From: DMHC Licensing eFiling

Subject: APL 24-023 (OPL) - Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)

Date: Friday, December 20, 2024 8:44 AM

Attachments: APL 24-023 (OPL) - Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session) (12.20.2024).pdf

Dear Health Plan Representative:

The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) 24-023, which outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: December 20, 2024

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 24-023 (OPL) - Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)

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, 2]

In this APL, the Office of Plan Licensing (OPL) identifies and discusses 23 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. Please note the summaries below do not address every aspect of the bill. 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 2024 Legislation Amendment filing.
[2] This APL applies to Medi-Cal plans unless specifically indicated below.

Compliance with Newly Enacted Statutes

Unless otherwise indicated below, please submit by March 21, 2025, one filing to demonstrate or affirm compliance with all newly enacted statutory requirements discussed in this APL.

- Submit the filing[3] via eFiling as an **Amendment** titled "**Compliance with 2024 Legislation.**"

- In the Compliance with 2024 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)[4] and other applicable laws[5]. For example, plans in Covered California must file 2026 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 1842 (Reyes, Ch. 633, Stats. 2024)—Medication-assisted treatment

Codified in Health and Safety Code § 1342.75.

a. Overview of the bill:

[3] 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.
[4] 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.
[5] Nothing in this APL shall be construed to require the plan to cover services beyond what is required pursuant to the Act and Rules.

- Applies to plans offering an outpatient prescription drug benefit for the treatment of mental health and substance use disorders. Excludes Medi-Cal plans.

- Requires plans, by January 1, 2025, to provide coverage for at least one medication approved by the United States Food and Drug Administration (FDA) in each of the following categories without prior authorization, step therapy, or utilization review:

    - (1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.

    - (2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.

    - (3) A long-acting buprenorphine product.

    - (4) A long-acting injectable naltrexone product.

- Clarifies that Section 1342.75 does not prohibit a plan from selecting 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, to meet each of the categories described above.

b. Compliance and filing requirements:

- Affirm the plan will provide coverage for at least one medication approved by the FDA in each of the following categories without prior authorization, step therapy, or utilization review:

    - (1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.

    - (2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.

    - (3) A long-acting buprenorphine product.

    - (4) A long-acting injectable naltrexone product.

- Submit updated utilization management policies, as an Exhibit J-9, to demonstrate compliance with AB 1842 and Section 1367.22(a).

- State either:

    - The plan reviewed its policies and procedures, administrative service agreements (ASAs), Pharmacy Benefit Manager (PBM) contracts,

plan-to-plan contracts, Summaries of Benefits or other detailed cost sharing documents (collectively referred to as "SOBs"), Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 1842.

OR

- The plan reviewed its policies and procedures, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 1842. The plan will amend these documents to comply with AB 1842 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 1936 (Cervantes, Ch. 815, Stats. 2024)—Maternal Mental Health Screenings

Codified in Health and Safety Code § 1367.625.

a. Overview of the bill:

- Applies to all plans that cover mental health services. Applies to Medi-Cal plans to the extent that the Department of Health Care Services obtains any necessary federal approvals.

- Requires, by January 1, 2025, a plan's existing maternal mental health program to consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider.

b. Compliance and filing requirements:

- Affirm the plan's existing maternal mental health program, by January 1, 2025, will consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider.

- Describe how the plan will incorporate the required screenings into its existing maternal mental health program.

- Submit any updated policies and procedures, as an Exhibit J-9, needed to demonstrate compliance with AB 1936.

- Describe how the plan will inform relevant medical providers of the new screening requirements. Submit any provider notices, as an Exhibit I-7, to demonstrate notification of such requirements to relevant medical providers.

- State either:

    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 1936.

OR

    - The plan reviewed its policies and procedures, provider notices, provider contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 1936.The plan will amend these documents to comply with AB 1936 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.

3. AB 2063 (Maienschein, Ch. 818, Stats. 2024)—Health Care Coverage

Codified in Health and Safety Code § 1343.3.

a. Overview of the bill:

- Applies to the participant in the Southern California pilot program who has submitted an application and received approval from the DMHC in accordance with Section 1343.3.

- Limits the authority of the pilot program to the existing program in Southern California, whereby risk-bearing providers may undertake risk-bearing arrangements with a Voluntary Employee's Beneficiary Association.

- Extends the pilot program's sunset date from December 31, 2025 to December 31, 2027.

- Extends the DMHC's deadline from January 1, 2027 to January 1, 2029 to submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot program compared to fee-for-service payment models, including data on enrollee satisfaction, consumer and provider grievances, appeals, and independent medical reviews.

- Extends the sunset date of Section 1343.3 from January 1, 2028 to January 1, 2030.

b. Compliance and filing requirements:

- This bill does not require a filing with the DMHC at this time. Further guidance regarding ongoing compliance and other specific filing requirements may be forthcoming and issued under a separate communication.

4. AB 2072 (Weber, Ch. 374, Stats. 2024)—Group Health Care Coverage: Biomedical Industry

Codified in Health and Safety Code § 1357.503.

a. Overview of the bill:

- Applies to plans that offer fully insured benefits to a registered multiple employer welfare arrangement (MEWA) through a large group health care service plan contract.

