AMENDED IN ASSEMBLY APRIL 21, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 980

Introduced by Assembly Member Arambula

February 20, 2025

An act to amend Section 3428 of the Civil Code, *to add Section 1367.52 to the Health and Safety Code, and to add Section 10123.52 to the Insurance Code,* relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 980, as amended, Arambula. Health ~~care service plan: managed care entity: duty of care~~. *care: medically necessary treatment.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. Existing law generally authorizes a health care service plan or health insurer to use utilization review to approve, modify, delay, or deny requests for health care services based on medical necessity.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the

delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

Under existing law, a health care service plan or managed care entity has a duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers or enrollees and is liable for all harm legally caused by its failure to exercise that ordinary care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee and the subscriber or enrollee suffers substantial harm, as defined.

This bill would define "medically necessary health care service" for purposes of the above-described provision to mean legally prescribed medical care that is reasonable and comports with the medical community standard.

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 no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 3428 of the Civil Code is amended to read:

3428. (a) For services rendered on or after January 1, 2001, a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of

medically necessary health care service to its subscribers and enrollees, if the health care service is a benefit provided under the plan or through the entity, and shall be liable for all harm legally caused by its failure to exercise that ordinary care when both of the following apply:

(1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.

(2) The subscriber or enrollee suffered substantial harm.

(b) (1) For purposes of this section: (A) "substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss; (B) health care services need not be recommended or furnished by an in-plan provider, but may be recommended or furnished by a health care provider practicing within the scope of the provider's practice; and (C) health care services shall be recommended or furnished at any time prior to the inception of the action, and the recommendation need not be made prior to the occurrence of substantial harm.

(2) For purposes of this section, "medically necessary health care service" means legally prescribed medical care that is reasonable and comports with the medical community standard.

(c) Health care service plans and managed care entities are not health care providers under any law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 or 3333.2 of this code, or Sections 340.5, 364, 425.13, 667.7, or 1295 of the Code of Civil Procedure.

(d) A health care service plan or managed care entity shall not seek indemnity, whether contractual or equitable, from a provider for liability imposed under subdivision (a). Any provision to the contrary in a contract with providers is void and unenforceable.

(e) This section shall not create a liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees or on behalf of self-funded employee benefit plans.

(f) Waiver by a subscriber or enrollee of the provisions of this section is contrary to public policy and shall be unenforceable and void.

(g) This section does not create any new or additional liability on the part of a health care service plan or managed care entity for

harm caused that is attributable to the medical negligence of a treating physician or other treating health care provider.

(h) This section does not abrogate or limit any other theory of liability otherwise available at law.

(i) This section does not apply in instances where subscribers or enrollees receive treatment by prayer, consistent with the provisions of subdivision (a) of Section 1270 of the Health and Safety Code, in lieu of medical treatment.

(j) Damages recoverable for a violation of this section include, but are not limited to, those set forth in Section 3333.

(k) (1) A person may not maintain a cause of action pursuant to this section against an entity required to comply with an independent medical review system or independent review system required by law unless the person or the person's representative has exhausted the procedures provided by the applicable independent review system.

(2) Compliance with paragraph (1) is not required in a case where either of the following applies:

(A) Substantial harm, as defined in subdivision (b), has occurred prior to the completion of the applicable review.

(B) Substantial harm, as defined, in subdivision (b), will imminently occur prior to the completion of the applicable review.

(*l*) If any provision of this section or the application thereof to a person or circumstance is held to be unconstitutional or otherwise invalid or unenforceable, the remainder of the section and the application of those provisions to other persons or circumstances shall not be affected by that holding.

SEC. 2. Section 1367.52 is added to the Health and Safety Code, to read:

1367.52. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) A health care service plan contract shall not limit benefits or coverage for physical conditions and diseases to short-term or acute treatment.

(b) The benefits covered pursuant to this section shall include all of the following:

(1) Basic health care services, as defined in Section 1345.

(2) Intermediate services, including the full range of levels of care, including residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits covered pursuant to this section that shall be applied equally to all benefits under the plan contract shall include all of the following enrollee financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of physical conditions and diseases are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(e) (1) A health care service plan shall base a medical necessity determination or the utilization review criteria that the plan, and an entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases on current generally accepted standards of health care.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases in children, adolescents, and adults, a health care service plan or an entity acting on the plan's behalf shall apply the criteria and guidelines set forth in the most

recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan or an entity acting on the plan's behalf shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan or an entity acting on the plan's behalf from applying utilization review criteria to health care services and benefits for physical conditions and diseases that meet either of the following criteria:

(A) Are outside the scope of the criteria and guidelines set forth in the sources specified in paragraph (2), provided the utilization review criteria were developed in accordance with paragraph (1).

(B) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in paragraph (2), provided that the utilization review criteria were developed in accordance with paragraph (1).

(4) If a health care service plan or an entity acting on the plan's behalf purchases or licenses utilization review criteria pursuant to subparagraph (A) or (B) of paragraph (3), the plan or entity shall verify and document before use that the criteria were developed in accordance with paragraph (1).

(5) To ensure the proper use of the criteria described in paragraph (2), a health care service plan or an entity acting on the plan's behalf shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(B) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(C) Provide, at no cost, the clinical review criteria and any training material or resources to providers and enrollees.

