RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

NOTICE

TO: **All Disability Insurers Providing Health Insurance Coverage in California**

FROM: **Insurance Commissioner Ricardo Lara**

DATE: **February 26, 2024**

RE: **Statutes Impacting Health Insurers in 2024**

This Notice highlights some key statutory requirements applicable to health insurers[1] that were either newly enacted during the 2023 legislative session or were enacted earlier but are effective in 2024. The Department is issuing this Notice to remind health insurers of their obligation to comply with these statutory requirements as of their effective dates, as noted below for each chaptered law. The Department may issue subsequent guidance or instructions on compliance with specific statutory requirements listed in this Notice.

Insurance Code citations in this Notice are to the law as amended. Unless otherwise noted below, all statutes apply to both non-grandfathered health insurance policies, including student health insurance coverage for policy years that begin in 2024,[2] and health insurance policies that qualify as grandfathered health plans. In some instances, this Notice provides further detail on statutory applicability based on grandfathered status.

This Notice does not identify or address every newly enacted statutory requirement that applies to health insurers, is only intended to highlight certain key provisions, and does not constitute legal advice. Therefore, health insurers should consult with their legal counsel to ensure that they are complying with all newly enacted or effective statutory requirements.

---

[1] The statutes covered by this Notice may apply to either a disability insurance policy that provides hospital, medical or surgical coverage or benefits, or a health insurance policy. Given that a health insurance policy is a disability insurance policy that provides hospital, medical or surgical benefits, the term health insurance is used throughout this Notice, and insurers of these products are referred to as health insurers.

[2] *See* Ins. Code § 10965.03.

1. SB 523 (Leyva, ch. 630, Stats. 2022)—Contraceptive Equity Act of 2022

Amended Insurance Code section 10123.196 to:

- Add subdivision (b)(1)(A)(ii), providing that a health insurance policy, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2024, shall:
    - Not require a prescription to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.[3]
    - Provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost sharing or medical management restrictions.[4]

Both non-grandfathered health insurance policies and grandfathered health plans must provide point-of-sale coverage for over-the-counter contraceptives,[5] including but not limited to male condoms, at in-network pharmacies without a prescription, cost sharing, or medical management restrictions, including prior authorization and quantity limits.[6] Point-of-sale coverage means that a claim must be processed by in-network pharmacies without cost sharing; therefore, an insured may not be required to pay upfront and submit a claim for reimbursement.

Please note that additional amendments to section 10123.196 went into effect in 2023, as follows:

- The coverage mandate applies with respect to all policyholders and insureds, not just women.[7]
- Any clinical services related to the provision or use of contraception must be covered, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.[8]
- If a therapeutically equivalent generic substitute is unavailable, an insurer shall provide coverage without cost sharing for the original, brand name contraceptive.[9]
- If a covered therapeutic equivalent of a contraceptive drug, device, or product is deemed medically inadvisable by the insured's provider, an insurer shall defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive without imposing any cost-sharing requirements. Medical inadvisability includes considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the provider.[10]

---

[3] Ins. Code § 10123.196(b)(1)(A)(ii)(I).
[4] Ins. Code § 10123.196(b)(1)(A)(ii)(II).
[5] FDA-approved over-the-counter contraceptives currently include the following: Opill (when available); male and female condoms; levonorgestrel emergency contraceptive; vaginal sponge; and nonoxynol-9 spermicide products such as suppository, gel, film, and foam.
[6] Ins. Code § 10123.196(b)(1)(A)(ii).
[7] Ins. Code § 10123.196(b)(1).
[8] Ins. Code § 10123.196(b)(1)(C).
[9] Ins. Code § 10123.196(b)(2)(B).
[10] Ins. Code § 10123.196(b)(2)(C).