- Extends the sunset date from January 1, 2026, to January 1, 2030, for an association of employers that is the sponsor of a MEWA to offer a large group health plan contract to small group employer members that met the criteria set forth under Section 1357.503.

- Requires the DMHC, by June 30, 2026, to submit evidence demonstrating ongoing compliance by an association and MEWA to the Legislature in accordance with Government Code Section 9795.

- Requires the DMHC to conduct an analysis of the impacts on the small employer health insurance market in California of plans currently issuing large group contracts to small employers through MEWAs. Plans and MEWAs must comply with the DMHC's requests for information to complete this analysis. The bill permits coordination between the California Department of Insurance and the DMHC. The DMHC may also contract with consultants with expertise to assist the DMHC with its analysis. By July 1, 2026, the DMHC is required to post on its website a report summarizing the analysis.

b. Compliance and filing requirements:

- This bill does not require a filing with the DMHC at this time. Further guidance regarding how plans must demonstrate ongoing compliance and other specific filing requirements may be forthcoming and issued under a separate communication to the plans.

5. AB 2105 (Lowenthal, Ch. 822, Stats. 2024)—Coverage for PANDAS and PANS

Codified in Health and Safety Code § 1367.38.

a. Overview of the bill:

- Applies to plans that cover pediatric benefits. Excludes dental plans and vision plans.

- Requires plans' health care service plan contracts issued, amended, or renewed on or after January 1, 2025, to provide coverage for prophylaxis, diagnosis, and treatment for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature.

- Requires covered treatment for PANDAS/PANS to include antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

- Prohibits coverage for PANDAS/PANS from being subject to a copayment, coinsurance, deductible, or other cost-sharing that is greater than that applied to other benefits provided by the contract.

- If an authorization is required for PANDAS/PANS prophylaxis, diagnosis, or treatment, that authorization is to be provided in a timely manner that is appropriate for the severity of the enrollee's condition pursuant to Section 1367.03.

- Prohibits plans from denying or delaying coverage for PANDAS/PANS therapies because the enrollee previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the enrollee was diagnosed with or received treatment for their condition under a different diagnostic name, including autoimmune encephalopathy.

- Prohibits plans from limiting coverage of immunomodulating therapies for PANDAS/PANS in a manner that is inconsistent with the treatment recommendations pursuant to Section 1367.38(d) or requiring a trial of

therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies.

- Requires coverage for PANDAS/PANS to adhere to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

- Requires PANDAS/PANS to be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services create and assign a specific code or codes for PANDAS/PANS. After the creation of that code or codes, PANDAS/PANS may be coded as autoimmune encephalitis, PANDAS, or PANS. If PANDAS or PANS is known by a different common name in the future, it may be coded under that name and this section shall apply to that disorder or syndrome.

b. Compliance and filing requirements:

- Affirm the plan will provide coverage for prophylaxis, diagnosis, and treatment for PANDAS/PANS that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature.

- Affirm the plan will cover PANDAS/PANS treatment, which will include antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

- Affirm the plan's coverage for PANDAS/PANS will not be subject to a copayment, coinsurance, deductible, or other cost-sharing that is greater than that applied to other benefits provided by the contract.

- If the plan requires authorization for PANDAS/PANS prophylaxis, diagnosis, or treatment, affirm the plan will authorize PANDAS/PANS prophylaxis, diagnosis, or treatment to be provided in a timely manner that is appropriate for the severity of the enrollee's condition pursuant to Section 1367.03.

- Affirm the plan will not deny or delay coverage for PANDAS/PANS therapies because the enrollee previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the enrollee was diagnosed with or received treatment for their condition under a different diagnostic name, including autoimmune encephalopathy.

- Affirm the plan will not limit coverage of immunomodulating therapies for PANDAS/PANS in a manner that is inconsistent with the treatment recommendations pursuant to Section 1367.38(d) nor require a trial of

therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies.

- Affirm the plan will provide coverage for PANDAS/PANS that adheres to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

- Affirm that PANDAS/PANS will be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services create and assign a specific code or codes for PANDAS/PANS.

- Affirm that after the creation of the code or codes by the American Medical Association and the federal Centers for Medicare and Medicaid Service, PANDAS/PANS will be coded as autoimmune encephalitis, PANDAS, or PANS.

- Affirm that if PANDAS or PANS is known by a different common name in the future, it will be coded under that name and the Plan will apply Section 1367.38 to that disorder or syndrome.

- Submit updated utilization management policies and procedures, as an Exhibit J-9, to demonstrate compliance with AB 2105.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 2105.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 2105. The plan will amend these documents to comply with AB 2105 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 2129 (Petrie-Norris, Ch. 950, Stats. 2024)—Immediate Postpartum Contraception

Codified in Health and Safety Code § 1367.627.

a. Overview of the bill:

- Applies to plans that cover maternity benefits.
- Requires a contract issued, amended, or renewed on or after January 1, 2025, between a plan and a health care provider to authorize a provider to separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center.
- Prohibits provider contracts from considering such devices, implants, or services to be part of a payment for a general obstetric procedure.
- Clarifies that "immediate postpartum contraception" means the postpartum insertion of intrauterine devices or contraceptive implants performed before the enrollee is discharged from the general acute care hospital or licensed birth center and includes the devices or implants themselves.
- Clarifies that Section 1367.627 does not affect an enrollee's right to directly access women's health care services, including contraceptive services, and informed consent.