(D) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(E) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review.

(F) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(G) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(6) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract, or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section does not expand or alter the benefits available to the enrollee.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with physical conditions and diseases shall be conducted in accordance with this subdivision. This subdivision does not deprive an enrollee of the other protections of this chapter, including grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) Notwithstanding any other law, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing in the provision of benefits required by this section, if these practices are consistent with Section 1367.01 of this code, and Section 2052 of the Business and Professions Code.

(9) This section does not limit the independent medical review rights of an enrollee under this chapter.

(10) The director may assess administrative penalties for violations of this subdivision as provided for in Section 1368.04, in addition to any other remedies permitted by law.

(f) (1) To comply with this section, a health care service plan may provide coverage for all or part of the health care services required by this section through a separate specialized health care service plan or health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the physical conditions and diseases treatment coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements may require enrollees who reside or work in geographic areas served by specialized health care service plans or health plans to secure all or part of their health services within those geographic areas served by specialized health care service plans or health plans, if all physical conditions and diseases treatment services are actually available within those geographic service areas within timeliness standards.

(g) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(h) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.

(i) For purposes of this section:

(1) "Generally accepted standards of care for physical conditions and diseases" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based

sources establishing generally accepted standards of health care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of physical conditions and diseases" means a service or product addressing the specific needs of that enrollee, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of care for physical conditions and diseases.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the enrollee, treating physician, or other health care provider.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or reviewed community guidelines used by a health care service plan to conduct utilization review.

(j) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of

Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(k) This section does not deny or restrict the department's authority to ensure plan compliance with this chapter.

SEC. 3. Section 10123.52 is added to the Insurance Code, to read:

10123.52. (a) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) A health insurance policy shall not limit benefits or coverage for physical conditions and diseases to short-term or acute treatment.

(b) The benefits covered pursuant to this section shall include all of the following:

(1) Basic health care services, as defined in Section 10112.281.

(2) Intermediate services, including the full range of levels of care, including residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the policy includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits covered pursuant to this section that shall be applied equally to all benefits under the policy shall include all of the following insured financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of physical conditions and diseases are not available in network within the geographic and timely access standards set by law or regulation, the health insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes providing

services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from an in-network provider.

(e) (1) A health insurer shall base a medical necessity determination or the utilization review criteria that the insurer, and an entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases on current generally accepted standards of health care.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases in children, adolescents, and adults, a health insurer or an entity acting on the insurer's behalf shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health insurer or an entity acting on the insurer's behalf shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health insurer or an entity acting on the insurer's behalf from applying utilization review criteria to health care services and benefits for physical conditions and diseases that meet either of the following criteria:

(A) Are outside the scope of the criteria and guidelines set forth in the sources specified in paragraph (2), provided the utilization review criteria were developed in accordance with paragraph (1).

(B) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in paragraph (2), provided that the utilization review criteria were developed in accordance with paragraph (1).

(4) If a health insurer or an entity acting on the insurer's behalf purchases or licenses utilization review criteria pursuant to subparagraph (A) or (B) of paragraph (3), the insurer or entity shall verify and document before use that the criteria were developed in accordance with paragraph (1).

(5) To ensure the proper use of the criteria described in paragraph (2), a health insurer or an entity acting on the insurer's behalf shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health insurer's staff, including any third parties contracted with the health insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(B) Make the education program available to other stakeholders, including the health insurer's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(C) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insureds.

(D) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(E) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review.

(F) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(G) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(6) A health insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This section does not expand or alter the benefits available to the insured.

(7) All medical necessity determinations by the health insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with physical conditions and diseases shall be conducted in accordance with this subdivision. This subdivision does not deprive an insured of the other protections of this chapter, including grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) Notwithstanding any other law, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing in the provision of benefits required by this section, if these practices are consistent with Section 10123.135 of this code, and Section 2052 of the Business and Professions Code.

(9) This section does not limit the independent medical review rights of an insured under this chapter.

(10) If the commissioner determines that an insurer has violated this subdivision, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(f) (1) To comply with this section, a health insurer may provide coverage for all or part of the health care services required by this section through a separate specialized health insurer or health insurer, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the physical conditions and diseases treatment coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurance policies that provide benefits to insureds through preferred provider contracting arrangements may require insureds who reside or work in geographic areas served by specialized health insurers or health insurers to secure all or part of their health services within those geographic areas served by specialized health insurers or health insurers, if all physical conditions and

diseases treatment services are actually available within those geographic service areas within timeliness standards.

(g) A health insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(h) A health insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.

(i) For purposes of this section:

(1) "Generally accepted standards of care for physical conditions and diseases" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources establishing generally accepted standards of health care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of physical conditions and diseases" means a service or product addressing the specific needs of that insured, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of care for physical conditions and diseases.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the health insurer and policyholders or for the convenience of the insured, treating physician, or other health care provider.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health insurance policy is covered as medically necessary for an insured.

(4) "Utilization review criteria" means any criteria, standards, protocols, or reviewed community guidelines used by a health insurer to conduct utilization review.

(j) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(k) This section does not deny or restrict the department's authority to ensure insurer compliance with this chapter.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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