- Except to the extent authorized by the statute with respect to therapeutic equivalents, an insurer is prohibited from infringing upon an insured's choice of contraceptive or imposing prior authorization, step therapy, and other utilization management techniques.[11]

- The religious employer exception does not apply to a contraceptive that is used for purposes other than contraception.[12]

Added Insurance Code section 10123.1945, providing that:

- A health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2024, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy services or procedures.[13] The cost-sharing prohibition does not apply to a policy providing excepted benefits, a grandfathered health plan, or a qualifying health plan for a health savings account.[14]
- For a qualifying health plan for a health savings account, an insurer shall establish the plan's cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under Internal Revenue Service laws, regulations, and guidance.[15]
- An insurer shall not impose any restrictions or delays, including, but not limited to, prior authorization, on vasectomy services and procedures.[16]

Added Insurance Code section 10127.09, providing that:

- A health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2024, and that is issued to a bona fide public or private institution of higher learning and provides coverage to its students and their dependents, or to its faculty, staff, administration, and their respective dependents, shall comply with the coverage requirements of sections 10123.1945 and 10123.196.
- Section 10127.09 does not apply to a policy providing only dental or vision benefits.

2. AB 1823 (Bryan, ch. 688, Stats. 2022)—Student health insurance

Added Insurance Code section 10965.03, providing that:

- For policy years beginning on or after January 1, 2024, a blanket disability insurance policy that meets the definition of student health insurance coverage set forth in the statute shall be considered individual health insurance coverage for purposes of section 106(b).[17]
- Except as otherwise expressly provided by the statute, a blanket disability insurance policy that meets the definition of student health insurance coverage shall comply with

[11] Ins. Code § 10123.196(b)(3).
[12] Ins. Code § 10123.196(e)(1).
[13] Ins. Code § 10123.1945(a)(1).
[14] *Ibid.*
[15] *Ibid.*
[16] Ins. Code § 10123.1945(a)(2).
[17] Ins. Code § 10965.03(a).

the provisions of the Insurance Code that are applicable to nongrandfathered individual health insurance, including, but not limited to, essential health benefits requirements as set forth in section 10112.27, rating factors consistent with section 10965.9, the annual limit on maximum out-of-pocket expenses as set forth in section 10112.28, the prohibition against annual and lifetime limits pursuant to section 10112.1, and all rules and regulations issued thereunder.[18]

- Student health insurance coverage shall provide at least 60 percent actuarial value, as calculated in accordance with section 10112.295. The issuer shall specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage, or the next lowest level of coverage, and how the coverage would otherwise satisfy requirements under sections 10112.295 and 10112.296.
- Student health insurance coverage shall be subject to the nongrandfathered large group market rate review requirements pursuant to Article 4.5[19] (commencing with section 10181) of Chapter 1 of Division 2 of the Insurance Code, except section 10181(b)(2) and section 10181.4.[20]
- Student health insurance coverage shall be subject to the requirements of:[21]
    - Sections 10270.3(b) and (c), 10290, 10291.5(b)(1), and 10382.
- A notice, as specified in the statute, shall be provided in the student health insurance enrollment materials provided to a student or a dependent of a student.[22]
- "Student health insurance coverage" is a blanket disability policy under section 10270.2(a)(2), that covers hospital, medical, or surgical benefits, that is provided pursuant to a written agreement between an institution of higher education, as defined in the federal Higher Education Act of 1965, and a disability insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets all of the following conditions:
    - Does not make coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education.
    - Does not condition eligibility for the insurance coverage on any health status-related factor relating to a student or a dependent of a student.
    - Does not condition eligibility, an offer, issuance, a sale, or a renewal for the insurance coverage on any factor other than enrollment as a student or dependent of a student in the institution of higher education.[23]

All student health coverage offered by an institution of higher education in California, except self-funded student health coverage offered by the University of California, must comply with section 10965.03.[24] This summary does not include all provisions of the statute. Exemptions

[18] Ins. Code § 10965.03(c).
[19] Although section 10965.03 refers to Article 4.7, section 10181 *et. seq.* is located in Article 4.5.
[20] Ins Code § 10965.03(e)(4).
[21] Ins Code § 10965.03(e)(6).
[22] Ins Code § 10965.03(g)(1).
[23] Ins. Code § 10965.03(b).
[24] AB 1823 (Bryan, ch. 688, Stats. 2022), § 1.

from, and modifications to, certain statutory requirements are set forth in the statute; therefore, please consult the statute for further details.