b. Compliance and filing requirements:

- Affirm the plan will authorize a health care provider to separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception, if the birth takes place in a general acute care hospital or licensed birth center.
- Affirm the plan will not consider such devices, implants, or services to be part of a payment for a general obstetric procedure.
- Submit updated claims policies and procedures, as an Exhibit II-4, to demonstrate compliance with AB 2129.
- Submit updated boilerplate provider contracts, as an Exhibit K, to demonstrate compliance with AB 2129.
- Provide an explanation regarding how the plan intends on revising its existing provider contracts, upon amendment or renewal, to demonstrate compliance with AB 2129.

- 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 AB 2129.

    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 AB 2129. The plan will amend these documents to comply with AB 2129 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 2198 (Flora, Ch. 386, Stats. 2024)—Health Information

Codified in Health and Safety Code § 1374.196.

a. Overview of the bill:

- Applies to all plans.

- Supersedes the establishment and implementation date of application programming interfaces (API) set forth in SB 1419 (Becker, Ch. 888, Stats. 2022) under APL 22-031 and APL 23-022.

- Amends the effective date that a plan must establish and maintain patient access API, provider access API, payer-to-payer API, and prior authorization API to January 1, 2027, or when final federal rules are implemented, whichever occurs later.

- Permits the Director, until January 1, 2027, to issue guidance to plans regarding compliance with Section 1374.196.

b. Compliance and filing requirements:

- Further guidance regarding the requirements for this new law will be forthcoming and issued under a separate communication once the final federal rules are implemented.

8. AB 2258 (Zbur, Ch. 708, Stats. 2024)—Health Care Coverage: Cost Sharing

Codified in Health and Safety Code § 1367.002.

a. Overview of the bill:

- Applies to all plans[6]. Excludes specialized plans that do not cover an Essential Health Benefit (EHB) and Medi-Cal plans.

- Prohibits plans' health care service plan contracts issued, amended, or renewed on or after January 1, 2025, from imposing any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is set forth in Section 1367.002(a)(1)-(4), regardless of whether or not the integral item or service is billed separately from an item or service required by Section 1367.002.

- Prohibits plans from imposing cost sharing for office visits associated with a preventive care service described in Section 1367.002 if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

- Requires plans to cover items and services in accordance with applicable requirements, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

- Does not prohibit plans from: (1) providing coverage for preventive items or services in addition to those required by Section 1367.002(a); or (2) denying coverage for services that are not recommend by the U.S. Preventive Services Task Force, except as provided in Section 1367.002(d).

b. Compliance and filing requirements:

- Affirm the plan will not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is set forth in Section 1367.002(a)(1)-(4), regardless of whether the integral item or service is billed separately from a required item or service.

- Affirm the plan will not impose cost sharing for office visits associated with a preventive care service described in Section 1367.002 if the preventive care service is not billed separately, or is not tracked as an individual encounter

[6] Applies to health savings account-eligible health care service plans (HSA plans) to the extent an HSA plan does not fail to be treated as a high deductible health plan (HDHP) under Section 223 of Title 26 of the United States Code.

separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

- Affirm the plan will cover items and services in accordance with applicable requirements, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 2258.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 2258. The plan will amend these documents to comply with AB 2258 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 2434 (Grayson, Ch. 398, Stats. 2024)—Health Care Coverage: Multiple Employer Welfare Arrangements (Engineering, Surveying or Design Industry)

Codified in Health and Safety Code § 1357.505.

a. Overview of the bill:

- Permits an association of employers to offer a large group plan to small group employer members of the association, consistent with ERISA, if the large group health care service plan contract includes coverage of common law employees, and their dependents, who are employed by an association member in the engineering, surveying, or design industry and whose employer has operations in California.

b. Compliance and filing requirements:

- This bill does not require a filing with the DMHC at this time. For further questions, email mewa.registration@dmhc.ca.gov.

10. AB 2435 (Maienschein, Ch. 236, Stats. 2024)—California Health Benefit Exchange

Codified in Government Code § 100504.

a. Overview of the bill:

- Extends Covered California's emergency rulemaking authority included in AB 133 (Committee on Budget, Ch. 143, Stats. 2021). Specifically, the authority of the Covered California Executive Board to adopt necessary rules and regulations in accordance with the Administrative Procedure Act, except those implementing Section 1043, as emergency regulations is extended until January 1, 2030.

- Permits the Office of Administrative Law to approve more than two readoptions of an emergency regulation adopted pursuant to this section until January 1, 2035.

- Applies the extensions to a regulation adopted before 2025.

b. Compliance and filing requirements:

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

11. AB 2556 (Jackson, Ch. 200, Stats. 2024)—Behavioral Health and Wellness Screenings: Notice.

Codified in Health and Safety Code § 1368.017.

a. Overview of the bill:

- Applies to all plans that cover mental health benefits. Excludes Medi-Cal plans.

- Requires plans, by January 1, 2025, to provide a written or electronic notice to enrollees regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.

- Requires the notice to provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.

