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ALL PLAN LETTER

DATE: December 19, 2025

TO: All Health Care Service Plans

FROM: Jenny Phillips
Deputy Director
Office of Plan Licensing

SUBJECT: APL 25-020 (OPL) - Newly Enacted Statutes Impacting Health Plans (2025 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 12 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 2025 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 19, 2026, 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 2025 Legislation.**"

- In the Compliance with 2025 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 2027 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 or necessitated for compliance with the newly enacted legislation.

- 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 116 (Committee on Budget, Ch. 21, Stats. 2025)—Health Omnibus Trailer Bill

Codified in Health and Safety Code §§ 1342.2, 1356.3, 1374.55, 1385.001, 1385.008, 1385.009, 1385.0010, 1385.0011, 1385.0012, 1385.0013, 1385.0014, 1385.0015,

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[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.

1385.0016, 1385.0017, 1385.0018, 1385.0019, 1385.0020, 1385.0021, 1385.0022, 1385.0023, 1385.0024, 1385.0025, and 1385.026.

a. Overview of the bill:

- Became effective immediately on June 30, 2025.
- See APL 25-015: Assembly Bill 144 and Coverage of Preventive Care Services for updated requirements related to Section 1342.2.[6]
- Section 1374.55.
    - Postpones the timeframe for a large group health care service plan contract to comply with Section 1374.55, as amended by SB 729. It now requires large group health care service plan contracts issued, amended or renewed on or after January 1, 2026 to provide coverage for the diagnosis and treatment of infertility and fertility services pursuant to Section 1374.55.
    - Postpones the timeframe for a small group health care service plan contract to comply with Section 1374.55, as amended by SB 729. It now requires small group health care service plan contracts issued, amended or renewed on or after January 1, 2026 to offer coverage for the diagnosis and treatment of infertility and fertility services pursuant to Section 1374.55.
    - Permits the Director, until January 1, 2027, to issue guidance regarding compliance with Section 1374.55.

b. Compliance and filing requirements:

- Section 1374.55.
    - Further guidance regarding how plans must demonstrate compliance with Section 1374.55 coverage requirements will be forthcoming and issued under a separate communication to the plans.
- Sections 1356.3, 1385.001, 1385.008, 1385.009, 1385.0010, 1385.0011, 1385.0012, 1385.0013, 1385.0014, 1385.0015, 1385.0016, 1385.0017, 1385.0018, 1385.0019, 1385.0020, 1385.0021, 1385.0022, 1385.0023, 1385.0024, 1385.0025, and 1385.026.
    - Further guidance regarding Pharmacy Benefit Manager (PBM) licensure and other specific filing requirements for this new law as it

[6] AB 144 expanded the requirements established by AB 116 under Section 1342.2.

relates to PBM licensure will be forthcoming and issued under a separate communication.

2. **AB 260 (Aguiar-Curry, Ch. 136, Stats. 2025)—Sexual and Reproductive Health Care**

Codified in Health and Safety Code §§ 1367.21 and 1375.61

a. Overview of the bill:

- Became effective on September 26, 2025 as an urgency statute.
- Section 1367.21.
    - Applies to all plans that provide prescription drug coverage. Excludes Medi-Cal plans.
    - Prohibits health care service plan contracts from being issued, amended, delivered, or renewed if the contract limits or excludes coverage for brand name or generic mifepristone solely on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the United States Food and Drug Administration (FDA) or that varies from an approved risk evaluation and mitigation strategy pursuant to Section 355-1 of Title 21 of the United States Code, except if the state deems it necessary to address an imminent health or safety concern regarding brand name or generic mifepristone.
    - Requires health care service plan contracts to include coverage for brand name or generic mifepristone, even if the drug has not been approved by the FDA for abortion if the requirements of Section 1367.21(b)(3) have been met, except if the state deems it necessary to address an imminent health or safety concern regarding brand name or generic mifepristone.
    - If a name brand or generic mifepristone has not been approved by the FDA for abortion, coverage is required pursuant to Section 1367.21(b)(2) if the drug is a recognized medication for abortion by the World Health Organization (WHO) Model List of Essential Medicines, the WHO abortion care guideline, or the National Academies of Science, Engineering, and Medicine Consensus Study Report, or if the state approves its use based on peer-reviewed studies and prior approval of the drug that is no longer in effect.
- Section § 1375.61.
    - Applies to all plans, including EAPs.

- Prohibits provider contracts from including any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on either of the following:
    - A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.
    - The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.
- Prohibits plans from discriminating, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of either of the following:
    - A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.
    - The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.

b. Compliance and filing requirements:

- Section 1367.21.
    - Affirm the plan's health care service plan contract will not be issued, amended, delivered, or renewed in this state if the contract limits or excludes coverage for brand name or generic mifepristone solely on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA or that varies from an approved risk evaluation and mitigation strategy pursuant to Section 355-1 of Title 21 of the United States Code, except if the state deems it necessary to address an imminent health or safety concern regarding brand name or generic mifepristone.

- Affirm the plan's health care service plan contract will include coverage for brand name or generic mifepristone, even if the drug has not been approved by the FDA for abortion if the requirements of Section 1367.21(b)(3) have been met, except if the state deems it necessary to address an imminent health or safety concern regarding brand name or generic mifepristone.