Instructions on submitting rate filings under section 10181.45 may be distributed in the future. Additional reporting requirements that apply to student health insurance coverage beginning in 2024 include the health insurance covered lives report[25] and prescription drug information.[26]

3. SB 326 (Eggman, ch. 790, Stats. 2023)—The Behavioral Health Services Act

While SB 326 did not amend the Insurance Code, it made numerous amendments to the Mental Health Services Act (Prop. 63, approved Nov. 2, 2004). However, most changes are subject to voter approval on the March 5, 2024 primary election ballot. Therefore, insurers should review the amendments for any potential impact on their existing and, should voter approval occur, future, obligations under the Mental Health Services Act.

4. SB 421 (Limón, ch. 607, Stats. 2023)—Health care coverage: cancer treatment

Amended Insurance Code section 10123.206, effective January 1, 2024, to:

- Delete the January 1, 2024 sunset date.
- Specify that the section does not apply to a specialized health insurance policy that covers only dental or vision benefits.[27]

5. SB 487 (Atkins, ch. 261, Stats. 2023)—Abortion: provider protections

Added Insurance Code section 10133.641, providing that:

- A contract issued, amended, or renewed on or after January 1, 2024, between a health insurer and a provider of health care services shall not contain any term that would result in termination or nonrenewal of the contract based solely on a civil judgment issued in another state, a criminal conviction in another state, or another professional disciplinary action in another state, if those actions were 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 California.[28]
- A health insurer shall not discriminate against a licensed provider based solely on a civil judgment issued in another state, a criminal conviction in another state, or another professional disciplinary action in another state, if those actions were 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 California.[29]

[25] Ins. Code §§ 10127.19(a)
[26] Ins. Code § 10123.205.
[27] Ins. Code § 10123.206(b).
[28] Ins. Code § 10133.641(a).
[29] Ins. Code § 10133.641(b).

6. SB 496 (Limón, ch. 401, Stats. 2023)—Biomarker testing

Added Insurance Code section 10123.209, providing that:

- A health insurance policy that is issued, amended, delivered, or renewed on or after July 1, 2024, shall cover medically necessary biomarker testing, as specified.[30]
- Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition.[31]
- A health insurer shall ensure that biomarker testing is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.[32]
- Utilization review is permitted, except that the section is subject to the provisions of section 10123.20[33] for an insured with advanced or metastatic stage 3 or 4 cancer.[34]
- Medical necessity requirements are subject to section 10123.135(f).[35]
- Grievance and appeal processes under Public Health Service Act section 2719 (42 USC Sec. 300gg-19) and applicable regulations apply to restricted or denied use of biomarker testing.[36]

7. SB 621 (Caballero, ch. 495, Stats. 2023)—Health care coverage: biosimilar drugs

Amended Insurance Code section 10123.201, effective January 1, 2024, to:

- Add that the section does not prohibit an insurer or utilization review organization (URO) from requiring an insured to try a biosimilar, as defined in 42 USC section 262(i)(2), before providing coverage for the equivalent branded prescription drug.[37]
- Specify that the definition of interchangeable biological product is found in 42 USC section 262(i)(3).[38]
- Specify that subdivision (c)(2)(C)(ii) (permitting an insurer or URO to require an insured to try an AB-rated generic equivalent, biosimilar, or interchangeable biological product before providing coverage for the equivalent branded prescription drug) does not supersede a step therapy exception request.[39]

---

[30] Ins. Code § 10123.209(a).
[31] *Ibid.*
[32] Ins. Code § 10123.209(c).
[33] Ins. Code § 10123.20(b) prohibits prior authorization for biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer, including testing for cancer progression or recurrence.
[34] Ins. Code § 10123.209(a), (f).
[35] Ins. Code § 10123.209(d).
[36] *Ibid.*
[37] Ins. Code § 10123.201(c)(2)(C)(ii).
[38] *Ibid.*
[39] Ins. Code § 10123.201(c)(2)(C)(iii).

A step therapy exception request for a brand prescription drug must be approved if any of the criteria for an exception are satisfied, such as if an insured has already tried, or has a contraindication to, the generic equivalent, biosimilar, or interchangeable biological product.[40]

Insurers are reminded that section 10123.201 applies to *any* health insurance policy that covers outpatient prescription drugs,[41] and therefore it applies to both a non-grandfathered policy and a grandfathered health plan.