- Requires plans to provide the notice annually.

b. Compliance and filing requirements:

- Affirm the plan will provide a written or electronic notice to enrollees regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.

- Affirm the notice will provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.

- Affirm the plan will provide the notice annually.

- Provide an explanation as to how the plan will provide the required annual written or electronic notice to enrollees.

- State either:

    - The plan reviewed its policies and procedures, enrollee notices, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 2556.

OR

    - The plan reviewed its policies and procedures, enrollee notices, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 2556. The plan will amend these documents to comply with AB 2556 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. AB 2749 (Wood, Ch. 841, Stats. 2024)—California Health Benefit Exchange: Financial Assistance

Codified under Government Code § 100523.

a. Overview of the bill:

- Changes the prior "prospective enrollee" terminology to "qualified individual" for purposes of the financial assistance program offered through Covered California and clarifies that the income threshold for individuals receiving subsidies is a "household income".

- Provides that an individual is a qualified individual for purposes of financial assistance if all of the following are met: (1) the individual loses minimum essential coverage from an employer as a result of a strike, lockout or labor

dispute; (2) the employer that provided the minimum essential coverage to the individual is involved in the strike, lockout, or labor dispute; and (3) the individual provides a self-attestation confirming that they lost minimum essential coverage from an employer as a result of a strike, lockout, or labor dispute, and that the employer that provided them the minimum essential coverage is involved in the strike, lockout, or labor dispute.[7]

- Provides that the effective date of coverage is the first day of the month of application submission and plan selection or the first day of the following month, at the discretion of the qualified individual.

- Provides that, upon resolution of a strike, lockout, or labor dispute, an individual shall no longer be eligible for financial assistance when the Exchange verifies that employer-provided minimum essential coverage from the employer has been reinstated for that individual and dependents and only after prior notification to the qualified individual of loss of financial assistance.

- Requires an employer or labor organization[8] to notify the Exchange before employer-provided coverage is affected by a strike, lockout, or labor dispute. Permits the Exchange to contact an employer, labor organization, or other appropriate representative to determine the status of a strike, lockout, or labor dispute, its impact to coverage, and any other information necessary to determine eligibility for financial assistance.

b. Compliance and filing requirements:

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

13. AB 2767 (Santiago, Ch. 116, Stats. 2024)—Financial Solvency Standards Board: Membership

Codified in Health and Safety Code § 1347.15.

a. Overview of the bill:

- Requires the DMHC's Financial Solvency Standards Board (FSSB) to consist of 11 members, including 10 members appointed by the Director.

- Permits the 10 members of the FSSB appointed by the Director to include health care consumer advocates and individuals with training and experience in large group health insurance purchasing.

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[7] *See* Government Code § 100523(g)(2), (4) and (5) for the definitions of "labor dispute," "lockout" and "strike".
[8] *See* Government Code § 100523(g)(3) for the definition of "labor organization".

b. Compliance and filing requirements:

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

14. AB 2843 (Petrie-Norris, Ch. 971, Stats. 2024)—Health Care Coverage: Rape and Sexual Assault

Codified in Health and Safety Code § 1367.37.

a. Overview of the bill:

- Applies to all plans. Excludes specialized plans.
- Requires plans' health care service plan contracts issued, amended, or renewed on or after July 1, 2025, to provide coverage for emergency room medical care and follow-up health care treatment for an enrollee who is treated following a rape or sexual assault[9] without imposing cost sharing for the first nine months after the enrollee initiates treatment.[10] "Follow-up health care treatment" includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault.
- Provides that the waiver of cost sharing only applies if the enrollee's treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault.
- Prohibits plans from requiring any of the following to provide the required coverage: (1) an enrollee to file a police report on the rape or sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault.
- Provides that enrollees are not authorized to receive follow-up health care treatment furnished by a nonparticipating provider, with the exception of the following: (1) plans are required to arrange for the provision of follow-up health care treatment from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03; and (2) a plan shall cover follow-up health care treatment that is for emergency services and care as defined in Section 1317.1.

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[9] *See* Penal Code §§ 261, 261.6, 263, 263.1, 286, 287 and 288.7 for the definitions of "rape" and "sexual assault".

[10] For a health care service plan contract that meets the definition of a HDHP set forth in Section 223(c)(2) of Title 26 of the United States Code, the requirements of AB 2843 only apply once an enrollee's deductible has been satisfied for the year.

- Provides the required coverage is considered a sensitive service provided to a protected individual as defined in Civil Code Section 56.05 and pursuant to Civil Code Section 56.107.

b. Compliance and filing requirements:

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will provide coverage for emergency room medical care and follow-up health care treatment for enrollees who are treated following a rape or sexual assault without imposing cost sharing for the first nine months after enrollees initiate treatment.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will apply the waiver of cost sharing if the enrollee's treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will not require any of the following to provide the required coverage: (1) an enrollee to file a police report on the rape or sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will arrange and provide coverage for the provision of follow-up health care treatment from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will cover follow-up health care treatment furnished by a nonparticipating provider if those services are for emergency services and care as defined in Section 1317.1.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will treat the required coverage as coverage of sensitive services provided to a protected individual as defined in Civil Code Section 56.05 and pursuant to Civil Code Section 56.107.

