

AMENDED IN ASSEMBLY AUGUST 24, 2012

AMENDED IN ASSEMBLY AUGUST 20, 2012

AMENDED IN SENATE APRIL 16, 2012

AMENDED IN SENATE MARCH 26, 2012

SENATE BILL

No. 951

Introduced by Senator Hernandez

(Principal coauthor: Assembly Member Monning)

January 5, 2012

An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 951, as amended, Hernandez. Health care coverage: essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

~~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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and and requires health insurance policies to cover various benefits.~~

This bill would require an individual or small group ~~health care service plan contract~~ or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the health benefits covered by particular benchmark plans. The bill would ~~authorize a plan or insurer to place scope and duration limits on those benefits, except as specified, provided that the limits are not greater than~~ *prohibit treatment limits imposed on these benefits from exceeding* the *corresponding* limits imposed by the benchmark plans and would generally prohibit a ~~plan or an~~ insurer from making substitutions of the benefits required to be covered. The bill would specify that these provisions apply regardless of whether the ~~contract or~~ policy is offered inside or outside the Exchange but would provide that they do not apply to grandfathered plans or plans that cover ~~only~~ excepted benefits, as specified. The bill would prohibit a ~~health care service plan or~~ health insurer, when *issuing, delivering, renewing, offering, selling, or marketing a plan contract or* policy, from indicating or implying that the ~~contract or~~ policy covers essential health benefits unless the ~~contract or~~ policy covers essential health benefits as provided in the bill. The bill would *authorize the Department of Insurance to adopt emergency regulations implementing these provisions until March 1, 2016, and* enact other related provisions.

These provisions would only be implemented to the extent essential health benefits are required pursuant to PPACA. *The bill would provide that it shall become operative only if AB 1453 is also enacted.*

~~Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

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

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

1 SECTION 1. The Legislature hereby finds and declares the
2 following:

3 (a) Commencing January 1, 2014, the federal Patient Protection
4 and Affordable Care Act (PPACA) requires a health insurance
5 issuer that offers coverage to small employers or individuals, both
6 inside and outside of the California Health Benefit Exchange, with
7 the exception of grandfathered plans as defined under Section 1251
8 of PPACA, to provide minimum coverage that includes essential
9 health benefits, as defined.

10 (b) It is the intent of the Legislature to comply with federal law
11 and consistently implement the essential health benefits provisions
12 of PPACA and related federal guidance and regulations, by
13 adopting the uniform minimum essential benefits requirement in
14 state-regulated health care coverage regardless of whether the
15 policy or contract is regulated by the Department of Managed
16 Health Care or the Department of Insurance and regardless of
17 whether the policy or contract is offered to individuals or small
18 employers inside or outside of the California Health Benefit
19 Exchange.

20 ~~SEC. 2. Section 1367.005 is added to the Health and Safety~~
21 ~~Code, to read:~~

22 ~~1367.005. (a) An individual or small group health care service~~
23 ~~plan contract issued, amended, or renewed on or after January 1,~~
24 ~~2014, shall, at a minimum, include coverage for essential health~~
25 ~~benefits. For purposes of this section, "essential health benefits"~~
26 ~~means all of the following:~~

27 ~~(1) (A) The health benefits covered by the Kaiser Foundation~~
28 ~~Health Plan Small Group HMO 30 plan (federal health product~~
29 ~~identification number 40513CA035) as this plan was offered during~~
30 ~~the first quarter of 2012, including, but not limited to, all of the~~
31 ~~following:~~

32 ~~(i) The health benefits covered by the plan within the categories~~
33 ~~identified in subsection (b) of Section 1302 of PPACA, including,~~
34 ~~but not limited to, ambulatory patient services, emergency services,~~
35 ~~hospitalization, maternity and newborn care, mental health and~~

1 substance use disorder services, including behavioral health
2 treatment, prescription drugs, rehabilitative and habilitative services
3 and devices, laboratory services, preventive and wellness services
4 and chronic disease management, and pediatric services, including
5 oral and vision care.

