AB 1048

Dental benefits and rate review. This bill, on and after January 1, 2024, would prohibit a health care service plan or health insurer that covers dental services, and a specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as defined, upon an enrollee or insured. On and after January 1, 2024, the bill also would require a health care service plan or health insurer to disclose, at the time of verification for patient eligibility, whether or not the enrollee's or insured's dental coverage is subject to regulation by the relevant department. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would include health care service plan contracts and health insurance policies covering dental services, and specialized health care service plan contracts and specialized health insurance policies covering dental services, within those provisions. The bill would retain the exclusion with respect to specialized health care service plan contracts and specialized health insurance policies that do not provide dental services. The bill would require the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a specialized health care service plan contract or specialized health insurance policy covering dental services is unreasonable, or not justified, under the applicable requirements of the rate review provisions. By making specialized health care service plan contracts that provide dental services subject to these rate review provisions, the bill would expand the scope of a crime, thereby imposing a state-mandated local program.

AB 1241

Telehealth.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual

communication modalities when those services and settings meet certain criteria. Existing law requires providers furnishing service through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified.

This bill would additionally authorize a provider to meet the above-described requirement by maintaining protocols for patient referral to appropriate in-person care, when the standard of care cannot be met by video synchronous interaction or audio-only synchronous interaction.

AB 1481

Medi-Cal: pregnant individuals or targeted low-income children.

This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program “Presumptive Eligibility for Pregnant People” (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified.

The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

AB 1202

Medi-Cal: time or distance standards: children’s health care services.
This bill would require the department to conduct an analysis to identify the number of Medi-Cal providers needed to ensure adequate access to children’s health care services, through compliance by Medi-Cal managed care plans with the above-described time or distance and appointment time standards across all service areas or counties of the state. The bill would require the department to prepare a report of the analysis and to submit the report to the Legislature no later than January 1, 2026. The bill would repeal the analysis and reporting provisions on January 1, 2030. Status: Vetoed by Governor.

AB 1288

Health care coverage: Medication-assisted treatment. This bill would prohibit a medical service plan and a health insurer from subjecting a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder that is prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder to prior authorization. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. Status: Vetoed by Governor.

AB 1437

Medi-Cal: serious mental illness. Under this bill, a treatment authorization request would not be required for the provision of a prescription drug prescribed to prevent, assess, or treat a serious mental illness, as defined. Under the bill, a prescription for a drug for serious mental illness would automatically be approved if the department verifies a record of a paid claim that documents a diagnosis of a serious mental illness within 365 days before the date of that prescription. Status: Vetoed by Governor.

AB 1451

Behavioral health crisis treatment. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition, as specified. The bill would authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care. The bill would require the treatment to be provided without preauthorization, and would authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. Status: Vetoed by Governor.

AB 1645

Health care coverage: cost sharing.
This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit those contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria its median contracted rate in the general geographic region for screening tests and integral items and services rendered, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a

state-mandated local program. Status: vetoed by Governor.

State Insulin Price Caps Seen as New Front in Drug Price Fight

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Community Health Systems seeks growth through acquisitions