8. SB 743 (Nguyen, ch. 217, Stats. 2023)—Insurance: false and fraudulent claims

Amended Insurance Code section 1871.2, effective January 1, 2024, to:

- Replace "seeks to make a change to an existing policy" with "seeks to amend insurance coverage, or furnishes information relating to underwriting criteria affecting premium or eligibility for coverage, under an existing policy…."[42]

9. SB 805 (Portantino, ch. 635, Stats. 2023)—Health care coverage: pervasive developmental disorders or autism

Amended Insurance Code section 10144.51, effective January 1, 2024, to:

- Expand the definition of "qualified autism service professional" to include a psychological associate, associate marriage and family therapist, associate clinical social worker, or associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.[43]

- Require that a qualified autism service professional who is a psychological associate, associate marriage and family therapist, associate clinical social worker, or associate professional clinical counselor also meets the criteria set forth in the regulations adopted pursuant to Welfare and Institutions Code section 4686.4 for a behavioral health professional.[44]

10. SB 793 (Glazer, ch. 184, Stats. 2023)—Insurance: privacy notices and personal information

Added Insurance Code section 791.045, effective January 1, 2024, providing that:

- In addition to the notice required by section 791.04, an insurance institution or agent shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. For purposes of section 791.045, "annually" means at least once in any period of 12 consecutive months during which that relationship exists.[45]

---

[40] Ins. Code § 10123.201(c)(2)(B).
[41] Ins. Code § 10123.201(a).
[42] Ins. Code § 1871.2(a).
[43] Ins. Code § 10144.51(c)(4)(D)(ii).
[44] Ins. Code § 10144.51(c)(4)(E)(ii).
[45] Ins. Code § 791.045(a)(1).

- The required notice shall comply with Title 10 of the California Code of Regulations, section 2698.7.[46]

- The notices required pursuant to sections 791.04 and 791.045 may be combined into a single notice or provided as separate notices, as long as the requirements of sections 791.04 and 791.045 are met.[47]

- If the insurance institution or agent uses a separate, standard privacy notice in addition to the notices required pursuant to sections 791.04 and 791.045, the notices required pursuant to sections 791.04 and 791.045 shall clearly state that any rights a consumer, claimant, or beneficiary may have as described in these are not limited by the standard privacy notice that the insurance institution or agent also uses.[48]

- An insurance institution or agent shall be deemed to comply with section 791.045 if all of the conditions specified in subdivision (c) are met.[49]

11. AB 118 (Committee on Budget, ch. 42, Stats. 2023)—Budget Act of 2023: health

Effective July 10, 2023, amended Insurance Code section 10144.57. Section 10144.57 now provides as follows:

- Coverage of mental health and substance use disorder treatment pursuant to section 10144.5 includes behavioral health crisis services that are provided to an insured by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility.[50]
- With respect to behavioral health crisis services that are provided to an insured by a 988 center or mobile crisis team, a health insurance policy shall cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.[51]
- A health insurer shall not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an insured before stabilization has occurred or before it has conducted utilization review in accordance with sections 10144.5 and 10144.52.[52]
- Notwithstanding any other law, payment for behavioral health crisis stabilization services and care shall not be denied unless a health insurer reasonably determines that care was not rendered.[53]
- If an insured receives behavioral health crisis services and care from a 988 center, mobile crisis team, or other provider of behavioral health crisis services that is an out-of-

[46] Ins. Code § 791.045(a)(2).
[47] Ins. Code § 791.045(b)(1).
[48] Ins. Code § 791.045(b)(2).
[49] Ins. Code § 791.045(c).
[50] Ins. Code § 10144.57(a).
[51] *Ibid.*
[52] Ins. Code § 10144.57(b)(4).
[53] Ins. Code § 10144.57(b)(2).

network provider, the insured shall pay no more than the same cost sharing that the insured would pay for the same items or services received from an in-network provider.[54]

