DEPARTMENT OF MANAGED HEALTH CARE

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> *Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.*
>
> — Business and Professions Code § 1601.2

The Department of Managed Health Care (DMHC), created on July 1, 2000, regulates the managed care industry in California. The creation of DMHC resulted from Governor Gray Davis's approval of AB 78 (Gallegos) (Chapter 525, Statutes of 1999), a bill that reformed the regulation of managed care in the state. DMHC is created in Health and Safety Code section 1341; DMHC's regulations are codified in Title 28 of the California Code of Regulations (CCR).

DMHC administers the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 et seq., which is intended to promote the delivery of health and medical care to Californians who enroll in services provided by a health care service plan. A "health care service plan" (health plan)—more commonly known as a health maintenance organization (HMO) or managed care organization (MCO)—is defined broadly as any person who undertakes to arrange for the provision of health care services to enrollees, or to pay for or reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of enrollees.

In Health and Safety Code section 1342, the legislature has expressly instructed the Department Director to ensure the continued role of the professional as the determiner of the

patient's health needs; ensure that enrollees are educated and informed of the benefits and services available in order to increase consumer choice in the healthcare market; and promote effective representation of the interests of enrollees, including ensuring the best possible health care at the lowest possible cost by transferring the financial risk of health care from patients to providers. The Department Director must also prosecute individuals and/or health plans who engage in fraud or misrepresent or deceive consumers, ensure the financial stability of health plans through proper regulation, and ensure that health care be accessible to enrollees and rendered in a manner to provide continuity of care, which includes a grievance process that is expeditious and thoroughly reviewed by DMHC.

The Director of DMHC is appointed by and serves at the pleasure of the Governor. The Department's staff of attorneys, financial examiners, health plan analysts, physicians, health care professionals, consumer service representatives, and support staff assist the DMHC Director in licensing and regulating more than 130 health plans in California. Licensed health plans include HMOs and other full-service health plans, as well as several categories of specialized health plans such as prepaid dental, vision, mental health, chiropractic, and pharmacy plans. DMHC-licensed health plans provide health care services to approximately 26 million California enrollees.

Created in Health and Safety Code section 1374.30 et seq., DMHC's independent medical review (IMR) system allows health plan enrollees to seek an independent review when medical services are denied, delayed, or otherwise limited by a plan or one of its contracting providers, based on a finding that the service is not medically necessary or appropriate. The independent reviews are conducted by expert medical organizations that are independent of the health plans and certified by an accrediting organization. An IMR determination is binding on the health plan, and the Department will enforce it.

SB 260 (Speier) (Chapter 529, Statutes of 1999), added section 1347.15 to the Health and Safety Code to create the Financial Solvency Standards Board (FSSB). Comprised of the DMHC Director and seven members appointed by the Director, FSSB periodically monitors and reports on the implementation and results of those requirements and standards, and reviews proposed regulatory changes. FSSB advises the DMHC Director on matters of financial solvency affecting the delivery of health care services. FSSB develops and recommends financial solvency requirements and standards relating to plan operations.

DMHC houses the Help Center, which is open 24 hours a day, 365 days a year, and functions in many languages to help consumers who experience problems with their health plan. The Help Center educates consumers about their health care rights; resolves consumer complaints; helps consumers navigate and understand their coverage; and ensures access to appropriate health care services. The DMHC Help Center provides direct assistance to health care consumers through a call center and online access. DMHC is funded by assessments on its regulated health plans.

HIGHLIGHTS

FSSB Receives a Preview of the Department's Upcoming Proposals for Regulations

On November 7, 2019, FSSB held its quarterly meeting in Sacramento. At the meeting, as reflected in the meeting transcript, DMHC Acting General Counsel, Sarah Ream previewed for the Board four regulations that DMHC is currently developing and intends to submit to the Office of Administrative Law (OAL) early in 2020.

The first is a regulation that would adopt a standard methodology for health plans to report their compliance with the Department's timely access to care requirements. The second proposed regulation is being developed in response to concerns raised by consumer groups, and would adopt

specified time frames in which health plans must respond to consumer inquiries about their out-of-pocket maximum charges, and require health care plans to treat such as grievances, so that enrollees are informed as quickly as possible about this information.