6 ~~(ii) The health benefits mandated to be covered by the plan~~
7 ~~pursuant to statutes enacted before December 31, 2011, including,~~
8 ~~but not limited to, basic health care services required to be covered~~
9 ~~pursuant to Section 1367, as defined in Section 1345 and in Section~~
10 ~~1300.67 of Title 28 of the California Code of Regulations. These~~
11 ~~benefits are required to be covered to the extent described in the~~
12 ~~following sections: Sections 1367.002, 1367.06, and 1367.35~~
13 ~~(preventive services for children); Section 1367.25 (prescription~~
14 ~~drug coverage for contraceptives); Section 1367.45 (AIDS~~
15 ~~vaccine); Section 1367.46 (HIV testing); Section 1367.51~~
16 ~~(diabetes); Section 1367.54 (alpha feto protein testing); Section~~
17 ~~1367.6 (breast cancer screening); Section 1367.61 (prosthetics for~~
18 ~~laryngectomy); Section 1367.62 (maternity hospital stay); Section~~
19 ~~1367.63 (reconstructive surgery); Section 1367.635 (mastectomies);~~
20 ~~Section 1367.64 (prostate cancer); Section 1367.65~~
21 ~~(mammography); Section 1367.66 (cervical cancer); Section~~
22 ~~1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);~~
23 ~~Section 1367.68 (surgical procedures for jaw bones); Section~~
24 ~~1367.71 (anesthesia for dental); Section 1367.9 (conditions~~
25 ~~attributable to diethylstilbestrol); Section 1368.2 (hospice care);~~
26 ~~Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency~~
27 ~~response ambulance or ambulance transport services); subdivision~~
28 ~~(b) of Section 1373 (sterilization operations or procedures); Section~~
29 ~~1373.4 (inpatient hospital and ambulatory maternity); Section~~
30 ~~1374.56 (phenylketonuria); Section 1374.17 (organ transplants for~~
31 ~~HIV); Section 1374.72 (mental health parity); and Section 1374.73~~
32 ~~(autism/behavioral health treatment).~~

33 ~~(iii) The health benefits covered by the plan that are not~~
34 ~~otherwise required to be covered under this chapter, to the extent~~
35 ~~required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,~~
36 ~~1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the~~
37 ~~California Code of Regulations, whether or not the health benefits~~
38 ~~are specifically referenced in the plan contract.~~

39 ~~(B) Coverage of mental health and substance use disorder~~
40 ~~services pursuant to this paragraph, along with any scope and~~

1 duration limits imposed on the benefits, shall be in compliance
2 with the Paul Wellstone and Pete Domenici Mental Health Parity
3 and Addiction Equity Act of 2008 (Public Law 110-343), and all
4 binding rules, regulations, or guidance issued pursuant to Section
5 2726 of the federal Public Health Service Act (42 U.S.C. Sec.
6 300gg-26).

7 ~~(2) With respect to habilitative services, in addition to any~~
8 ~~habilitative services identified in paragraph (1), coverage shall~~
9 ~~also be provided as required by binding federal rules, regulations,~~
10 ~~and guidance issued pursuant to Section 1302(b) of PPACA.~~
11 ~~Habilitative services shall be covered under the same terms and~~
12 ~~conditions applied to rehabilitative services under the plan contract.~~

13 ~~(3) With respect to pediatric vision care, the same health benefits~~
14 ~~for pediatric vision care covered under the Federal Employees~~
15 ~~Dental and Vision Insurance Program vision plan with the largest~~
16 ~~national enrollment as of the first quarter of 2012. The pediatric~~
17 ~~vision care benefits covered pursuant to this paragraph shall be in~~
18 ~~addition to, and shall not replace, any vision services covered under~~
19 ~~the plan identified in paragraph (1).~~

20 ~~(4) With respect to pediatric oral care, the same health benefits~~
21 ~~for pediatric oral care covered under the dental plan available to~~
22 ~~subscribers of the Healthy Families Program in 2011-12, including~~
23 ~~the provision of medically necessary orthodontic care provided~~
24 ~~pursuant to the federal Children's Health Insurance Program~~
25 ~~Reauthorization Act of 2009. The pediatric oral care benefits~~
26 ~~covered pursuant to this paragraph shall be in addition to, and shall~~
27 ~~not replace, any dental or orthodontic services covered under the~~
28 ~~plan identified in paragraph (1).~~

29 ~~(5) Except as otherwise provided in subdivision (p), any other~~
30 ~~benefits required to be covered under this chapter.~~

31 ~~(b) (1) Medically necessary health benefits described in this~~
32 ~~section shall be covered subject to cost sharing approved by the~~
33 ~~director and any limitations consistent with this section. Limitations~~
34 ~~imposed on health benefits shall be no greater than the limitations~~
35 ~~imposed by the corresponding plans identified in subdivision (a).~~

36 ~~(2) A plan may place scope and duration limits on health benefits~~
37 ~~described in this section, other than basic health care services~~
38 ~~described in clause (ii) of subparagraph (A) of paragraph (1) of~~
39 ~~subdivision (a), provided that the scope and duration limits are no~~

1 greater than the scope and duration limits imposed on those benefits
2 by the corresponding plans identified in subdivision (a).