- Affirm the plan has evaluated the implications of the new requirements set forth in AB 2843 with respect to MHPAEA and that the plan complies with MHPAEA. If the plan is unable to make the affirmation, explain how the plan will ensure that it complies with AB 2843 and MHPAEA.

- Explain how the plan will ensure coverage is provided for emergency room medical care and follow-up health care treatment for enrollees who are treated following a rape or sexual assault without imposing cost sharing for

the first nine months after the enrollees initiate treatment, including, but not limited to, the following: (1) how providers will notify the plan that emergency room medical care and follow-up health care treatment were provided following a rape or sexual assault; (2) how providers will be informed of the meaning of "follow-up health care treatment" set forth in AB 2843, as well as the definitions of "rape" and "sexual assault" as specified in Penal Code Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7; and (3) how the plan will track relevant care for the required nine month period after an enrollee initiates treatment.

- Provide any policies and procedures, as an Exhibit J-27, regarding the steps the plan will take to ensure coverage is provided for emergency room medical care and follow-up health care treatment for enrollees who are treated following a rape or sexual assault without imposing cost sharing for the first nine months after the enrollees initiate treatment, including, but not limited to, the following: (1) how providers will notify the plan that emergency room medical care and follow-up health care treatment were provided following a rape or sexual assault; (2) how providers will be informed of the meaning of "follow-up health care treatment" set forth in AB 2843, as well as the definitions of "rape" and "sexual assault" as specified in Penal Code Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7; and (3) how the plan will track relevant care for the required nine month period after an enrollee initiates treatment.

- Provide the plan's revised claims processing policies and procedures, as an Exhibit II-4, to demonstrate compliance with AB 2843.

- Provide the plan's revised utilization management policies and procedures, as an Exhibit J-9, to demonstrate compliance with AB 2843, including the application of the nine-month coverage period and the prohibition of any conditions on coverage related to the filing of a police report, criminal charges against an assailant, or the conviction of an offense.

- Provide any policies and procedures, as an Exhibit I-6, regarding the steps the plan will take for arranging follow-up health care treatment from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services for enrollees.

- Provide any template notices, as an Exhibit I-7, that the plan will send to providers to inform them of the prohibition against imposing cost-sharing pursuant to AB 2843.

- Provide any notices, as an Exhibit I-7, that the plan will send to noncontracting providers in arranging for the provision of follow-up health care treatment, as set forth in AB 2843, from providers outside the plan's network when those services are unavailable within the network.

- Submit updated SOBs, Disclosure Forms, and EOCs as Exhibits Q, S, T, and/or U to demonstrate compliance with AB 2843.

- Provide any revisions to the following needed to demonstrate compliance with the requirements of AB 2843: (1) provider contracts, as an Exhibit K-1; (2) ASAs, as an Exhibit N-1; (3) and plan-to-plan agreements, as an Exhibit P-5.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, provider notices, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of AB 2843.

OR

    - The plan reviewed its policies and procedures, provider contracts, provider notices, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of AB 2843. The plan will amend these documents to comply with AB 2843 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. AB 3059 (Weber, Ch. 975, Stats. 2024)—Human Milk

Codified in Health and Safety Code §§ 1367.624, 1635.1 and 1648

a. Overview of the bill:

- Applies to all plans that cover basic health care services.

- Specifies that the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) is a basic health care service.

b. Compliance and filing requirements:

- Affirm the plan will cover the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) as a basic health care service.

- 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 3059.

    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 3059. The plan will amend these documents to comply with AB 3059 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. AB 3221 (Pellerin, Ch. 760, Stats. 2024)—DMHC: Review of Records

Codified in Health & Safety Code §§ 1380, 1381 and 1386.

a. Overview of the bill:

- Applies to all plans, including EAP plans.

- Requires, effective January 1, 2025, all records, books and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or services to a plan, management company, solicitor, or solicitor firm to be open to inspection, including through electronic means, by the Director.

- Pursuant to a request by the Director to inspect the records, books, and papers, requires the plan, management company, solicitor, or solicitor firm, and a provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm to:

    - Furnish in electronic media records, books, and papers that are possessed in electronic means, and

    - Conduct a diligent review of the records, books, and papers and make every effort to furnish those responsive to the Director's request.

- Requires, to the greatest extent feasible, all records, books, and papers to be furnished in a format that is digitally searchable.

- Requires, if requested by the DMHC, all records, books and papers to be preserved until furnished.

- In connection with an investigation or action authorized by Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code, allows the Director to:

    - Inspect and copy records, books and papers, and

    - Seek relief from an administrative law proceeding if a plan, management company, solicitor, or solicitor firm, and a provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm fails to fully or timely respond to a duly authorized request for production or records, books, and papers.

- Clarifies that "records, books, and papers" include records, books, and papers that are possessed in any medium, including electronic media.

b. Compliance and filing requirements:

- Affirm all records, books and papers of the plan, the plan's contracted management company, solicitor, or solicitor firm, and any plan provider or subcontractor providing health care or services to the plan, will be open to inspection, including through electronic means, by the Director.

- Affirm, pursuant to a request by the Director to inspect the records, books, and papers, the plan, its contracted management company, solicitor, or solicitor firm, and any plan provider or subcontractor providing health care or services to the plan will:

    - Furnish in electronic media records, books, and papers that are possessed in electronic means, and

    - Conduct a diligent review of the records, books, and papers and make every effort to furnish those responsive to the Director's request.