The third regulation is being developed to implement SB 1008 (Skinner) (Chapter 933, Statutes of 2018), and would develop a standard matrix for dental plans to use, allowing enrollees to compare and understand the coverage and cost of different plans. Lastly, DMHC is developing a regulation to improve the help center, correct regulation inconsistencies, and better reflect what health centers and plans actually do. At this writing, the Department has not yet published formal notice of these proposed regulations with OAL.

DMHC Director Approves Anthem, Inc.'s Acquisition of Beacon Health Options

At FSSB's February 5, 2020 meeting, DMHC Director Shelley Rouillard announced her approval of Anthem, Inc.'s proposed acquisition of Beacon Health Options. The Department has new authority to review potential mergers involving health plans within DMHC's jurisdiction, and the Director has discretion to disapprove a transaction if she believes it would substantially lessen competition, pursuant to AB 595 (Wood) (Chapter 292, Statutes of 2018). *[see 24:1 CRLR 33–34]* Anthem, Inc. announced its plan to acquire Beacon Health Options (Beacon), "the largest independently held behavioral health organization in the country," on June 6, 2019, stating its intent to expand its focus on behavioral health solutions as part of whole person care.

According to Ms. Rouillard's statements (p. 8:16) at the February meeting, a Department analysis concluded that the proposed merger did not constitute a "major transaction" pursuant to AB 595, and thus her approval was made without need for an open public meeting or impact statement in accordance with the Bagley-Keene Open Meeting Act. The term "major transaction"

is defined in section 1399.65 (g)(1) of the Health and Safety Code, and includes the following criteria: "(A) Affects a significant number of enrollees; (B) Involves a material amount of assets; (C) Adversely affects either the subscribers or enrollees or the stability of the health care delivery system because of the entity's market position, including, but not limited to, the entity's market exit from a market segment or the entity's dominance of a market segment."

While Director Rouillard did mention at the July and November FSSB meetings that she was reviewing the merger, no public statement or order approving the merger has been issued at this writing, other than her announcement at the February meeting. Pursuant to section 1399.65(b)(2) of the Health and Safety Code, if a member of the public requests it, the Director must make available to the public her determination that her approval did not require a public hearing.

Department Fines Health Plans $1.9 Million for Failing to Provide Care to California Enrollees

On December 18, 2019, the DMHC announced enforcement action against 12 health plans, imposing fines totaling $1.9 million for their failure to properly oversee a contracted medical group that was improperly denying and delaying enrollees' health care. Fines ranged from $2,500 on Cigna HealthCare of California, Inc. to $450,000 on Blue Cross of California Partnership Plan. The Department determined the various fine amounts based on factors such as the plans' enrollment assigned to the contractor in question; cooperation with DMHC;corrective steps taken; and the nature, scope, and gravity of the violations.

DMHC originally opened an investigation into the Employee Health Care Systems Group (EHS), a medical group contracting several health plans, following a whistleblower report in October 2017. EHS subcontracted with SynerMed to oversee the care of over 550,000 health plan

enrollees and fulfill all of EHS's contracted duties, such as handling health care services requests and managing payments to provider medical claims. SynerMed and EHS shared many of the same personnel and were effectively the same organization. In December 2017, the Department issued a cease and desist order to the 12 health plans, directing them to terminate their contract with EHS to prevent further harm to enrollees.

DMHC's investigation revealed that EHS and SynerMed had been illegally denying enrollees access to care in order to make a profit by implementing a host of unlawful tactics, including restricting access to specialists who were deemed too expensive to be covered; discriminating against enrollees requesting high-cost treatments for special conditions by sending them to a team designed to pressure them to leave EHS, and in fact diverting over 5,000 enrollees who then experienced delays in care; and systematically forging thousands of audit documents to make it appear as though it sent enrollees denial or modification notices, when in fact it had not.

DMHC reached individual settlement agreements with each of the 12 health plans, imposing the fines, and requiring the health plans to implement corrective action plans that include better oversight tactics, system integrity tests, and outreach to affected enrollees. Under the terms of the agreements, the plans must also prevent any illegal use of economic profiling and ensure that employees of contracted entities have appropriate outlets to report internal fraud and abuse. According to DMHC's Director, Shelley Rouillard, "The health plans must improve their oversight to make sure their enrollees have proper access to care and their contractors follow the law."