- A health insurer shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency or nonemergency behavioral health crisis services and care consistent with the requirements of sections 10123.13, 10123.147, and any other applicable requirement.[55]
- A health insurer shall not require prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.[56]
- If its prior authorization requirements comply with section 10144.4, a health insurer may require prior authorization for poststabilization care. If there is a disagreement between a health insurer and behavioral health crisis services provider or facility regarding the need for poststabilization care, an insurer shall assume responsibility for care of the insured by promptly arranging for care pursuant to section 10144.5 at a level of care determined in accordance with utilization review criteria under section 10144.52.[57]
- A health insurer shall prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized insured's care to another provider or authorization to provide poststabilization care.[58]
- If prior authorization is required for poststabilization care, a health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall, within 30 minutes of the time the provider makes the initial contact, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the insured's care to another provider.[59]
- A health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall reimburse the provider or facility for poststabilization care rendered to the insured if any of the following occur:
    - The health insurer authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care.[60]
    - The health insurer did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the insured's care within 30 minutes of the time the provider made the initial contact.[61]

[54] Ins. Code § 10144.57(d)(2) (*see also*, (c)(5)).
[55] Ins. Code § 10144.57(d).
[56] Ins. Code § 10144.57(b)(1).
[57] Ins. Code § 10144.57(b)(3).
[58] Ins. Code § 10144.57(c)(3).
[59] Ins. Code § 10144.57(c)(1).
[60] Ins. Code § 10144.57(c)(2)(A).
[61] Ins Code. § 10144.57(c)(2)(B), (c)(1).

    - There is an unreasonable delay in the transfer of the insured's care to another provider, and the provider determines that the insured requires poststabilization care.[62]

- An insured is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider or facility, the insured's condition is such that, within reasonable medical probability, both of the following criteria are satisfied:
    - Material deterioration of the insured's condition is unlikely to result from, or occur during, the discharge or transfer of the insured to the care of another provider or facility.[63]
    - The insured is able to travel safely from the site of care using nonmedical transportation or nonemergency medical transportation. A health insurer shall continue to cover all services and care as behavioral health crisis stabilization services until the insured is discharged or transferred.[64]

Section 10144.57 applies to a health insurance policy, except Medicare supplement, dental-only, and vision-only policies.[65]

12. AB 317 (Weber, ch. 322, Stats. 2023)—Pharmacist service coverage

Amended Insurance Code section 10125.1, effective January 1, 2024, to:

- Provide that every insurer issuing disability insurance that covers hospital medical, or surgical expenses that offers coverage for a service that is within the scope of practice of a duly licensed pharmacist shall pay or reimburse the cost of the service performed by a pharmacist at an in-network pharmacy or an out-of-network pharmacy if the insurer has an out-of-network pharmacy benefit.[66]

Section 10125.1 now applies to any health insurance policy, not just group, that offers coverage for a service that is within the scope of practice of a licensed pharmacist.[67]

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

Amended Insurance Code section 10123.18 to:

- Delete language in subdivision (a), limiting the application to a policy that includes coverage for treatment or surgery of cervical cancer. Therefore, any health insurance policy issued, amended, or renewed on or after January 1, 2024, shall provide coverage for an annual cervical cancer screening test, as specified.[68]

---

[62] Ins. Code § 10144.57(c)(2)(C).
[63] Ins. Code § 10144.57(e)(4)(A).
[64] Ins. Code § 10144.57(e)(4)(B).
[65] Ins. Code § 10144.57(g).
[66] Ins. Code § 10125.1(a).
[67] *Ibid.*
[68] Ins. Code. § 10123.18(a).