3 ~~(e) Except as otherwise provided in subdivision (d), if it is
4 determined that a plan identified in subdivision (a), with respect
5 to benefits and services covered by a plan contract and any scope
6 and duration limits applied to those benefits and services pursuant
7 to the contract, is not fully in compliance with this chapter, the
8 identification of that plan pursuant to this section shall not be
9 construed to exempt the plan from full compliance with this
10 chapter.~~

11 ~~(d) Notwithstanding subdivision (c) or any other provision of
12 this section, the home health services benefits covered under the
13 plan identified in paragraph (1) of subdivision (a) shall be deemed
14 to not be in conflict with this chapter.~~

15 ~~(e) Except as provided in subdivision (f), nothing in this section
16 shall be construed to permit a health care service plan to make
17 substitutions for the benefits required to be covered under this
18 section, regardless of whether those substitutions are actuarially
19 equivalent.~~

20 ~~(f) To the extent permitted under Section 1302 of PPACA and
21 any binding rules, regulations, or guidance issued pursuant to that
22 section, and to the extent that substitution would not create an
23 obligation for the state to defray costs for any individual, a plan
24 may substitute its prescription drug formulary for the formulary
25 provided under the plan identified in subdivision (a) as long as the
26 formulary complies with the sections referenced in clauses (ii) and
27 (iii) of subparagraph (A) of paragraph (1) of subdivision (a) that
28 apply to prescription drugs.~~

29 ~~(g) No health care service plan, or its agent, solicitor, or
30 representative, shall offer, market, represent, or sell any product,
31 contract, or discount arrangement as minimum coverage, or as
32 compliant with the essential health benefits requirement in federal
33 law, unless it meets all of the requirements of this section.~~

34 ~~(h) This section shall apply regardless of whether the plan
35 contract is offered inside or outside the California Health Benefit
36 Exchange created by Section 100500 of the Government Code.~~

37 ~~(i) A plan contract subject to this section shall comply with
38 Section 1367.001.~~

- 1 ~~(j) A plan contract subject to this section shall comply with state~~
2 ~~and federal statutory and regulatory requirements regarding~~
3 ~~nondiscrimination, including, but not limited to, Section 1365.5.~~
4 ~~(k) This section shall not be construed to prohibit a plan contract~~
5 ~~from covering additional benefits, including, but not limited to,~~
6 ~~spiritual care services that are tax deductible under Section 213 of~~
7 ~~the Internal Revenue Code.~~
8 ~~(l) Subdivision (a) shall not apply to any of the following:~~
9 ~~(1) A specialized health care service plan contract.~~
10 ~~(2) A Medicare supplement plan.~~
11 ~~(3) A plan contract that qualifies as a grandfathered health plan~~
12 ~~under Section 1251 of PPACA or any binding rules, regulations,~~
13 ~~or guidance issued pursuant to that section.~~
14 ~~(m) Nothing in this section shall be implemented in a manner~~
15 ~~that is inconsistent with, or conflicts with, a requirement of~~
16 ~~PPACA.~~
17 ~~(n) This section shall be implemented only to the extent essential~~
18 ~~health benefits are required pursuant to PPACA.~~
19 ~~(o) An essential health benefit is required to be provided under~~
20 ~~this section only to the extent that federal law or policy does not~~
21 ~~require the state to defray the costs of the benefit.~~
22 ~~(p) A plan is not required to cover, under this section, changes~~
23 ~~to health benefits that are the result of statutes enacted on or after~~
24 ~~December 31, 2011.~~
25 ~~(q) No later than February 1, 2013, the director shall, in~~
26 ~~consultation with the Insurance Commissioner, develop and publish~~
27 ~~a list of covered health benefits and limitations contained in the~~
28 ~~plans subject to this section, to ensure consistency and uniformity~~
29 ~~between health care service plan contracts and health insurance~~
30 ~~policies. In developing the list, the director and commissioner shall~~
31 ~~take into account federal statutes, rules, regulations, and guidance~~
32 ~~applicable to essential health benefits as of that date. Development~~
33 ~~and publication of the list is not subject to the Administrative~~
34 ~~Procedure Act (Chapter 3.5 (commencing with Section 11340) of~~
35 ~~Part 1 of Division 3 of Title 2 of the Government Code).~~
36 ~~(r) (1) Notwithstanding the Administrative Procedure Act~~
37 ~~(Chapter 3.5 (commencing with Section 11340) of Part 1 of~~
38 ~~Division 3 of Title 2 of the Government Code), the department,~~
39 ~~until March 1, 2016, may implement and administer this section~~