- Affirm that if a name brand or generic mifepristone has not been approved by the FDA for abortion, the plan will provide coverage pursuant to Section 1367.21(b)(2) if the drug is a recognized medication for abortion by the WHO Model List of Essential Medicines, the WHO abortion care guideline, or the National Academies of Science, Engineering, and Medicine Consensus Study Report, or if the state approves its use based on peer-reviewed studies and prior approval of the drug that is no longer in effect.

- Submit updated utilization management policies, as an Exhibit J-9, to demonstrate compliance with Section 1367.21 of AB 260.

- Submit updated Summaries of Benefits or other detailed cost sharing documents (collectively referred to as "SOBs"), Disclosure Forms, and EOCs, as Exhibits Q, S, T and/or U, to demonstrate compliance with Section 1367.21 of AB 260.

- State either:

  - The plan reviewed its policies and procedures, administrative service agreements (ASAs), PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of Section 1367.21 of AB 260.

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 Section 1367.21 of AB 260. The plan will amend these documents to comply with Section 1367.21 of AB 260 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.

- Section 1375.61.
    - Affirm the plan will not include any terms in provider contracts that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on either of the following:
        - A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.
        - The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.
    - Affirm the plan will not discriminate with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of either of the following:
        - A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.
        - The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.
    - State either:
        - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are consistent with the requirements of Section 1375.61 of AB 260.

OR

- The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are not consistent with the requirements of Section 1375.61 of AB 260. The plan will amend these documents to comply with Section 1375.61 of AB 260 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 951 (Ta, Ch. 84, Stats. 2025)—Health Care Coverage: Behavioral Diagnosis

Codified in Health and Safety Code § 1374.73.

a. Overview of the bill:

- Applies to plans that provide behavioral health treatment for pervasive developmental disorder or autism. Excludes specialized plans that do not provide mental health or behavioral health services, and Medi-Cal plans.

- Prohibits health care service plan contracts issued, amended, or renewed on or after January 1, 2026, from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis[7] to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.

- Clarifies that a treating provider is not prohibited or restricted from reevaluating an enrollee for purposes of determining the appropriate treatment and requires the treatment plan to be made available to the plan upon request.

- Clarifies that a treating provider is not prohibited from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

- Prohibits plans from discontinuing or delaying existing treatment while waiting for a rediagnosis to be completed.

[7] *See* Section 1374.73(d)(5) for the definition of "rediagnosis."

- Clarifies that a health care service plan is not prohibited from requiring utilization review.[8]

b. Compliance and filing requirements:

- Affirm the plan's health care service plan contracts will not require an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.

- Affirm the plan will not prohibit or restrict a treating provider from reevaluating an enrollee for purposes of determining the appropriate treatment.

- Affirm the plan will not prohibit a treating provider from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

- Affirm the plan will not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.

- Explain how the plan will inform relevant providers of the requirements of AB 951. Submit any provider notices, as an Exhibit I-7, the plan will send to providers to inform them of the requirements of AB 951.

- 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 951.

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 951. The plan will amend these documents to comply with AB 951 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

[8] *See* Section 1374.73(d)(6) for the definition of "utilization review." For the purpose of Section 1374.73, utilization review is distinct from a rediagnosis.

separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

4. AB 1041 (Bennett, Ch. 630, Stats. 2025)—Health Care Coverage: Health Care Provider Credentials

Codified in Health and Safety Code §§ 1374.198 and 1380.2.

a. Overview of the bill:

- Section 1374.198.
    - Applies to all plans, including EAPs. Excludes Medi-Cal plans.
    - Requires plans or their delegates, by January 1, 2027, that credential providers for their networks to make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application, including all required third-party verifications.
    - Requires plans or their delegates, upon receipt of the application by the credentialing department, to notify the applicant within 10 business days to verify receipt and inform the applicant whether the application is complete.
    - Requires plans to activate the provider upon successful approval and notify the applicant of the activation within 10 days of approval if the approval occurs prior to the end of the 90-day timeline.
    - Clarifies that the 90-day timeline shall apply only to the credentialing process and does not include contracting completion.
    - Requires plans or their delegates to provisionally approve the applicant's credentials for 120 days if the plan or its delegate does not meet the 90-day requirement, unless any of the following apply:
        - The applicant is subject to discipline by the licensing entity for that applicant,
        - The applicant has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank, or
        - The applicant has not been credentialed by the plan in the past five years.
- Section 1380.2.

- Applies to full-service plans. Excludes Medi-Cal plans.
- Requires, on and after January 1, 2028, plans or their delegates to subscribe to and use the most recent version of the Council for Affordable Quality Healthcare (CAQH) credentialing form and comply with the CAQH credentialing processes.
- Requires plans or their delegates to only request additional information from a provider to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the provider's application. Providers are required to respond to the request within 10 business days.
- Requires plans or their delegates to minimize the number of requests for additional information from providers.
- Requires providers to submit their credentialing form and maintain their credentialing information in the CAQH database in a manner consistent with CAQH standards.

b. Compliance and filing requirements:

- Section 1374.198.
  - Affirm that by January 1, 2027, the plan or its delegates that credentials providers for its networks will make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application, including all required third-party verifications.
  - Affirm the plan or its delegates, upon receipt of the application by the credentialing department, will notify the applicant within 10 business days to verify receipt and inform the applicant whether the application is complete.
  - Affirm the plan will activate the provider upon successful approval and notify the applicant of the activation within 10 days of approval if the approval occurs prior to the end of the 90-day timeline.
  - Affirm the plan will apply the 90-day timeline only to the credentialing process and that the 90-day timeline will not include contracting completion.
  - Affirm the plan or its delegates will provisionally approve the applicant's credential for 120 days if the plan or its delegate does not meet the 90-day requirement, unless any of the following applies:

- The applicant is subject to discipline by the licensing entity for that applicant,
- The applicant has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank, or
- The applicant has not been credentialed by the health care service plan in the past five years.