DMHC Releases 2018 Timely Access Report

In January 2020, the Department published its Timely Access Report for 2018. The Timely Access Regulation, section 1300.67.2.2, Title 28, of the CCR, which became effective in 2010, requires that health plan networks be sufficient to meet a set of standards, which include specific

timeframes under which enrollees must be able to obtain care. These standards include wait times to access urgent and non-urgent care appointments and availability of telephone triage or screening services during and after regular business hours. The regulation requires health plans to submit annual compliance reports to the DMHC, which then summarizes this data into the Timely Access Report.

Key Findings for Full-Service Health Plans. The Report provides the data each health care plan reported, including graphs displaying the percentage of surveyed providers that meet the wait time standards set forth in section 1300.67.2.2(c). These standards state the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment which is no longer than fifteen business days, *or* in cases involving urgent care is within 48 hours of the request for appointment (*see* 28 CCR § 1300.67.2.2(c)). The Report further delineated the data, separating information by product survey results (Commercial, Individual/Family and Medi-Cal) and then all provider types (primary care, specialty, non-physician mental health, and ancillary).

Consistently, Sharp Health Plan, Kaiser Permanente, and Kern Health Systems ranked among the top three health plans in compliance with the appointment wait time standards. The top plans reported eighty to ninety percent of their providers in compliance. Consistently, the lowest-performing plans were Central California Alliance for Health and Community Care Health Plan, Inc., reporting in the high sixties and low seventies for both urgent and non-urgent compliant providers. Larger providers like Aetna Health of California, Blue Shield of California, and Anthem Blue Cross all remain generally towards the median reporting within the high seventies and low eighties. [*See* Report at 12 (Chart 1)]

Notably, providers' lowest compliance occurs among providers who are expected to meet the urgent appointment wait time standards. [*See* Report at 20 (Chart 9)]

Behavioral Health Plans. Of the six reporting behavioral health plans, Managed Health Network held the highest compliance percentage at 80 percent. OptumHealth Behavioral Solution of California was the lowest at 73 percent. For non-urgent appointments, this percentage increased as the plans reported compliance ranging from a high of 90 percent to a low of 82 percent. [*See* Report at 29 (Chart 17)]

Conclusions and Next Steps. According to the report's conclusions, the Department plans to improve the accuracy and completeness of the yearly timely access compliance data. Health plans are obligated to follow the mandatory methodology under the CCR, but it is up to the Department to enforce such compliance and refer those that fail to comply to the DMHC Office of Enforcement (*see* 28 CCR § 1300.67.2.2(g)).

DMHC also reports that it plans to amend the existing timely access regulation in 2020 to include a rate of compliance standard that will be applied to each health plan network rather than aggregated by health plan. DMHC also hopes to require health plans to continue utilizing an external vendor to perform a quality assurance review and include a validation report of the health plans' data before submission to the Department. The Department has also committed to review stakeholder input as it begins the formal rulemaking process to amend its timely access regulation. At this writing, the Department has not yet formally noticed these proposed amendments to the OAL.

DMHC Response to Covid-19 Crisis

- ***All Plan Letter encouraging health plans take actions to help slow the spread of COVID-19.*** On March 12, 2020, DMHC acting general counsel, Sarah Ream, issued an All Plan

Letter to all health care service plans in response to the COVID-19 pandemic. The letter addresses the declaration of a pandemic by the World Health Organization (WHO) and the state of emergency issued by California Governor Gavin Newsom on March 4, 2020. The Department encourages health plans to assist with medically appropriate "social distancing" in the delivery of health care services pursuant to WHO, the Centers for Disease Control and Prevention (CDC), and the California Department Public Health recommendations. In addition to this, the All Plan Letter also outlines further actions health care service plans should take to further prevent the spread of the virus.

The first action outlined is the expansion of telehealth healthcare delivery. DMHC encourages the health plans to expedite or relax the preauthorization requirements that allow contracted providers to have covered telehealth care, as defined in Business and Professions Code section 2290.5. In addition, DMHC asks that the plans waive applicable cost-sharing for care delivered via telehealth in spite of a cost-share being applicable if the provider had delivered the care in-person. This recommendation was further discussed in a prior letter issued on March 5, 2020, which directs all plans to immediately reduce cost-sharing (including, but not limited to, co-pays, deductibles, or coinsurance) to zero for all medically necessary screening and testing for COVID-19, including hospital visits (including emergency department), urgent care visits, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19.