1 through all-plan letters or similar instruction from the department
2 until regulations are adopted.

3 ~~(2) The department may adopt emergency regulations~~
4 ~~implementing this section. The department may, on a one-time~~
5 ~~basis, readopt any emergency regulation authorized by this section~~
6 ~~that is the same as, or substantially equivalent to, an emergency~~
7 ~~regulation previously adopted under this section.~~

8 ~~(3) The initial adoption of emergency regulations implementing~~
9 ~~this section and the readoption of emergency regulations authorized~~
10 ~~by this subdivision shall be deemed an emergency and necessary~~
11 ~~for the immediate preservation of the public peace, health, safety,~~
12 ~~or general welfare. Initial emergency regulations and the readoption~~
13 ~~of emergency regulations authorized by this section shall be exempt~~
14 ~~from review by the Office of Administrative Law. The initial~~
15 ~~emergency regulations and the readoption of emergency regulations~~
16 ~~authorized by this section shall be submitted to the Office of~~
17 ~~Administrative Law for filing with the Secretary of State and each~~
18 ~~shall remain in effect for no more than 180 days, by which time~~
19 ~~final regulations may be adopted.~~

20 ~~(4) The director shall consult with the Insurance Commissioner~~
21 ~~to ensure consistency and uniformity in the development of all-plan~~
22 ~~letters and regulations.~~

23 ~~(s) For purposes of this section, the following definitions shall~~
24 ~~apply:~~

25 ~~(1) “Habilitative services” means health care services and health~~
26 ~~care devices that assist an individual in partially or fully acquiring~~
27 ~~or improving skills and functioning and that are necessary to~~
28 ~~address a health deficit or health condition, to the maximum extent~~
29 ~~practical. These services address the skills and abilities needed for~~
30 ~~functioning in interaction with an individual’s environment.~~
31 ~~Habilitation services do not include respite, day care, recreational~~
32 ~~care, residential treatment, social services, custodial care, or~~
33 ~~education services of any kind, including, but not limited to,~~
34 ~~vocational training. Habilitative services shall be covered under~~
35 ~~the same terms and conditions applied to rehabilitative services~~
36 ~~under the plan contract.~~

37 ~~(2) (A) “Health benefits,” unless otherwise required to be~~
38 ~~defined pursuant to binding federal rules, regulations, or guidance~~
39 ~~issued pursuant to Section 1302(b) of PPACA, means health care~~
40 ~~items or services for the diagnosis, cure, mitigation, treatment, or~~

1 prevention of illness, injury, disease, or a health condition,
2 including a mental health condition.

3 (B) “Health benefits” does not mean any cost-sharing
4 requirements or limitations such as copayments, coinsurance, or
5 deductibles.

6 (3) “PPACA” means the federal Patient Protection and
7 Affordable Care Act (Public Law 111-148), as amended by the
8 federal Health Care and Education Reconciliation Act of 2010
9 (Public Law 111-152), and any rules, regulations, or guidance
10 issued thereunder.

11 (4) “Small group health care service plan contract” means a
12 group health care service plan contract issued to a small employer,
13 as defined in Section 1357.