- Explain whether the plan delegates responsibilities under Section 1374.198 to a contracted entity, and if so, identify how the plan will ensure the delegated entity will comply with Section 1374.198 of AB 1041. Submit updated delegation agreements and monitoring and oversight policies and procedures needed to comply with Section 1374.198 of AB 1041.
- State either:
  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are consistent with the requirements of Section 1374.198 of AB 1041.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are not consistent with the requirements of Section 1374.198 of AB 1041. The plan will amend these documents to comply with Section 1374.198 of AB 1041 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.

- Section 1380.2.
  - Affirm that on and after January 1, 2028, the plan or its delegates will subscribe to and use the most recent version of the CAQH credentialing form and comply with the CAQH credentialing processes.
  - Affirm the plan or its delegates will only request additional information from a provider to clarify and confirm information that is provided on

the CAQH credentialing form, including verification of information not specifically disclosed on the provider's application.

- Affirm the plan or its delegates will minimize the number of requests for additional information from providers.

- Explain whether the plan delegates responsibilities under Section 1380.2 to a contracted entity, and if so, identify how the plan will ensure the delegated entity will comply with Section 1380.2 of AB 1041. Submit updated delegation agreements and monitoring and oversight policies and procedures needed to comply with Section 1380.2 of AB 1041.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are consistent with the requirements of Section 1380.2 of AB 1041.

OR

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, and plan-to-plan contracts, and those documents are not consistent with the requirements of Section 1380.2 of AB 1041. The plan will amend these documents to comply with Section 1380.2 of AB 1041 and file the documents per the Act's applicable timeframes.

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

5. SB 40 (Wiener, Ch. 737, Stats. 2025)—Health Care Coverage: Insulin

Codified in Health and Safety Code § 1367.51.

a. Overview of the bill:

- Applies to plans that provide prescription drug coverage. Excludes Medi-Cal plans and specialized plans.

- Prohibits plans, on or after January 1, 2026, from imposing step therapy protocols on at least one insulin in each drug type approved by the FDA as a

prerequisite to authorizing coverage of an insulin prescription drug (includes both self-administered drugs and physician-administered drugs).

- Large group health care service plan contracts.
    - Prohibits large group health care service plan contracts, issued, amended, or renewed on or after January 1, 2026, from imposing a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply.
    - Requires large group health care service plan contracts to include at least one insulin for a given drug type in all forms and concentrations on the prescription drug formulary.
- Individual and small group health care service plan contracts.
    - Prohibits individual and small group health care service plan contracts issued, amended or renewed on or after January 1, 2027, from imposing a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply.
    - Requires individual and small group health care service plan contracts that maintain a drug formulary grouped into tiers to comply with the following:
        - The cost-sharing cap of $35 for a 30-day supply only applies to insulin prescription drugs that are in Tier 1 and Tier 2.
        - At least one insulin for a given drug type in all forms and concentrations shall be on Tier 1 or Tier 2.
        - If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for the member, the plan shall limit the cost sharing for a higher tier drug to no more than $35 for a 30-day supply for an individual member.
- Prohibits health care service plan contracts that meet the definition of a high deductible health plan (HDHP) as set forth in Section 223(c)(2) of Title 26 of the United States Code, from imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription that exceeds $35 for a 30-day supply, unless applying the $35 limitation would conflict with federal requirements for HDHPs.

- Requires plans to apply deductible and copayment limitations described in SB 40 to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug that is labeled or produced by the state.[9]

b. Compliance and filing requirements:

- Affirm the plan will not impose step therapy protocols on at least one insulin in each drug type approved by the FDA as a prerequisite to authorizing coverage of an insulin prescription drug (includes both self-administered drugs and physician-administered drugs).

- Affirm the plan's large group health care service plan contracts, issued, amended, or renewed on or after January 1, 2026, will not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply.

- Affirm the plan's large group health care service plan contracts will include at least one insulin for a given drug type in all forms and concentrations on the prescription drug formulary.

- Affirm the plan's individual and small group health care service plan contracts issued, amended or renewed on or after January 1, 2027, will not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply.

- Affirm the plan's individual and small group health care service plan contracts issued, amended or renewed on or after January 1, 2027, that maintain a drug formulary grouped into tiers will comply with the following: (1) the cost-sharing cap of $35 for a 30-day supply will apply only to insulin prescription drugs that are in Tier 1 and Tier 2, (2) at least one insulin for a given drug type in all forms and concentrations shall be on Tier 1 or Tier 2, and (3) if there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for the member, the plan shall limit the cost sharing for a higher tier drug to no more than $35 for a 30-day supply for an individual member.