The March 12 All Plan Letter also recommends that plans decrease the need for in-person pharmacy visits by providing coverage for outpatient prescription drug benefits. To do this, DMHC encourages plans to allow enrollees to receive a 90-day supply maintenance of drugs, as indicated in section 1300.67.24(d)(3)(D), Title 28 of the CCR. The letter also advises plans to suspend prescription drug refill limitations and waive delivery charges for home delivery of prescriptions.

- ***DMHC Issues Series of All Plan Letters Directing Health Plans to Ensure Californians Can Access Necessary Medical Care Through Telehealth.*** In a March 18, 2020 All Plan Letter, the Department directed health plans to reimburse providers for care provided through telehealth at the same rate as in-person care and to ensure enrollee cost-sharing is not changed for telehealth services. DMHC followed this initial directive with an April 7, 2020 All Plan Letter, directing plans to "mitigate negative health outcomes due to COVID-19." The letter acknowledged the pervasive impacts of crises, such as pandemics or natural disasters, on the mental and physical health of the public. This is not just in terms of physical stress responses, but lack of access to resources and health care as well. DMHC reminded plans and providers of their responsibility to address and minimize these negative impacts, in part by educating providers on "disaster-responsive, trauma-informed care," developing trust between patients and providers, responding to signs of patients' physical and mental stress, and demonstrating sensitivity to patients' identities.

An April 15, 2020 All Plan Letter reiterated this message in regards to the health care needs of the elderly and other at-risk populations, especially those patients who live alone. These vulnerable populations require the support of their health plans and their communities to maintain their mental, physical, and social needs during the coronavirus crisis. To do this, the letter directed health plans to continue providing all medically appropriate telehealth services, and to continually assess "the provision for allowable additional services and supports during this time . . . that may be vital for an older or at-risk adult staying home and staying healthy."

The letter provides a list of resources and hotlines that address the basic needs of vulnerable patient populations, including resources for check-in calls, food security, social interaction, stress-related health, and weekly activities.

- ***All Plan Letter Regarding Populations Vulnerable to Coronavirus.*** In a March 27, 2020 All Plan Letter addressed to all full-service commercial, full-service Medi-Cal, and full-service Medicare Advantage Plans, DMHC advised that people with chronic conditions, disabled people, and people over 65 are especially vulnerable to coronavirus, and directs the health plans to "actively engag[e] with enrollees in these groups to ensure the enrollees continue to receive the care they need while practicing appropriate social distancing."

The letter required health plans to file a report with DMHC by March 31, 2020, with a description of the steps the health plan is taking to contact vulnerable enrollees and ensure they receive the care they need; and an approximation of the number of enrollees the health plan has contracted in each of the three vulnerable categories (over 65 years old, disabled, chronic health conditions), counting enrollees who fall into multiple categories only once.

MAJOR PUBLICATIONS

The following reports and studies have been conducted by or about DMHC during this reporting period:

- ***2018 Prescription Drug Cost Transparency Report***, Department of Managed Health Care, January 10, 2020 (Annual report pursuant to SB 17 (Hernandez) (Chapter 603, Statutes of 2017), summarizing the findings and the impact of prescription drug costs on health care premiums; reveals that increases in prescription drug costs significantly outpaced increases in overall medical expenses in California in 2018; finds health plans paid more than $400 million more on prescription drugs in 2018 than they did in 2017—comprising 12.7 percent of total health plan premiums in 2018.)