- Provide that a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall provide coverage for the human papillomavirus (HPV) vaccine for insureds for whom the vaccine is approved by the FDA.[69]
- Provide that a health insurance policy shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the HPV vaccine.[70]

This statute, including the prohibition on cost sharing for the HPV vaccine, applies to a grandfathered health plan.[71] Non-grandfathered health insurance policies must also comply with this statute, including to the extent it exceeds the requirements of section 10112.2.[72]

14. AB 716 (Boerner, ch. 454, Stats. 2023)—Ground medical transportation

Added Insurance Code section 10126.66, providing that:

- A health insurance policy issued, amended, or renewed on or after January 1, 2024, shall require an insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting ground ambulance provider, or the "in-network cost sharing amount."[73]
- The in-network cost sharing amount shall count toward the in-network annual limit on out-of-pocket expenses under section 10112.28, and any deductible, in the same manner as cost sharing would be attributed to a contracting provider.[74]
- At the time of payment to the noncontracting provider, insurers must inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured, and shall disclose whether or not the coverage is state-regulated, specifically by the Department.[75]
- Unless otherwise agreed to, a health insurer shall directly reimburse a noncontracting ground ambulance provider for services an amount equal to the difference between the in-network cost sharing amount and an amount specified in the statute.[76]

Repealed Insurance Code section 10352.

15. AB 904 (Calderon, ch. 349, Stats. 2023)—Health care coverage: doulas

Added Insurance Code section 10123.868, providing that:

- On or before January 1, 2025, a health insurer shall develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant

[69] Ins. Code § 10123.18(b).
[70] *Ibid.*
[71] Ins. Code § 10123.18(a), (b).
[72] *Ibid.*
[73] Ins. Code § 10126.66(a)
[74] Ins. Code § 10126.66(b).
[75] Ins. Code § 101266.66(a)(2).
[76] Ins. Code § 10126.66(d).

health outcomes through the use of doulas. This may be achieved by integrating the program into existing maternal mental health programs, including those encouraging the coverage of doula care, or by expanding existing doula programs.

16. AB 948 (Berman, ch. 820, Stats. 2023)—Prescription drugs

Amended Insurance Code section 10123.1932, effective January 1, 2024, to:

- Provide that a copayment or percentage coinsurance for an outpatient prescription drug shall not exceed 50 percent of the cost to the insurer, as described in Title 28 of the California Code of Regulations, section 1300.67.24.[77]
- Provide that if there is a generic equivalent to a brand name drug, an insurer shall ensure that the insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary.[78]
- Delete "biologics" from the tier 4 definition.[79]
- Delete the January 1, 2024 sunset date.

Section 10123.1932 applies only to non-grandfathered health insurance policies that cover outpatient prescription drugs.

17. AB 952 (Wood, ch. 125, Stats. 2023)—Dental Coverage Disclosures

Added Insurance Code section 10120.42, providing that:

- On or after January 1, 2025, a health insurer that issues, sells, renews, or offers a policy covering dental services, including a specialized health insurer covering dental services,[80] must do the following:
    - Assist a provider in determining if an insured's coverage is regulated by the State of California by disclosing whether an insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request.[81]
    - If the insured's dental coverage is subject to regulation by the Department, include the statement "State Regulated" on an electronic or physical identification card, or both if available.[82]

[77] Ins. Code § 10123.1932(a)(6).
[78] Ins. Code § 10123.1932(a)(7).
[79] Ins. Code § 10123.1932(b)(1)(D).
[80] Ins. Code § 10120.42(c).
[81] Ins. Code § 10120.42(a).
[82] Ins. Code § 10120.42(b).

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

Added Insurance Code section 10120.41, providing that:

- On and after January 1, 2025, a health insurer shall not issue, sell, renew, or offer a large group dental insurance policy that imposes a dental waiting period provision, as defined.[83]
- On and after January 1, 2025, a health insurer shall not issue, sell, renew, or offer a dental insurance policy that imposes a preexisting condition provision, as defined.[84]

Section 10120.41 applies to a health insurer, as defined, that issues, sells, renews, or offers a health insurance policy covering dental services, including a specialized health insurance policy covering dental services.[85]

Amended Insurance Code section 10181.2 to:

- Apply rate review requirements to a specialized health insurance policy covering dental services.

Added section 10181.14, providing that:

- On and after January 1, 2025, a specialized health insurance policy covering dental services is subject to rate filing requirements.[86]

The Department may issue guidance related to the new rate filing requirements by July 1, 2024.[87]

[83] Ins. Code § 10120.41(b).
[84] *Ibid.*
[85] *Ibid.*
[86] Ins. Code § 10181.14(a).
[87] Ins. Code § 10181.14(g)(2), (g)(3).