- Affirm, to the greatest extent feasible, all records, books, and papers will be furnished in a format that is digitally searchable.

- Affirm, if requested by the DMHC, all records, books and papers will be preserved until furnished.

- Affirm that any description or definition of "records, books, and papers" contained in the plan's contracts will include records, books, and papers that are possessed in any medium, including electronic media.

- Submit boilerplate provider contracts, as an Exhibit K-1, ASAs, as an Exhibit N-1, plan-to-plan contracts, as an Exhibit P-5, and solicitor and broker agreements, as an Exhibit BB-2, demonstrating compliance with AB 3221.

- Provide an explanation regarding how the plan intends on revising its existing provider contracts, ASAs, plan-to-plan contracts, and solicitor and broker agreements to demonstrate compliance with AB 3221.

- State either:

    - The plan reviewed its provider contracts, ASAs, plan-to-plan contracts, and solicitor and broker agreements, and those documents are consistent with the requirements of AB 3221.

OR

    - The plan reviewed its provider contracts, ASAs, plan-to-plan contracts, and solicitor and broker agreements, and those documents are not consistent with the requirements of AB 3221. The plan will amend these documents to comply with AB 3221 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.

17. AB 3275 (Soria, Ch. 763, Stats. 2024)—Health Care Coverage: Claim Reimbursement

Codified in Health & Safety Code §§ 1371, 1371.34 and 1371.35.

a. Overview of the bill:

- Applies to all plans, including EAP plans.

- Requires plans, by January 1, 2026, to reimburse a complete claim or a portion thereof, whether in state or out of state, as soon as practicable, but no later than 30 calendar days after receipt of the claim.

- Requires plans, if a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, to notify the claimant, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after the receipt of the claim.

- Requires plans, if a complete claim is not reimbursed within 30 calendar days after the receipt, to pay interest at a rate of 15 percent per annum beginning with the first calendar day after the 30-day calendar period. Also, requires plans to automatically include in its payment of the claim all interest that has accrued without requiring the claimant to submit a request for the interest amount. Increases the penalty on plans for not automatically paying the interest owed on a claim from ten dollars to fifteen dollars or ten percent of the accrued interest on the claim.

- Requires plans to not contest claims consistent with the procedure or revenue codes and services approved by prior authorization, with appropriate documentation included on the claim.

- Requires plans, if a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof, to complete reconsideration of the claim within 30 calendar days after receipt of this additional information.

- Requires plans to treat complaints by an enrollee about a delay or denial of a payment of a claim as a grievance subject to that grievance process whether or not the enrollee uses “grievance” as part of the complaint.

b. Compliance and filing requirements:

- 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.

18. SB 339 (Weiner, Ch. 1, Stats. 2024)—HIV Preexposure Prophylaxis and Postexposure Prophylaxis

Codified in Health & Safety Code § 1342.74.

a. Overview of the bill:

- Applies to all plans that provide coverage for outpatient prescription drugs. Excludes Medi-Cal and specialized plans.

- Took immediate effect as an urgency statute on February 6, 2024.

- Requires plans to cover preexposure prophylaxis and postexposure prophylaxis that have been furnished by a pharmacist as authorized in Business and Professions Code Sections 4052.02 and 4052.03, including the pharmacist’s services and related testing ordered by the pharmacist.

- Requires plans to pay or reimburse for 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 pharmacy benefit.

b. Compliance and filing requirements:

- Affirm the plan covers preexposure prophylaxis and postexposure prophylaxis that have been furnished by a pharmacist as authorized in Business and Professions Code Sections 4052.02 and 4052.03, including the pharmacist's services and related testing ordered by the pharmacist.

- Affirm the plan will pay or reimburse for 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 pharmacy benefit.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, PBM contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 339.

OR

  - The plan reviewed its policies and procedures, provider contracts, PBM contracts, ASAs, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 339. The plan will amend these documents to comply with SB 339 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.

19. SB 729 (Menjivar, Ch. 930, Stats. 2024)—Health Care Coverage: Treatment for Infertility and Fertility Services

Codified in Health & Safety Code § 1374.55.

a. Overview of the bill:

- Applies to all plans that offer group products[11]. Excludes Medi-Cal plans and specialized plans.

- Requires plans' large group health care service plan contracts issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

- Requires plans' small group health care service plan contracts issued, amended, or renewed on or after July 1, 2025 to offer coverage for the diagnosis and treatment of infertility and fertility services.

- Requires plans to include a notice of infertility and fertility services in the plans' large group and small group EOC.

- Defines "infertility" as a condition or status characterized by any of the following:

    - A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.

    - A person's inability to reproduce either as an individual or with their partner without medical intervention.

    - The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

- Prohibits plans' health care service plan contracts that provide coverage for infertility and fertility services from:

[11] Compliance with Section 1374.55 for CalPERS products is effective July 1, 2027.

- Excluding, limiting, or otherwise restricting coverage of fertility medications that are different from those imposed on other prescription medications.

- Excluding or denying coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. "Third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

- Imposing any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility.