- ***Task Force on Pharmacy Benefit Management Report***, Department of Managed Health Care, February 2020 (Legislative report, pursuant to AB 315 (Wood) (Chapter 905, Statutes of 2018), assesses what information related to pharmaceutical costs DMHC should require to be reported by health care service plans or their contracted Pharmacy Benefit Managers (PBMs); recommends that PBMs report both drug-specific and aggregate information on the services PBMs provide for commercial health plans to DMHC, including a list of the 100 most expensive drugs, the 100 most prescribed drugs, and the 100 highest revenue-producing drugs, identify the drugs as "generic," "brand," "specialty," or "other," and for each individual drug, identify the type of pharmacy that fills the drug prescription, ("integrated," "chain," "independent," "specialty," or "mail order" pharmacies), as well as its price and rebate information. Additionally, recommends that PBMS report aggregate information including revenue and expense information; a list of health plans that the PBM contracts with, the scope of services each plan provides, and the number of enrollees the PBM served; revenue from manufacturers, health plans, pharmacies, and other sources; and expenses, including payments to pharmacies, claims processing, special programs, administration, and other expenses.)

LEGISLATION

- **AB 1904 (Boerner Horvath)**, as introduced January 8, 2020, would add section 1367.623 to the Health and Safety Code to require health care plans to cover pelvic floor physical therapy after a pregnancy. For health care plans, willful violation of this requirement would be a crime and the bill would impose a state-mandated local program. *[A. Health]*

- **AB 1973 (Kamlager)**, as amended February 27, 2020, would add section 1367.251 to the Health and Safety Code to prohibit a health care service plan from imposing any cost-sharing

requirement on coverage for all abortion services. Cost-sharing is also prohibited from being imposed on Medi-Cal enrollees for all abortion services. *[A. Health]*

- **AB 1986 (Gipson)**, as introduced January 23, 2020, would add section 1367.668 to the Health and Safety Code to require a health care plan to cover colorectal cancer screenings. Coverage would have to include additional screenings if the enrollee has a high risk for colorectal cancer. The plan or policy would be prohibited from imposing cost-sharing for colonoscopies conducted for specific reasons on enrollees between 50 and 75 years old. *[A. Health]*

- **AB 2118 (Kalra)**, as introduced February 6, 2020, would add section 1385.043 to the Health and Safety Code to expand reporting requirements for health plans to include specified information on premiums, cost sharing, benefits, enrollment, and trend factors as reported in all rate filings for the health care service plan. The bill would also require DMHC, beginning in 2022 to annually present the information at a meeting regarding large group rates and at a public meeting of the board of Covered California. *[A. Health]*

- **AB 2144 (Arambula)**, as amended March 12, 2020, would amend sections 1367.241 and 1367.244, and add section 1367.206 to the Health and Safety Code to clarify that health care service plans may require step therapy if there is more than one drug that is appropriate to treat a medical condition. The bill also clarifies the circumstances under which health service plans must expedite the grant of a step therapy exception; provides procedures for enrollees to file an appeal of prior authorization or denial of step therapy exception requests; and imposes reporting requirements for plans to report specific information about step therapy exception requests annually to DMHC. *[A. Health]*

- **AB 2157 (Wood)**, as introduced February 10, 2020, would amend section 1371.30 of the Health and Safety Code to require DMHC's independent dispute resolution organization to

establish procedures for each party to submit confidential evidence; conduct de novo reviews of claim disputes based solely on information and documents timely submitted by the parties as evidence; and ensure that reviewers are assigned according to their education, background, and experience. *[A. Health]*

- **AB 2204 (Arambula)**, as amended February 27, 2020, would add section 1367.48 to the Health and Safety Code to require health care plans issued after January 1, 2021, to cover the testing and treatment of sexually transmitted diseases at a non-contracting health facility at the same cost-sharing rate as an enrollee or insurer would pay at a contracting facility. *[A. Health]*

- **AB 2239 (Maienschein and Chiu)**, as amended March 12, 2020, would amend sections 1341.45 and 128552 of the Health and Safety Code to increase the annual amount of funds transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians from $1,000,000 to $2,000,000 to repay the loans of physicians in medically underserved areas through the Steven M. Thompson Physician Corps Loan Repayment Program. It would also expand the definition of qualifying "practice settings" for the loan repayment program to include a program or facility that is operated by or contracted to a county mental health plan. *[A. Health]*

- **AB 2242 (Levine)**, as introduced on February 13, 2020, would add section 1367.014 to the Health and Safety Code to require a health care service plan that includes coverage for mental health services to approve the mental health services for persons who are detained for 72 hour treatment under the Lanterman-Petris-Short Act to schedule an initial outpatient appointment within 48 hours of the person's release from detention. *[A. Health]*

