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ALL PLAN LETTER

DATE: September 18, 2025

TO: All Full Service Health Plans[1]

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 25-015: Assembly Bill 144 and Coverage of Preventive Care Services

On September 17, 2025, Governor Gavin Newsom signed Assembly Bill 144, to ensure California enrollees can continue to access necessary preventive care services. AB 144 directs health plans to cover preventive care items and services, including immunizations, if such care was recommended by existing federal bodies (e.g., the CDC) as of January 1, 2025, or is recommended by the California Department of Public Health (CDPH).

This APL outlines the obligations of health plans to cover preventive care items and services prior to enactment of AB 144 and summarizes AB 144's new requirements regarding coverage of preventive care items and services. The APL also highlights recent recommendations by CDPH regarding immunizations to protect against COVID-19, RSV, and influenza.

I. Background

A. State law requirements prior to AB 144

Health and Safety Code sections 1342.2, 1342.3, and 1367.002 require health plans to cover preventive care items and services that have an "A" or "B" recommendation from the United States Preventive Services Task Force (USPSTF). Likewise, those sections require plans to cover immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal Centers for Disease Control and Prevention (CDC). These coverage requirements include preventive care items and services, including immunizations, to prevent or mitigate COVID-19 or any other disease for which the Governor has declared a public health emergency. Plans must cover such services without cost-sharing or utilization management.

[1] The APL applies to all full-service commercial plans. It also applies to full-service Medi-Cal managed care plans to the extent Knox-Keene Act sections described herein apply to such plans. This APL does not apply to Medicare Advantage plans or to specialized health care service plans.

With respect to women, infants, children, and adolescents, plans must cover without cost-sharing the evidence-informed preventive care services and screenings contained in the comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA).[2]

Finally, group health plans must cover periodic health evaluations, immunizations, and laboratory services as contained in the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the ACIP, and the American Academy of Family Physicians.

B. Recent changes to FDA approval for COVID-19 vaccines

The U.S. Food and Drug Administration (FDA) recently released approvals for several COVID-19 vaccines.[3] Unlike previous approvals, the FDA approved these vaccines only for individuals 65 years of age and older or for people who are younger than 65 but have at least one underlying condition that puts them at high risk for severe outcomes from COVID-19.

II. AB 144 codifies the federal recommendations in effect on January 1, 2025, and allows the California Department of Public Health to supplement those recommendations.

A. Requirements of AB 144

AB 144, available at Leg. Info., amends Health and Safety Code sections 1342.2, 1342.3, 1367.002, 1367.3, and 1367.35. For reference, the attachment to this APL contains a “redlined” version of these sections as amended by AB 144.

The amendments to sections 1342.2 (COVID-19 services), 1342.3 (public health emergency), and 1367.002 (preventive services generally) require plans to cover, without cost-sharing or utilization management, all items, services, and immunizations related to COVID-19 with a USPSTF “A” or “B” recommendation as of January 1, 2025. Plans must continue to cover these services even if USPSTF removes or downgrades its recommendations. The amendments allow CDPH to modify or supplement the USPSTF recommendations and require plans to cover the modifications or supplements within 15 business days after CDPH publishes the updated recommendations.

The amendments to sections 1367.3 and 1367.35 require group health plan products to cover the childhood periodic health evaluations, immunizations, and laboratory services contained in the Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, ACIP, and the American Academy of Family Physicians. CDPH may modify or supplement such recommendations taking into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the

[2] Health and Safety Code section 1367.002.
[3] The approved COVID-19 vaccines are: MNEXSPIK and SPIKEVAX (both manufactured by Moderna Tx, Inc.); COMIRNATY (manufactured by BioNTech Manufacturing GmbH); and NUVAXOVID (manufactured by Novavax, Inc.)

American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

These amendments took effect immediately on September 17, 2025, when the Governor signed AB 144.

B. High-Deductible Health Plan products

For enrollees in high-deductible health plan products (HDHPs), plans must cover preventive services in conformance with AB 144, unless doing so would disqualify the HDHP from eligibility for a health savings account pursuant to Internal Revenue Code section 223 (26 U.S.C. § 223).

III. CDPH Immunization Recommendations

On September 17, 2025, CDPH issued guidance regarding COVID-19, influenza, and RSV immunizations. That guidance can be found at CDPH and provides as follows:

COVID-19

- **Children:** All children 6-23 months; All children 2-18 years with certain risk factors; All children with close contact with others with risk factors; All children who choose protection
- **Adults:** All adults age 65 years or older; All adults ages 18-64 years with certain risk factors; All adults with close contact with others with risk factors; All adults who choose protection
- **Pregnancy:** All planning, pregnant, postpartum, or lactating

Influenza

- **Children:** All children 6 months or older
- **Adults:** All adults 18 years or older
- **Pregnancy:** All planning, pregnant, postpartum, or lactating

RSV

- **Children:** All children 8 months or younger; All children 8-19 months with risk factors
- **Adults:** All adults 75 years or older; All adults 50-74 years with risk factors
- **Pregnancy:** Pregnant between 32-36 weeks gestational age

Per AB 144 all health care service plans must cover the CDPH-recommended immunizations without cost-sharing or utilization management. If the immunization is not already encompassed within recommendations by ACIP or the USPSTF, plans must

begin covering the immunization by October 8, 2025, which is 15 business days following CDPH's publication of its recommendation.