- Affirm the plan's health care service plan contracts that meet the definition of HDHP as set forth in Section 223(c)(2) of Title 26 of the United States Code, will not impose a deductible, coinsurance, or any other cost sharing on an insulin prescription that exceeds $35 for a 30-day supply, unless applying the $35 limitation would conflict with federal requirements for HDHPs.

- If the plan is stating that applying the $35 limitation would conflict with federal requirements for its health care service plan contracts that meet the definition

[9] This requirement will apply when the state has the capacity to label or produce an insulin prescription drug.

of HDHP as set forth in Section 223(c)(2) of Title 26 of the United States Code, provide a detailed explanation supporting the plan's position.

- Affirm the plan will apply the deductible and copayment limitations described in SB 40 to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug that is labeled or produced by the state.[10]

- Submit revised utilization management policies, as an Exhibit J-9, to demonstrate compliance with SB 40 and Sections 1367.206 and 1367.241.

- Submit revised SOBs, Disclosure Forms and EOCs, as Exhibits Q, S, T and/or U, to demonstrate compliance with SB 40.

- Submit revised Formularies, as an Exhibit T-3, to demonstrate compliance with SB 40.

- Submit revised PBM contracts, as an Exhibit N-1, to demonstrate compliance with SB 40.

- State either:

    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 40.

OR

    - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 40. The plan will amend these documents to comply with SB 40 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. SB 41 (Wiener, Ch. 605, Stats. 2025)—Pharmacy Benefits

[10] This requirement will apply when the state has the capacity to label or produce an insulin prescription drug.

Codified in Health and Safety Code §§ 1367.2075, 1385.001, 1385.0011, 1385.0021, 1385.0022, 1385.0023, 1385.0026, 1385.0027, 1385.0028, 1385.0029, 1385.0031, 1385.0032, 1385.0033, and 1385.0034.

a. Overview of the bill:

- Section 1367.2075.
    - Applies to all plans that provide prescription drug coverage.
    - Prohibits health care service plan contracts issued, amended, or renewed on or after January 1, 2026, from calculating an enrollee's cost sharing at an amount that exceeds the actual rate paid by the plan for the prescription drug.
    - Requires health care service plan contracts to include cost sharing provisions, which include deductibles and copayments, consistent with Section 4079 of the Business and Professions Code.
    - Prohibits, to the extent that a plan's PBM contract includes a disclosure on the net price paid by the PBM, an enrollee's cost share from being calculated at an amount that exceeds that net price paid.
    - Requires that if a preexisting contract between a PBM licensed pursuant to Article 6.1 and a plan authorizes spread pricing, any subsequent amendment or renewal of that PBM contract will not authorize spread pricing.
    - Prohibits any contract that is executed on or after January 1, 2026, between a PBM licensed pursuant to Article 6.1 and a plan from authorizing spread pricing.
- Section 1385.0022.
    - Applies to plans that contract with PBMs[11].
    - Clarifies, on or after January 1, 2026, that a PBM's fiduciary duty to its contracted plans includes a duty to be fair and truthful toward the plans, to act in the plans' best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence.
- Section 1385.0026.

[11] A PBM does not include the California Department of Health Care Services (DHCS), including any contracts between DHCS and another entity related to the negotiation and collection of drug or medical supply rebates.

- Applies to plans that contract with PBMs[11].
- Prohibits PBMs, on or after January 1, 2026, from imposing any requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs.
- Explains that prohibited discrimination by PBMs includes all of the following:
  - Terms or conditions applied to nonaffiliated pharmacies based on their status as a nonaffiliated pharmacy.
  - Refusing to contract with or terminating a contract with a nonaffiliated pharmacy on the basis that the pharmacy is a nonaffiliated pharmacy or for reasons other than those that apply equally to affiliated pharmacies.
  - Retaliation against a nonaffiliated pharmacy based on its exercise of any right or remedy under Article 6.1.
  - Engaging in an unlawful action against a covered entity, including a violation of Section 127471.
  - Reimbursing a nonaffiliated pharmacy less for a pharmacist service than the PBM would reimburse an affiliated pharmacy for the same pharmacist service.

- Section 1385.0027.
  - Applies to plans that contract with PBMs[11].
  - Prohibits PBMs, on or after January 1, 2026, from doing any of the following:
    - Requiring an enrollee to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network.
    - Financially inducing an enrollee to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network.
    - Requiring a nonaffiliated pharmacy to transfer a prescription to an affiliated pharmacy if there are nonaffiliated pharmacies in the network.

- Unreasonably restricting an enrollee from using a particular contracted pharmacy for the purpose of receiving pharmacist services covered by the enrollee's health care service plan contract.

- Communicating to or misleading an enrollee, in any manner, that the enrollee is required to have a prescription dispensed at, or pharmacy services provided by, a particular affiliated pharmacy or pharmacies if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network.

- Denying a nonaffiliated contract pharmacy the opportunity to participate in a PBM network as a preferred participation status if the pharmacy is willing to accept the same terms and conditions that the PBM has established for affiliated pharmacies as a condition of preferred network participation status.

- Section 1385.0028.
  - Applies to plans that contract with PBMs[11].
  - Requires contracts between nonaffiliated pharmacies and PBMs, on or after January 1, 2026, to not prohibit the pharmacy from offering either of the following as an ancillary service of the pharmacy:
    - The delivery of a prescription drug by mail or common carrier to a patient or personal representative on request of the patient or personal representative if the request is made before the drug is delivered.
    - The delivery of a prescription to a patient or personal representative by an employee or contractor of the pharmacy.
  - Prohibits pharmacies from charging PBMs for the delivery service described above. Note, this language does not prohibit the use of remote pharmacies, secure locker systems, or other types of pickup stations if those services are otherwise permitted by law.