14 SEC. 3.

15 SEC. 2. Section 10112.27 is added to the Insurance Code, to
16 read:

17 10112.27. (a) An individual or small group health insurance
18 policy ~~marketed, offered, sold, issued, delivered, issued, amended,~~
19 or renewed on or after January 1, 2014, shall, at a minimum,
20 include coverage for essential health benefits *pursuant to PPACA*
21 *and as outlined in this section. This section shall exclusively govern*
22 *what benefits a health insurer must cover as essential health*
23 *benefits. For purposes of this section, “essential health benefits”*
24 means all of the following:

25 (1) *Health benefits within the categories identified in Section*
26 *1302(b) of PPACA: ambulatory patient services, emergency*
27 *services, hospitalization, maternity and newborn care, mental*
28 *health and substance use disorder services, including behavioral*
29 *health treatment, prescription drugs, rehabilitative and habilitative*
30 *services and devices, laboratory services, preventive and wellness*
31 *services and chronic disease management, and pediatric services,*
32 *including oral and vision care.*

33 (1)

34 (2) (A) The health benefits covered by the Kaiser Foundation
35 Health Plan Small Group HMO 30 plan (federal health product
36 identification number 40513CA035) as this plan was offered during
37 the first quarter of 2012, ~~including, but not limited to, all of the~~
38 ~~following:~~ *as follows, regardless of whether the benefits are*
39 *specifically referenced in the plan contract or evidence of coverage*
40 *for that plan:*

1 (i) ~~The health benefits covered by the plan within the categories~~
2 ~~identified in subsection (b) of Section 1302 of PPACA, including,~~
3 ~~but not limited to, ambulatory patient services, emergency services,~~
4 ~~hospitalization, maternity and newborn care, mental health and~~
5 ~~substance use disorder services, including behavioral health~~
6 ~~treatment, prescription drugs, rehabilitative and habilitative services~~
7 ~~and devices, laboratory services, preventive and wellness services~~
8 ~~and chronic disease management, and pediatric services, including~~
9 ~~oral and vision care.~~

10 (i) *Medically necessary basic health care services, as defined*
11 *in subdivision (b) of Section 1345 of the Health and Safety Code*
12 *and in Section 1300.67 of Title 28 of the California Code of*
13 *Regulations.*

14 (ii) The health benefits mandated to be covered by the plan
15 pursuant to statutes enacted before December 31, 2011, ~~including,~~
16 ~~but not limited to, basic health care services required to be covered~~
17 ~~pursuant to Section 1367, as defined in Section 1345 of the Health~~
18 ~~and Safety Code, and in Section 1300.67 of Title 28 of the~~
19 ~~California Code of Regulations. These benefits are required to be~~
20 ~~covered to the extent as described in the following sections of the~~
21 ~~Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35~~
22 ~~(preventive services for children); Section 1367.25 (prescription~~
23 ~~drug coverage for contraceptives); Section 1367.45 (AIDS~~
24 ~~vaccine); Section 1367.46 (HIV testing); Section 1367.51~~
25 ~~(diabetes); Section 1367.54 (alpha feto protein testing); Section~~
26 ~~1367.6 (breast cancer screening); Section 1367.61 (prosthetics for~~
27 ~~laryngectomy); Section 1367.62 (maternity hospital stay); Section~~
28 ~~1367.63 (reconstructive surgery); Section 1367.635 (mastectomies);~~
29 ~~Section 1367.64 (prostate cancer); Section 1367.65~~
30 ~~(mammography); Section 1367.66 (cervical cancer); Section~~
31 ~~1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);~~
32 ~~Section 1367.68 (surgical procedures for jaw bones); Section~~
33 ~~1367.71 (anesthesia for dental); Section 1367.9 (conditions~~
34 ~~attributable to diethylstilbestrol); Section 1368.2 (hospice care);~~
35 ~~Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency~~
36 ~~response ambulance or ambulance transport services); Subdivision~~
37 ~~(b) of Section 1373 (sterilization operations or procedures); Section~~
38 ~~1373.4 (inpatient hospital and ambulatory maternity); Section~~
39 ~~1374.56 (phenylketonuria); Section 1374.17 (organ transplants for~~

1 HIV); Section 1374.72 (mental health parity); and Section 1374.73
2 (autism/behavioral health treatment).

3 *(iii) Any other benefits mandated to be covered by the plan*
4 *pursuant to statutes enacted before December 31, 2011, as*
5 *described in those statutes.*

6 ~~(iii)~~

7 *(iv) The health benefits covered by the plan that are not*
8 *otherwise required to be covered under Chapter 2.2 (commencing*
9 *with Section 1340) of Division 2 of the Health and Safety Code,*
10 *to the extent otherwise required pursuant to Sections 1367.18,*
11 *1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health*
12 *and Safety Code, and Section 1300.67.24 of Title 28 of the*
13 *California Code of Regulations, whether or not the health benefits*
14 *are specifically referenced in the health insurance policy.*

