludes Medi-Cal products.
- Prohibits PBMs, on or after January 1, 2024, from imposing any requirements, conditions, or exclusions that:
  - Discriminate[8] against a covered entity[9] or a specified pharmacy[10] in connection with dispensing covered drugs[11].
  - Prevent a covered entity from retaining the benefit of discounted price for purchasing covered drugs.

b. Compliance and filing requirements:

- If a plan contracts with a PBM, affirm the plan's contract with the PBM will not discriminate against a covered entity or a specified pharmacy in connection with dispensing covered drugs.
- If a plan contracts with a PBM, affirm the plan's contract with the PBM will not prevent a covered entity from retaining the benefit of discounted price for purchasing covered drugs.
- Submit any revisions needed to the plan's PBM contract for compliance with SB 786 as an Exhibit N-1.
- State either:

[8] *See* Health and Safety Code § 127471(b) for types of prohibited discrimination.
[9] *See* Health and Safety Code § 127470(b) for the definition of "covered entity".
[10] *See* Health and Safety Code § 127470(d) for the definition of "specified pharmacy".
[11] *See* Health and Safety Code § 127470(a) for the definition of "covered drug".

- The plan reviewed its ASAs and PBM contracts, and those documents are consistent with the requirements of SB 786.

OR

- The plan reviewed its ASAs and PBM contracts, and those documents are not consistent with the requirements of SB 786. The plan will amend these contracts to comply with SB 786 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

16. SB 805 (Portantino, Ch. 635, Stats. 2023)—Health Care Coverage: Pervasive Developmental Disorders or Autism.

Codified in Health & Safety Code § 1374.73.

a. Overview of the bill:

- Applies to all plans that provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Excludes Medi-Cal products.

- Requires plans that provide coverage for behavioral health treatment for pervasive developmental disorder or autism to expand the criteria for a qualified autism service professionals to include psychological associates, associate marriage and family therapists, associate clinical social workers, or associate professional clinical counselors, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

- Requires that qualified autism service professionals who are psychological associates, associate marriage and family therapists, associate clinical social workers, or associate professional clinical counselors will also meet the criteria set forth in the regulations adopted on or before July 1, 2026 pursuant to Welfare & Institutions Code § 4686.4 for a Behavioral Health Professional.

b. Compliance and filing requirements:

- Further guidance regarding the requirements for this new law will be forthcoming and issued under a separate communication to the plans once the regulations noted in Welfare & Institutions Code § 4686.4 have been adopted.

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