- Requires plans, consistent with Section 1365.5, to cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

b. Compliance and filing requirements:

- Affirm the plan's large group health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the ASRM, using single embryo transfer when recommended and medically appropriate.

- Affirm the plan's small group health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will offer coverage for the diagnosis and treatment of infertility and fertility services.

- Affirm the plan's large group and small group EOCs issued, amended, or renewed on or after July 1, 2025, include a notice of infertility and fertility services.

- Affirm that the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will define "infertility" as a condition or status characterized by any of the following:

  - A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. Note: This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.

- A person's inability to reproduce either as an individual or with their partner without medical intervention.

- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

- Affirm the plan's large group and small group health care service plan contracts issued, amended, or renewed on or after July 1, 2025 that provide coverage for infertility and fertility services will not:

  - Exclude, limit, or otherwise restrict coverage of fertility medications that are different from those imposed on other prescription medications.

  - Exclude or deny coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. "Third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

  - Impose any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility.

- Affirm the plan's large group and small group health care service plan contracts issued, amended, or renewed on or after July 1, 2025, consistent with Section 1365.5, will cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

- Submit the plan's revised EOCs, Disclosure Forms and any other enrollee disclosure documents utilized in connection with its large group products that discuss the plan's coverage of infertility and fertility services and demonstrate compliance with SB 729.

- Submit the plan's revised EOCs, Disclosure Forms, supplemental benefit riders and any other enrollee disclosure documents utilized in connection with its small group products that discuss the plan's offer for coverage of infertility and fertility services and demonstrate compliance with SB 729.

- Identify the page numbers in the plan's large group and small group EOCs, that include coverage for infertility and fertility services, where a notice of infertility and fertility services can be located.

- Explain how the plan will not exclude, limit, or otherwise restrict coverage of fertility medications that are different from those imposed on other prescription medications. Specify which plan documents, along with page numbers within the specified documents, support the plan's explanation.

- Explain how the plan will not exclude or deny coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. Specify which plan documents, along with page numbers within the specified documents, support the plan's explanation.

- Explain how the plan will not impose any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility. Specify which plan documents, along with page numbers within the specified documents, support the plan's explanation.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, EOCs, and Formularies, and those documents are consistent with the requirements of SB 729.

    OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, EOCs, and Formularies, and those documents are not consistent with the requirements of SB 729. The plan will amend these documents to comply with SB 729 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.

20. SB 1120 (Becker, Ch. 879, Stats. 2024)—Health Care Coverage: Utilization Review

Codified in Health & Safety Code § 1367.01.

a. Overview of the bill:

- Applies to all plans that conduct utilization management, including Medi-Cal plans to the extent that the Department of Health Care Services obtains the necessary federal approvals[12] and EAP plans.

- Requires plans, by January 1, 2025, that use an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, or that contract with or otherwise work through an entity that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, to ensure all of the following:

    - The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:

        - An enrollee's medical or other clinical history,

        - Individual clinical circumstances as presented by the requesting provider,

        - Other relevant clinical information contained in the enrollee's medical or other clinical record.

    - The artificial intelligence, algorithm, or other software tool does not base its determination solely on a group dataset.

    - The artificial intelligence, algorithm, or other software tool's criteria and guidelines complies with applicable state and federal law.

    - The artificial intelligence, algorithm, or other software tool does not supplant health care provider decision making.

    - The use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against enrollees in violation of state or federal law.

    - The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services.

[12] At the time of publication of this APL, the Department of Health Care Services (DHCS) has not yet obtained the necessary federal approvals. Therefore, Medi-Cal plans will not be required to demonstrate compliance with this bill until further notice from DMHC that DHCS has obtained the necessary federal approvals.

- The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the DMHC pursuant to Section 1381.

- Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in the written policies and procedures.

- The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.

- Patient data is not used beyond its intended and stated purpose, consistent with the Confidentiality of Medical Information Act and the federal Health Insurance Portability and Accountability Act of 1996, as applicable.

- The artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to the enrollee.

- Prohibits plans from having the artificial intelligence, algorithm, or other software tool deny, delay, or modify health care services based, in whole or in part, on medical necessity. Requires denials, delays and/or modifications of medical necessity determinations to be made only by a licensed physician or a licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances.

- Requires plans to comply with applicable federal rules and guidance issued by the federal Department of Health and Human Services regarding the use of artificial intelligence, algorithm, or other software tools.

b. Compliance and filing requirements:

- Explain if the plan or its contracted entities or entities it otherwise works through utilize an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, or contracts with or otherwise works through an entity that use an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity. If so, provide the following affirmations:

  - Affirm the plan will ensure all the following:

- The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:
    - An enrollee's medical or other clinical history,
    - Individual clinical circumstances as presented by the requesting provider,
    - Other relevant clinical information contained in the enrollee's medical or other clinical record.
- The artificial intelligence, algorithm, or other software tool does not base its determination solely on a group dataset.
- The artificial intelligence, algorithm, or other software tool's criteria and guidelines complies with applicable state and federal law.
- The artificial intelligence, algorithm, or other software tool does not supplant health care provider decision making.
- The use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against enrollees in violation of state or federal law.
- The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services.
- The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the DMHC pursuant to Section 1381[13].
- Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in the written policies and procedures.
- The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.
- Patient data is not used beyond its intended and stated purpose, consistent with the Confidentiality of Medical

[13] This bullet does not apply to the artificial intelligence, algorithm, or other software tool utilized by the nonprofit associations (1) listed in Rule 1300.74.721(c) and (2) which the plan has filed and been approved to use.