- Section 1385.0029.
  - Applies to plans that contract with PBMs[11].

- Prohibits PBMs, on or after January 1, 2026, from deriving income from PBM services provided to a plan except for income derived from a pharmacy benefit management fee for PBM services provided.

- Requires the amount of any pharmacy benefit management fee to be set forth in the PBM contract.

- Requires PBMs to disclose the amount and types of the pharmacy benefit management fees to the plan.

- Requires PBMs to utilize a passthrough pricing model.

- Requires PBMs to direct 100 percent of all prescription drug manufacturer rebates received to the plan, if the PBM contract delegates the negotiation of rebates to the PBM, for the sole purpose of offsetting defined cost sharing, deductibles, and coinsurance contributions and reducing enrollee's premiums.

- Allows plans to pay performance bonuses to PBMs based on savings to the plans that decrease premiums paid by enrollees or that result in enrollees paying the lowest level of cost sharing, deductibles, and coinsurance for a drug, as long as the performance bonus is not based or contingent on any of the following:

    - The acquisition or ingredient cost of a drug.

    - The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the PBM.

    - The amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the PBM or its affiliated entities from enrollees or other persons on behalf of an enrollee, except for performance bonuses that are based or contingent on a decrease in premiums, deductibles, or other cost sharing.

- Prohibits PBMs from making or permitting any reduction of payment for pharmacist services by PBMs or plans directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.

- Prohibits a claim or aggregate of claims for pharmacist services from being directly or indirectly retroactively denied or reduced after

adjudication of the claim or aggregate of claims unless any of the following have occurred:

- The original claim was submitted fraudulently.
- The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services.
- The pharmacist services were not properly rendered by the pharmacy or pharmacist.

- Prohibits PBMs from reversing and resubmitting the claim of a contract pharmacy under the following circumstances:
  - Without prior written notification to the contract pharmacy.
  - Without just cause or attempt to first reconcile the claim with the pharmacy.
  - More than 90 days after the claim was first affirmatively adjudicated.
- Prohibits PBMs from charging a pharmacy or pharmacist a fee to process a claim electronically.
- Requires PBMs to make a payment due to the nonaffiliated pharmacy for an affirmatively adjudicated claim if the contract between the PBM and nonaffiliated pharmacy is terminated, unless payments are withheld because of an investigation relating to insurance fraud.
- Prohibits PBMs from retaliating as follows against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any rights or remedies:
  - Terminating or refusing to renew a contract with the pharmacist or pharmacy.
  - Subjecting the pharmacist or pharmacy to increased audits without cause.
  - Failing to promptly pay the pharmacist or pharmacy money owed by the PBM to the pharmacist or pharmacy.

- Section 1385.0031.

- Applies to plans that contract with PBMs[11].
- Prohibits PBMs, on or after January 1, 2026, from conducting spread pricing.
- Requires, upon renewal or amendment of a preexisting contract between a PBM and a plan that authorizes spread pricing, to remove the language authorizing spread pricing.
- Note: Spread pricing is permissible pursuant to SB 41 until the earlier of: (1) when a contract between a PBM and a plan is amended or renewed or (2) January 1, 2029. This means any contract amendments or renewals after January 1, 2026 between a PBM and a plan, including revisions being made to comply with SB 41, would prohibit these contracts from authorizing spread pricing.

- Section 1385.0032.
  - Applies to plans that contract with PBMs[11].
  - Prohibits PBMs, on or after January 1, 2026, from entering into, amending, enforcing or renewing a contract with manufacturers that implement implicit or express exclusivity for those manufacturers' drugs, unless the PBM can demonstrate the extent to which exclusivity results in the lowest cost to plans, and the lowest cost sharing for enrollees.
  - Prohibits PBMs from entering into, amending, enforcing, or renewing a contract with pharmacies or pharmacy services administration organizations that expressly or implicitly restrict, or impose implicit or express exclusivity on, nonaffiliated pharmacies' ability to contract with plans.

b. Compliance and filing requirements:

- Section 1367.2075.
  - Affirm the plan's health care service plan contracts will not calculate an enrollee's cost sharing at an amount that exceeds the actual rate paid by the plan for the prescription drug.
  - Affirm the plan's health care service plan contracts will include cost sharing provisions, which include deductibles and copayments, consistent with Section 4079 of the Business and Professions Code.

- Affirm, to the extent that the plan's PBM contract includes a disclosure on the net price paid by the PBM, that an enrollee's cost share will not be calculated at an amount that exceeds that net price paid.

- Affirm that if a preexisting contract between a PBM licensed pursuant to Article 6.1 and the plan authorizes spread pricing, any subsequent amendment or renewal of the PBM contract will not authorize spread pricing.

- Affirm any contract that is executed on or after January 1, 2026 between a PBM licensed pursuant to Article 6.1 and the plan will not authorize spread pricing.

- Explain how the plan will not calculate an enrollee's cost sharing at an amount that exceeds the actual rate paid by the plan for the prescription drug, and will include cost sharing provisions, which include deductibles and copayments, consistent with Section 4079 of the Business and Professions Code.