Please note, the FDA currently recommends COVID-19 immunizations only for people who are 65 years of age or older, or for younger people with at least one underlying condition that puts them at a greater risk for COVID-19. Notwithstanding the FDA's recommendation, per AB 144, health plans must cover COVID-19 immunizations per CDPH's recommendations even if doing so could be considered "off label."

If you have questions regarding this APL, please contact your health plan's assigned reviewer in the DMHC's Office of Plan Licensing.

Attachment

Assembly Bill 144 made the following amendments to Health and Safety Code sections 1342.2, 1342.3, 1367.002, 1367.3, and 1367.35

Health and Safety Code Section 1342.2, subdivision (b), as amended by AB 144:

(b) (1) A health care service plan contract that covers medical, surgical, and hospital benefits shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual enrollee:

(A) An evidence-based item or service that ~~has~~ had in effect on January 1, 2025, a rating of "A" or "B" in the ~~current~~ recommendations of the United States Preventive Services Task ~~Force.~~ Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(B) An immunization that ~~has~~ had in effect on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and P~~revention,~~ Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164, regardless of whether the immunization is recommended for routine use.

(2) The item, service, or immunization covered pursuant to paragraph (1) shall be covered upon operation of the act that amended this subdivision.

~~(2)~~ *(3)* ~~The item, service, or immunization covered pursuant to~~ Any modification or supplement to the recommendations described in paragraph (1) shall be covered or removed from coverage no later than 15 business days after the date on which the ~~United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization. A recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention is considered in effect after it has been adopted, or granted emergency use authorization, by the Director of the Centers for Disease Control and Prevention.~~ State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

~~(3)~~ *(4)* (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(C) With respect to an enrollee, a health care service plan shall reimburse the provider of the immunization according to either of the following:

(i) If the health plan has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health plan does not have a negotiated rate with such provider, the plan may negotiate a rate with such provider.

(D) A health care service plan shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(E)(i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

~~(4)~~ (5) A health care service plan subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (D) of paragraph (3).

~~(5)~~ (6) Changes to a contract between a health care service plan and a provider delegating financial risk for immunization related to a declared public health emergency, shall be considered a material change to the parties' contract. A health plan shall not

delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

Health and Safety Code section 1342.3, as amended by AB 144:

(a) A health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(1) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease and that is either of the following:

(A) An item or service that, as of January 1, 2025, had in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

~~(1)~~ (B) An ~~evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has~~ immunization that, as of January 1, 2025, had in effect a ~~rating of "A" or "B" or~~ recommendation of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and ~~Prevention.~~ Prevention, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(3) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(b) *(1)* The item, service, or immunization covered pursuant to paragraph (1) of subdivision (a) shall be covered ~~no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.~~ upon operation of the act that added this paragraph.

(2) Any modification or supplement to the recommendations described in subparagraphs (A) or (B) of paragraph (1) of subdivision (a) shall be covered or removed from coverage no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

(c) For purposes of this section, “health care service plan” includes a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to a Medi-Cal managed care plan contract only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

Health and Safety Code section 1367.002, as amended by AB 144:

(a) A group or individual nongrandfathered health care service plan contract shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that ~~have~~ had in effect on January 1, 2025, a rating of “A” or “B” in the recommendations of the United States Preventive Services Task ~~Force, as periodically updated.~~ Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) Immunizations that ~~have~~ had in effect ~~a recommendation, as periodically updated,~~ on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services ~~Administration~~ Administration, as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration f~~or purposes of this paragraph.~~ as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(5) For the purposes of this section:

(A) The ~~current~~ recommendations of the United States Preventive Services Task Force as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164, regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or

services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) ~~A~~ For the purposes of this section, a health care service plan contract shall not impose cost sharing for office visits associated with the preventive care services described in this section 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.

~~(b) This section does not prohibit a health care service plan contract from doing either of the following:~~

~~(1)~~ *(b)* ~~Providing~~ This section does not prohibit a health care service plan contract from providing coverage for preventive items or services in addition to those required by subdivision (a).

~~(2) Denying coverage for services that are not recommended by the United States Preventive Services Task Force, except as provided in subdivision (d).~~

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph ~~(1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a plan year is downgraded to a "D" rating, or~~ (1) and consistent with the authority granted to the State Department of Public Health pursuant to Section 120164, if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this chapter, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

(e) This section does not apply to a specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. This section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

Health and Safety Code section 1367.3, as amended by AB 144:

(a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The ~~most current version of the~~ Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family ~~Physicians, unless~~ Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health ~~determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.~~ pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

Health and Safety code Section 1367.35, as amended by AB 144:

(a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The ~~most current version of the~~ Recommended Childhood Immunization Schedule/United States, jointly adopted <u>as of January 1, 2025,</u> by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family ~~Physicians, unless~~ <u>Physicians. Immunizations subject to this subparagraph may be modified or supplemented by</u> the State Department of ~~Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.~~ <u>Public Health pursuant to Section 120164.</u>

(2) Provide for all of the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.