15 *(v) Any other health benefits covered by the plan that are not*
16 *otherwise required to be covered under Chapter 2.2 (commencing*
17 *with Section 1340) of Division 2 of the Health and Safety Code.*

18 *(B) Where there are any conflicts or omissions in the plan*
19 *identified in subparagraph (A) as compared with the requirements*
20 *for health benefits under Chapter 2.2 (commencing with Section*
21 *1340) of Division 2 of the Health and Safety Code that were*
22 *enacted prior to December 31, 2011, the requirements of Chapter*
23 *2.2 (commencing with Section 1340) of Division 2 of the Health*
24 *and Safety Code shall be controlling, except as otherwise specified*
25 *in this section.*

26 *(C) Notwithstanding subparagraph (B) or any other provision*
27 *of this section, the home health services benefits covered under*
28 *the plan identified in subparagraph (A) shall be deemed to not be*
29 *in conflict with Chapter 2.2 (commencing with Section 1340) of*
30 *Division 2 of the Health and Safety Code.*

31 ~~(B)~~

32 *(D) For purposes of this section, the Paul Wellstone and Pete*
33 *Domenici Mental Health Parity and Addiction Equity Act of 2008*
34 *(Public Law 110-343) shall apply to a policy subject to this section.*

35 Coverage of mental health and substance use disorder services
36 pursuant to this paragraph, along with any scope and duration
37 limits imposed on the benefits, shall be in compliance with the
38 Paul Wellstone and Pete Domenici Mental Health Parity and
39 Addiction Equity Act of 2008 (Public Law 110-343), and all
40 binding rules, regulations, and guidance issued pursuant to Section

1 2726 of the federal Public Health Service Act (42 U.S.C. Sec.
2 300gg-26).

3 ~~(2)~~

4 (3) With respect to habilitative services, in addition to any
5 habilitative services identified in paragraph~~(1)~~ (2), coverage shall
6 also be provided as required by ~~binding~~ federal rules, regulations,
7 or guidance issued pursuant to Section 1302(b) of PPACA.
8 Habilitative services shall be covered under the same terms and
9 conditions applied to rehabilitative services under the policy.

10 ~~(3)~~

11 (4) With respect to pediatric vision care, the same health benefits
12 for pediatric vision care covered under the Federal Employees
13 Dental and Vision Insurance Program vision plan with the largest
14 national enrollment as of the first quarter of 2012. The pediatric
15 vision care services covered pursuant to this paragraph shall be in
16 addition to, and shall not replace, any vision services covered under
17 the plan identified in paragraph~~(1)~~ (2).

18 ~~(4)~~

19 (5) With respect to pediatric oral care, the same health benefits
20 for pediatric oral care covered under the dental plan available to
21 subscribers of the Healthy Families Program in 2011–12, including
22 the provision of medically necessary orthodontic care provided
23 pursuant to the federal Children’s Health Insurance Program
24 Reauthorization Act of 2009. The pediatric oral care benefits
25 covered pursuant to this paragraph shall be in addition to, and shall
26 not replace, any dental or orthodontic services covered under the
27 plan identified in paragraph~~(1)~~ (2).

28 ~~(5) Except as otherwise provided in subdivision (p), any other~~
29 ~~benefits required to be covered under this part.~~

30 ~~(b) (1) Medically necessary health benefits described in this~~
31 ~~section shall be covered subject to cost sharing approved by the~~
32 ~~commissioner and any limitations consistent with this section.~~
33 ~~Limitations—Treatment limitations~~ imposed on health benefits
34 ~~described in this section~~ shall be no greater than the *treatment*
35 limitations imposed by the corresponding plans identified in
36 subdivision (a), *subject to the requirements set forth in paragraph*
37 *(2) of subdivision (a).*

38 ~~(2) A plan may place scope and duration limits on health benefits~~
39 ~~described in this section, other than basic health care services~~
40 ~~described in clause (ii) of subparagraph (A) of paragraph (1) of~~

1 subdivision (a), provided that the scope and duration limits are no
2 greater than the scope and duration limits imposed on those benefits
3 by the corresponding plans identified in subdivision (a).