- Affirm the plan will amend its PBM contract for compliance with the following Sections either added or amended by SB 41: (1) Section 1385.001, (2) Section 1385.0022, (3) Section 1385.0026, (4) Section 1385.0027, (5) Section 1385.0028, (6) Section 1385.0029, (7) Section 1385.0031, and (8) Section 1385.0032.

- Submit the revised PBM contract, as an Exhibit N-1, and the plan's oversight documents, as an Exhibit N-2 or N-5, to demonstrate compliance with SB 41. In the alternative, identify the page numbers in the PBM contract and the plan's oversight documents that comply with the following Sections set forth in SB 41: (1) Section 1367.2075, (2) Section 1385.001, (3) Section 1385.0022, (4) Section 1385.0026, (5) Section 1385.0027, (6) Section 1385.0028, (7) Section 1385.0029, (8) Section 1385.0031, and (9) Section 1385.0032.

- Submit new or revised claims policies and procedures, as an Exhibit II-4, to demonstrate compliance with SB 41.

- Submit new or revised pharmacy policies and procedures to demonstrate compliance with SB 41.

- State either:

  - The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 41.

OR

- The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 41. The plan will amend these documents to comply with SB 41 and file the documents per the Act's applicable timeframes.

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

- Further guidance regarding PBM licensure and other specific filing requirements for this new law as it relates to PBM licensure will be forthcoming and issued under a separate communication.

7. SB 62 (Menjivar, Ch. 739, Stats. 2025)—Health Care Coverage: Essential Health Benefits

Codified in Health and Safety Code § 1367.005.

a. Overview of the bill:

- Applies to all plans that provide essential health benefits coverage. Excludes Medi-Cal plans.

- Commencing on January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for California, the benchmark plan shall, in addition, include all of the following benefits:

  - Services to evaluate, diagnose, and treat infertility of all of the items enumerated in SB 62.

  - Durable medical equipment of all the items enumerated in SB 62.

  - An annual hearing exam.

  - One hearing aid per ear every three years.

- Note: The Insurance Code was similarly amended in AB 224.

b. Compliance and filing requirements:

- Further guidance regarding the requirements of this new law will be forthcoming and issued under a separate communication if the United States Department of Health and Human Services approves a new essential benefits benchmark plan for California.

8. SB 306 (Becker, Ch. 408, Stats. 2025)—Health Care Coverage: Prior Authorizations

Codified in Health and Safety Code § 1367.025.

a. Overview of the bill:

- Applies to all plans that conduct prior authorization as defined in Section 1367.025(l)(2). Excludes Medi-Cal plans and specialized plans that do not provide essential health benefits.

- Requires the DMHC, on or before July 1, 2026, to issue instructions to plans to report all covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by a plan or its delegated entity, and other statistics regarding prior authorization determinations.

- Requires plans, on or before December 31, 2026, to report to the DMHC, in accordance with the instructions issued, the covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by the plan or its delegated entity, data regarding requested or authorized duration, frequency, or level of care of the health care services, and other statistics regarding prior authorization determinations.

- Requires plans to obtain information required to be reported from each delegated entity and include that information in the report to the DMHC if the plan delegates responsibility for decisions regarding prior authorization requests to another entity.

- Requires the DMHC to evaluate the reports received from the plans and identify the health care services approved by the plans or their delegated entities at a rate that meets or exceeds the threshold rate of 90 percent.

- Requires the DMHC to consult with interested stakeholders prior to finalizing the list of covered health care services that cannot require prior authorization.

- Requires the DMHC, on or before July 1, 2027, to publish the list of covered health care services for which a plan cannot impose prior authorization and to issue instructions to plans regarding the items enumerated in SB 306.

- Requires plans and their delegated entities, on or before January 1, 2028, to cease requiring prior authorization for the covered health care services published by the DMHC pursuant to SB 306.

- Prohibits plans or their delegated entities from denying or reducing the contracted or agreed upon payment, or the applicable rate or reimbursement methodology specified in a plan contract, for a covered health care service exempted from a prior authorization requirement unless the provider failed to substantially perform or supply the covered health care service.

- Allows plans to reinstate prior authorization for a specific provider on a covered health care service for which prior authorization is otherwise prohibited only if the plan has determined, based on clear and convincing evidence that the provider has engaged in the actions enumerated in SB 306.

- Requires the DMHC to publish a report no later than four years after the date determined by the DMHC for cessation of prior authorization requirements regarding the impacts of the cessation of prior authorization requirements. Plans shall report information and data regarding the impacts of implementing SB 306, including effects on the volume of covered health care services subjected to prior authorization, statistics on prior authorization requests and determinations, administrative costs, timely access to care, enrollee health outcomes, and data on reinstatements of prior authorizations to be included in this report.

- Prohibits plans from delegating the requirements of SB 306 to a delegated provider, PBM, or other entity, unless the parties have negotiated and agreed upon a new provision to the parties' contract, as provided in Section 1375.7.

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.

9. SB 386 (Limón, Ch. 219, Stats. 2025)—Dental Providers: Fee-Based Payments

Codified in Health and Safety Code § 1371.11.

a. Overview of the bill:

- Applies to all plans that provide payment directly or through a contracted vendor[12] to a dental provider.[13]

- Requires plans, on or after April 1, 2026, that provide payment directly, or through a contracted vendor, to a dental provider[14] to have a non-fee-based default method of payment.