- **AB 2450 (Grayson)**, as introduced on February 19, 2020, would amend section 1371.55 of the Health and Safety Code to make technical, non-substantive changes to provisions

regarding the contracting and coverage for emergency medical transportation services, specifically air ambulances. *[A. Desk]*

- **AB 2625 (Boerner Horvath)**, as introduced on February 20, 2020, would add section 1371.56 to the Health and Safety Code to require a health care service plan contract that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. *[A. Health]*

- **AB 2640 (Gonzalez)**, as introduced on February 20, 2020, would amend section 1367.665 of the Health and Safety Code to prohibit an individual or group health care service plan contract from requiring prior authorization for genetic biomarker testing for an enrollee with metastatic or advanced stage 3 or 4 cancer. *[A. Health]*

- **AB 2781 (Wicks)**, as introduced on February 20, 2020, would repeal and add section 1374.55 of the Health and Safety Code to require every health care service plan contract to provide coverage for the treatment of infertility, revise the definition of infertility to include in vitro fertilization, and would delete the exemption for religiously-affiliated employers and health plans. *[A. Health]*

- **AB 2892 (Rivas)**, as introduced on February 21, 2020, would amend section 1348.9 of the Health and Safety Code to remove the January 1, 2024 sunset date on DMHC's Consumer Participation Program. [*A. Health]*

- **SB 175 (Pan)**, as amended January 6, 2020, is a two-year bill that would repeal and add section 1367.001 of the Health and Safety Code to delete the requirement that a health plan comply with the bar to lifetime or annual limits as required by federal law. It instead would bar an

individual or group health care service plan from establishing lifetime or annual limits on the dollar value of benefits for an enrollee. *[A. Desk]*

- **SB 406 (Pan)**, as amended January 6, 2020, would repeal and add section 1367.002 of the Health and Safety Code to delete the requirement that a health plan comply with federal requirements to cover preventive health services without cost sharing and would instead require an individual or group health care service plan to cover specified preventive services without any cost-sharing requirements for those services, at minimum. *[A. Desk]*

- **SB 854 (Beall)**, as introduced January 14, 2020, would add section 1374.78 to the Health and Safety Code to require health care plans that provide prescription drug benefits for the treatment of substance abuse to "place prescription medications approved by the U.S. Food and Drug Administration (FDA) on the lowest cost-sharing tier of the plan or insurer's prescription drug formulary." Plans would be required to make information related to treatment services available online and in printed provider directories and must state that these provisions do not apply to plan contracts under Medi-Cal. *[S. Health]*

- **SB 855 (Wiener)**, as introduced January 14, 2020, would add section 1367.045 and repeal and add section 1374.72 to the Health and Safety Code to require health plan contracts to cover the diagnosis and treatment of mental health and substance use disorders under the same terms and conditions as other medical conditions. Plans and policies would not be permitted to limit benefits or coverage for mental health or substance use disorders to short-term or acute treatment. *[S. Health, S. Jud.]*

- **SB 977 (Monning)**, as amended March 16, 2020, would add Division 1.7 (commencing with section 1190) to the Health and Safety Code to provide the Attorney General with additional oversight authority with respect to health care system consolidation. Specifically,

it would require health care systems, defined as entities that own two or more hospitals within multiple counties, or three or more hospitals in one county, to provide written notice to, and obtain the written consent of, the Attorney General prior to an affiliation or acquisition between the health care system and health care facility or provider. It would also require the Attorney General, beginning July 1, 2021, to establish a Health Policy Advisory Board to evaluate and analyze health care markets and produce an annual report. Additionally, the bill would make it unlawful for healthcare systems to use their market power for anticompetitive purposes and authorize the Attorney General to bring a civil action for violation of this unlawful conduct, including specified civil penalties. *[S. Health]*

- **SB 1033 (Pan)**, as introduced on February 14, 2020, would add section 1363.6 to the Health and Safety Code, to authorize DMHC to review a health plan's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. *[S. Health]*

- **SB 1452 (Morrell)**, as amended on March 25, 2020, would add section 1342.715 to the Health and Safety Code to require a health care service plan to include coverage for any biological product or biosimilar, as defined, if the health plan contract provides for medical or prescription drug benefits and coverage for any biological product or biosimilar. *[S. RLS]*