4 ~~(e) Except as otherwise provided in subdivision (d), if it is~~
5 ~~determined that a plan identified in subdivision (a), with respect~~
6 ~~to benefits and services covered by a policy and any scope and~~
7 ~~duration limits applied to those benefits and services pursuant to~~
8 ~~the policy, is not fully in compliance with this part, the~~
9 ~~identification of that plan pursuant to this section shall not be~~
10 ~~construed to exempt the plan from full compliance with this part.~~

11 ~~(d) Notwithstanding subdivision (c) or any other provision of~~
12 ~~this section, the home health services benefits covered under the~~
13 ~~plan identified in paragraph (1) of subdivision (a) shall be deemed~~
14 ~~to not be in conflict with this part.~~

15 ~~(e)~~

16 ~~(c) Except as provided in subdivision (f) (d), nothing in this~~
17 ~~section shall be construed to permit a health insurer to make~~
18 ~~substitutions for the benefits required to be covered under this~~
19 ~~section, regardless of whether those substitutions are actuarially~~
20 ~~equivalent.~~

21 ~~(f)~~

22 ~~(d) To the extent permitted under Section 1302 of PPACA and~~
23 ~~any binding rules, regulations, or guidance issued pursuant to that~~
24 ~~section, and to the extent that substitution would not create an~~
25 ~~obligation for the state to defray costs for any individual, an insurer~~
26 ~~may substitute its prescription drug formulary for the formulary~~
27 ~~provided under the plan identified in subdivision (a) as long as the~~
28 ~~formulary coverage for prescription drugs complies with the~~
29 ~~sections referenced in clauses (ii) and (iii) (iv) of subparagraph~~
30 ~~(A) of paragraph (1) (2) of subdivision (a) that apply to prescription~~
31 ~~drugs.~~

32 ~~(g)~~

33 ~~(e) No health insurer, or its agent, producer, or representative,~~
34 ~~shall issue, deliver, renew, offer, market, represent, or sell any~~
35 ~~product, policy, or discount arrangement as minimum coverage,~~
36 ~~or as compliant with the essential health benefits requirement in~~
37 ~~federal law, unless it meets all of the requirements of this section.~~
38 ~~*This subdivision shall be enforced in the same manner as Section*~~
39 ~~*790.03, including through the means specified in Sections 790.035*~~
40 ~~*and 790.05.*~~

1 ~~(h)~~

2 (f) This section shall apply regardless of whether the policy is
3 offered inside or outside the California Health Benefit Exchange
4 created by Section 100500 of the Government Code.

5 ~~(i) A health insurance policy subject to this section shall comply
6 with Section 10112.1.~~

7 ~~(j) A health insurance policy subject to this section shall comply
8 with state and federal statutory and regulatory requirements
9 regarding nondiscrimination, including, but not limited to, Section
10 10140.~~

11 (g) *Nothing in this section shall be construed to exempt a health
12 insurer or a health insurance policy from meeting other applicable
13 requirements of law.*

14 ~~(k)~~

15 (h) This section shall not be construed to prohibit a policy from
16 covering additional benefits, including, but not limited to, spiritual
17 care services that are tax deductible under Section 213 of the
18 Internal Revenue Code.

19 ~~(l)~~

20 (i) Subdivision (a) shall not apply to any of the following:

21 (1) ~~A policy consisting solely of coverage of that provides~~
22 ~~excepted benefits as described in Sections 2722 and 2791 of the~~
23 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42~~
24 ~~U.S.C. Sec. 300gg-91).~~

25 (2) A policy that qualifies as a grandfathered health plan under
26 Section 1251 of PPACA or any binding rules, regulation, or
27 guidance issued pursuant to that section.

28 ~~(m)~~

29 (j) Nothing in this section shall be implemented in a manner
30 ~~that is inconsistent with, or conflicts with,~~ a requirement of
31 PPACA.

32 ~~(n)~~

33 (k) This section shall be implemented only to the extent essential
34 health benefits are required pursuant to PPACA.

35 ~~(o)~~

36 (l) An essential health benefit is required to be provided under
37 this section only to the extent that federal law ~~or policy~~ does not
38 require the state to defray the costs of the benefit.

1 (m) Nothing in this section shall obligate the state to incur costs
2 for the coverage of benefits that are not essential health benefits
3 as defined in this section.

4 ~~(p)~~

5 (n) An insurer is not required to cover, under this section,
6 changes to health benefits that are the result of statutes enacted on
7 or after December 31, 2011.