- Requires plans to remit or associate with each payment the claims and claim details associated with payment.

- Requires plans or the plans' contracted vendor to obtain affirmative consent[15] from a dental provider who opts in to a fee-based payment[16] method before the plan or vendor provides a fee-based payment method to the provider.
- Requires plans or the plans' contracted vendor, at the time a dental provider opts in to a fee-based payment method, to provide information on the payment method, including a notice of the fees charged by the plan or contracted vendor, alternative methods of payment, instructions on how to opt out of the fee-based payment method, and a notice of the dental provider's ability to opt out of the fee-based payment method at any time.

- Allows, upon receipt of a dental provider's affirmative consent, plans or the plans' contracted vendor to subsequently issue payments to the dental provider using a fee-based payment method.

- Requires plans to notify the dental provider if the plan's contracted vendor is sharing a part of the profit, fee arrangement, or board composition with the plan.

- Allows dental providers to opt out of a fee-based payment method and opt in to a non-fee-based payment method at any time by providing affirmative consent to a plan or the plan's contracted vendor.

- Provides that if a dental provider opts in or opts out of a fee-based method of payment, the provider's payment method decision remains in effect until the provider informs the plan or contracted vendor of another preferred method of payment, including fee-based or non-fee-based methods.

- Requires plans or the plans' contracted vendor that obtain a dental provider's affirmative consent to opt in or opt out of a fee-based payment method to

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[12] *See* Section 1371.11(a)(2) for the definition of "contracted vendor."
[13] This section does not apply if a plan has a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.
[14] *See* Section 1371.11(a)(3) for the definition of "dental provider."
[15] *See* Section 1371.11(a)(1)(A)-(C) for the definition of "affirmative consent."
[16] *See* Section 1371.11(a)(4) for the definition of "fee-based payment."

apply the decision to include the dental provider's entire practice and to all products or services covered by the plan pursuant to a contract with the dental provider, including network provider contracts, as described in Section 1374.193.

b. Compliance and filing requirements:

- Affirm the plan, if it provides payment directly, or through a contracted vendor, to a dental provider, will have a non-fee-based default method of payment.
- Affirm the plan will remit or associate with each payment the claims and claim details associated with payment.
- Affirm the plan or the plan's contracted vendor will obtain affirmative consent from a dental provider who opts in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider.
- Affirm the plan or the plan's contracted vendor, at the time a dental provider opts in to a fee-based payment method, will provide information on the payment method, including a notice of the fees charged by the plan or contracted vendor, alternative methods of payment, instructions on how to opt out of the fee-based payment method, and a notice of the dental provider's ability to opt out of the fee-based payment method at any time.
- Affirm the plan will notify the dental provider if the plan's contracted vendor is sharing a part of the profit, fee arrangement, or board composition with the plan.
- Affirm the plan will allow dental providers to opt out of a fee-based payment method and opt in to a non-fee-based payment method at any time by providing affirmative consent to the plan or the plan's contracted vendor.
- Affirm that if a dental provider opts in or opts out of a fee-based method of payment, the provider's payment method decision will remain in effect until the provider informs the plan or contracted vendor of another preferred method of payment, including fee-based or non-fee-based methods.
- Affirm that if the plan or its contracted vendor obtains a dental provider's affirmative consent to opt in or opt out of a fee-based payment method, it will apply the decision to include the dental provider's entire practice and all products or services covered by the plan pursuant to a contract with the dental provider, including network provider contracts, as described in Section 1374.193.
- Submit a provider notice, as an Exhibit I-7, the plan will provide to a dental provider who opts in to a fee-based payment method, detailing the

information on the payment method, including a notice of the fees charged by the plan or contracted vendor, alternative methods of payment, instructions on how to opt out of the fee-based payment method, and a notice of the dental provider's ability to opt out of the fee-based payment method at any time.

- Submit a provider notice, as an Exhibit I-7, the plan will provide to notify the dental provider if the plan's contracted vendor is sharing a part of the profit, fee arrangement, or board composition with the plan.

- Explain how the plan will inform dental providers of their ability to opt out and opt in to a fee-based payment method at any time by providing affirmative consent to a plan or the plan's contracted vendor.

- Explain how the plan will inform dental providers that when the plan or the plan's contracted vendor obtains a dental provider's affirmative consent to opt in or opt out of a fee-based payment method that consent will apply to the dental provider's entire practice and to all products or services covered by the plan pursuant to a contract with the dental provider, including network provider contracts, as described in Section 1374.193.

- Submit updated claims policies and procedures, as an Exhibit II-4, to demonstrate compliance with SB 386.

- Submit updated provider contracts as an Exhibit K-1, updated plan-to-plan contracts as an Exhibit P-5, and updated ASAs as an Exhibit N-1 to demonstrate compliance with SB 386.

- State either:

    - The plan reviewed its notices, policies and procedures, ASAs, provider contracts, and plan-to-plan contracts, and those documents are consistent with the requirements of SB 386.

OR

    - The plan reviewed its notices, policies and procedures, ASAs, provider contracts, and plan-to-plan contracts, and those documents are not consistent with the requirements of SB 386.s The plan will amend these documents to comply with SB 386 and file the documents per the Act's applicable timeframes.