Information Act and the federal Health Insurance Portability and Accountability Act of 1996, as applicable.

- The artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to the enrollee.

- Affirm (a) the plan will not have the artificial intelligence, algorithm, or other software tool deny, delay, or modify health care services based, in whole or in part, on medical necessity[11] and (b) any denials, delays and/or modifications of medical necessity determinations will be made only by a licensed physician or a licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances.

- Affirm the plan will comply with applicable federal rules and guidance issued by the federal Department of Health and Human Services regarding the use of artificial intelligence, algorithm, or other software tools.

- Explain in what capacity the plan utilizes an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity. This bullet does not apply to the artificial intelligence, algorithm, or other software tool utilized by the nonprofit associations (1) listed in Rule 1300.74.721(c) and (2) which the plan has filed and been approved to use.

- Identify the plan's contracted entities or entities it otherwise works through that use an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity. Explain in what capacity the entities identified by the plan use an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, on the plan's behalf. This bullet does not apply to the artificial intelligence, algorithm, or other software tool utilized by the nonprofit associations (1) listed in Rule 1300.74.721(c) and (2) which the plan has filed and been approved to use.

- Submit the plan's updated utilization management policies and procedures, as an Exhibit J-9, to demonstrate compliance with SB 1120.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure

Forms, EOCs, and Formularies, and those documents are consistent with the requirements of SB 1120.

OR

- The plan reviewed its policies and procedures, provider contracts, ASAs, plan-to-plan contracts, PBM contracts, SOBs, Disclosure Forms, EOCs, and Formularies, and those documents are not consistent with the requirements of SB 1120. The plan will amend these documents to comply with SB 1120 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.

21. SB 1180 (Ashby, Ch. 884, Stats. 2024)—Health Care Coverage: Emergency Medical Services

Codified in Health & Safety Code § 1371.51.

a. Overview of the bill:

- Applies to all plans that cover mental health and substance use disorder services. Applies to Medi-Cal plans to the extent that the Department of Health Care Services obtains any necessary federal approvals.

- Requires plans' health care service plan contracts issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.

- Prohibits plans from requiring enrollees who receive covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay more than the in-network cost sharing amount for the same covered services received from a contracting community paramedicine program, triage to alternate destination program.

- Prohibits plans from adopting reimbursement rates that exceed the plan's usual and customary charges for services rendered.

b. Compliance and filing requirements:

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will not require enrollees who receive covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay more for the same covered services received from a contracting community paramedicine program, triage to alternate destination program.

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will not adopt reimbursement rates that exceed the plan's usual and customary charges for services rendered.

- Submit the plan's revised SOBs, Disclosure Forms and/or EOCs to disclose to enrollees the plan will not require enrollees who receive covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay more than the in-network cost sharing amount for the same covered services received from a contracting community paramedicine program, triage to alternate destination program, or mobile integrated health program.

- Submit the plan's revised claims policies and procedures, as an Exhibit II-4, to demonstrate compliance with SB 1180.

- 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 SB 1180.

    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 SB 1180. The plan will amend these documents to comply with SB 1180 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.

22. SB 1320 (Wahab, Ch. 135, Stats. 2024)—Mental Health and Substance Use Disorder Treatment

Codified in Health & Safety Code § 1374.725.

a. Overview of the bill:

- All plans that cover mental health and substance use disorder treatment services. Excludes Medi-Cal plans.

- Requires plans' health care service plan contracts issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services.

b. Compliance and filing requirements:

- Affirm the plan's health care service plan contracts issued, amended, or renewed on or after July 1, 2025, will establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services.

- Submit the plan's revised claims policies and procedures setting forth the plan's process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services, as an Exhibit II-4, to demonstrate compliance with SB 1320. If the plan is basing its processes upon federal rules or guidance issued for the Medicare program, please specify the federal rules or guidance issued for the Medicare program the plan is using as a basis for its processes.

- If the plan contracts with another plan for the provision of mental health and substance use disorder treatment services, explain (1) which plan will be responsible for reimbursement of the provision of mental health and substance use treatment services that are integrated with primary care services, (2) how the provision of mental health and substance use disorder treatment services that are integrated with primary care services will be communicated between plans, and (3) if the plan-to-plan contract needs to be amended to reflect who is responsible for reimbursement of the provision of mental health and substance use treatment services that are integrated with primary care services.

- 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 1320.

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 1320. The plan will amend these documents to comply with SB 1320 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.

23. SB 1511 (Committee on Health, Ch. 492, Stats. 2024)—Health Omnibus

Codified in Health & Safety Code §§ 1345 and 1367.39.

a. Overview of the bill:

- Applies to all plans, including EAPs.

- Clarifies that the definition of "group contract" means a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group. Reference to a "group" does not include a Medi-Cal managed care contract between a plan and the Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.

- Renumbers Section 1367.34 to Section 1367.39.

b. Compliance and filing requirements:

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

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