8 ~~(q) No later than February 1, 2013, the commissioner shall, in
9 consultation with the Director of the Department of Managed
10 Health Care, develop and publish a list of covered health benefits
11 and limitations contained in the health insurance policies subject
12 to this section, to ensure consistency and uniformity between health
13 insurance policies and health care service plan contracts. In
14 developing the list, the commissioner and director shall take into
15 account federal statutes, rules, regulations, and guidance applicable
16 to essential health benefits as of that date. Development and
17 publication of the list is not subject to the Administrative Procedure
18 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of
19 Division 3 of Title 2 of the Government Code).~~

20 ~~(r) (1) Notwithstanding the Administrative Procedure Act
21 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
22 Division 3 of Title 2 of the Government Code), the commissioner,
23 until March 1, 2016, may implement and administer this section
24 through insurer letters or similar instruction from the commissioner
25 until regulations are adopted.~~

26 ~~(2)~~

27 (o) (1) The commissioner may adopt emergency regulations
28 implementing this section. The commissioner may, on a one-time
29 basis, readopt any emergency regulation authorized by this section
30 that is the same as, or substantially equivalent to, an emergency
31 regulation previously adopted under this section.

32 ~~(3)~~

33 (2) The initial adoption of emergency regulations implementing
34 this section and the readoption of emergency regulations authorized
35 by this subdivision shall be deemed an emergency and necessary
36 for the immediate preservation of the public peace, health, safety,
37 or general welfare. ~~Initial emergency regulations and the readoption
38 of emergency regulations authorized by this section shall be exempt
39 from review by the Office of Administrative Law. The initial
40 emergency regulations and the readoption of emergency regulations~~

1 authorized by this section shall be submitted to the Office of
 2 Administrative Law for filing with the Secretary of State and each
 3 shall remain in effect for no more than 180 days, by which time
 4 final regulations may be adopted.

5 ~~(4)~~

6 (3) The commissioner shall consult with the Director of the
 7 Department of Managed Health Care to ensure consistency and
 8 uniformity in the development of ~~insurer letters and~~ regulations
 9 *under this subdivision.*

10 (4) *This subdivision shall become inoperative on March 1, 2016.*

11 ~~(s)~~

12 (p) Nothing in this section shall impose on health insurance
 13 policies the cost sharing or network limitations of the plans
 14 identified in subdivision (a) except to the extent otherwise required
 15 to comply with provisions of this code, including this section, and
 16 as otherwise applicable to all health insurance policies offered to
 17 individuals and small groups.

18 ~~(t)~~

19 (q) For purposes of this section, the following definitions shall
 20 apply:

21 (1) “Habilitative services” means *medically necessary* health
 22 care services and health care devices that assist an individual in
 23 partially or fully acquiring or improving skills and functioning and
 24 that are necessary to address a ~~health deficit or~~ health condition,
 25 to the maximum extent practical. These services address the skills
 26 and abilities needed for functioning in interaction with an
 27 individual’s environment. ~~Habilitation services do not include~~
 28 *Examples of health care services that are not habilitative services*
 29 *include, but are not limited to, respite care, day care, recreational*
 30 *care, residential treatment, social services, custodial care, or*
 31 *education services of any kind, including, but not limited to,*
 32 *vocational training. Habilitative services shall be covered under*
 33 *the same terms and conditions applied to rehabilitative services*
 34 *under the policy.*

35 (2) (A) “Health benefits,” unless otherwise required to be
 36 defined pursuant to ~~binding~~ federal rules, regulations, or guidance
 37 issued pursuant to Section 1302(b) of PPACA, means health care
 38 items or services for the diagnosis, cure, mitigation, treatment, or
 39 prevention of illness, injury, disease, or a health condition,
 40 including a ~~mental~~ *behavioral* health condition.

1 (B) “Health benefits” does not mean any cost-sharing
2 requirements ~~or limitations~~ such as copayments, coinsurance, or
3 deductibles.

4 (3) “PPACA” means the federal Patient Protection and
5 Affordable Care Act (Public Law 111-148), as amended by the
6 federal Health Care and Education Reconciliation Act of 2010
7 (Public Law 111-152), and any rules, regulations, or guidance
8 issued thereunder.

9 (4) “Small group health insurance policy” means a group health
10 care service insurance policy issued to a small employer, as defined
11 in Section 10700.

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

21 *SEC. 3. This act shall become operative only if Assembly Bill*
22 *1453 of the 2011–12 Regular Session is also enacted and becomes*
23 *operative.*