- If the plan is amending any plan documents, specify the following: (1) the date by which the plan will submit these amended documents to the DMHC, (2) whether the amended documents will be submitted in this filing or in a

separate filing, (3) which specific documents will be amended, and (4) which specific documents do not need to be amended.

10. SB 402 (Valladares, Ch. 413, Stats. 2025)—Health Care Coverage: Autism

Codified in Health and Safety Code §§ 1367.27, 1374.72 and 1374.73.

a. Overview of the bill:

- Applies to plans that provide behavioral health treatment for pervasive developmental disorder or autism. Excludes specialized plans that do not provide mental health or behavioral health services, and Medi-Cal plans.
- Moves the definition of "qualified autism service provider" from Section 1374.73 to Section 4999.200 of the Business and Professions Code and adds a reference to Section 4999.200 of the Business and Professions Code to Section 1374.73.
- Moves the definition of "qualified autism service professional" from Section 1374.73 to Section 4999.201 of the Business and Professions Code and adds a reference to Section 4999.201 of the Business and Professions Code to Section 1374.73.
- Moves the definition of "qualified autism service paraprofessional" from Section 1374.73 to Section 4999.202 of the Business and Professions Code and adds a reference to Section 4999.202 of the Business and Professions Code to Section 1374.73.

b. Compliance and filing requirements:

- Affirm the plan's definition of "qualified autism service provider" complies with Section 4999.200 of the Business and Professions Code.
- Affirm the plan's definition of "qualified autism service professional" complies with Section 4999.201 of the Business and Professions Code.
- Affirm the plan's definition of "qualified autism service paraprofessional" complies with Section 4999.202 of the Business and Professions Code.
- State either:
    - The plan reviewed its policies and procedures, ASAs, provider contracts, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 402.

OR

- The plan reviewed its policies and procedures, ASAs, provider contracts, plan-to-plan contracts, SOBs, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 402. The plan will amend these documents to comply with SB 402 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.

11. SB 439 (Weber Pierson, Ch. 318, Stats. 2025)—California Health Benefit Review Program: Extension

Codified in Health and Safety Code §§ 127660, 127662, and 127665.

a. Overview of the bill:

- Applies to all plans. Excludes specialized plans.

- Extends the California Health Benefit Review Program and the Health Care Benefits Fund until July 1, 2033.
- Provides that the provisions become inoperative on July 1, 2033 and the provisions are repealed as of January 1, 2034.

- For the 2026-27 through the 2032-33 fiscal years, increases the allowable total annual assessment on plans to $3,200,000.

- Removes the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation.

b. Compliance and filing requirements:

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

12. SB 497 (Wiener, Ch. 764, Stats. 2025)—Legally Protected Health Care Activity

Codified in Civil Code § 56.109.

a. Overview of the bill:

- Applies to all plans, including EAPs.

- Became effective on October 13, 2025 as an urgency statute.

- Prohibits a provider, plan or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care[17] or a person[18] or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care in response to any subpoena or request, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care or authorizes a person to bring a civil or criminal action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.

- Prohibits a provider, plan or contractor from releasing medical information to persons or entities who have requested that information and who are authorized by law to receive that information, pursuant to Civil Code section 56.10(c), if the information is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care or to a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil or criminal action against a person or entity that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care or who allows a child to receive gender-affirming health care or gender-affirming mental health care.

- Prohibits a provider, plan, contractor or employer from cooperating with any inquiry or investigation by, or providing medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care that is lawful under the laws of this state.

- Clarifies that compliance is not prohibited with the investigation of activity that is punishable as a crime under the laws of this state or an audit or investigation of activity that is unlawful under the laws of this state or federal law, or with an audit, review, or investigation conducted for purposes of licensure, registration, accreditation, or certification under the laws of this state or federal law or pursuant to an accrediting organization recognized by

[17] *See* Civil Code § 56.109(g)(1) for the definitions of "gender-affirming health care" and "gender-affirming mental health care."
[18] *See* Civil Code § 56.109(g)(2) for the definition of "person."

the State Department of Public Health or the federal Centers for Medicare and Medicaid Services.

b. Compliance and filing requirements:

- Affirm the plan and its contracted entities will not release medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care or a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care in response to any subpoena or request, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care or authorizes a person to bring a civil or criminal action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.

- Affirm the plan and its contracted entities will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information, pursuant to Civil Code section 56.10(c), if the information is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care or to a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil or criminal action against a person or entity that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care or who allows a child to receive gender-affirming health care or gender-affirming mental health care.

- Affirm the plan and its contracted entities will not cooperate with any inquiry or investigation by, or providing medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care that is lawful under the laws of this state.

- Submit updated provider contracts as an Exhibit K-1, ASAs as an Exhibit N-1, and plan-to-plan contracts as an Exhibit P-5 to demonstrate compliance with SB 497.

- Submit updated policies and procedures, as an Exhibit J-18, relating to the Confidentiality of Medical Information Act and Section 1364.5 to demonstrate compliance with SB 497.

- State either:

- The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are consistent with the requirements of SB 497.

OR

- The plan reviewed its policies and procedures, provider contracts, ASAs, PBM contracts, plan-to-plan contracts, SOBs, Formularies, Disclosure Forms, and EOCs, and those documents are not consistent with the requirements of SB 497. The plan will amend these documents to comply with SB 497 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.

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