AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 18

Introduced by Assembly Member Pan

December 3, 2012

An act to amend Sections ~~1367.003, 1367.005,~~ *1367.005* and 1385.02 of, and to add ~~Section 1367.013~~ *Sections 1367.013 and 1367.37* to, the Health and Safety Code, and to amend Sections ~~10112.25, 10112.27,~~ *10112.27* and 10181.2 of, and to add ~~Section 10112.35~~ *Sections 10112.35 and 10123.56* to, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 18, as amended, Pan. Health care coverage: pediatric oral care.

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, with respect to plan years on or after January 1, 2014, includes the essential health benefits package, which is defined to include pediatric oral care benefits. 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, as specified, and requires an exchange to allow an issuer to offer stand-alone dental plans in the exchange, provided that the plans cover the pediatric oral care benefits required under the essential health benefits package.

Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. Existing law requires carriers participating in the Exchange that sell products outside the Exchange to offer, market, and sell all products made available to individuals and small employers through the Exchange to individuals and small employers purchasing coverage outside the Exchange. *Existing law requires the board of the Exchange to establish the Small Business Health Options Program (SHOP) to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange.* 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 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 and defines those benefits to include the pediatric oral care benefits provided under a specified dental plan available to subscribers of the Healthy Families Program.

This bill would exempt a plan contract or policy offered ~~through the Exchange~~, *marketed, or sold through the SHOP or the small group market outside the Exchange* from covering those pediatric oral care benefits if the ~~Exchange~~ *SHOP or the small group market outside the Exchange* offers a stand-alone dental plan as described in PPACA and would require stand-alone dental plans offered through the ~~Exchange~~ *SHOP or the small group market outside the Exchange* to include coverage of those pediatric oral care benefits. ~~The bill would also require cost sharing that is imposed as a result of a specialized health care service plan contract or policy that covers pediatric oral care benefits to be coordinated with the cost sharing associated with a qualified health plan that is offered, marketed, or sold through the Exchange.~~ *The bill would also require a plan contract or policy covering pediatric oral care to waive the applicable dental out-of-pocket maximum upon notification from a qualified health plan that the applicable out-of-pocket maximum under the qualified health plan has been satisfied, and would require qualified health plans to develop a method for coordinating and tracking progress toward satisfying the out-of-pocket maximum.* The bill would also prohibit those specialized

plan contracts or policies from being regarded as providing excepted benefits, as specified.

Existing law requires a health care service plan and a health insurer to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio is less than a certain percentage, as specified.

This bill would require a specialized health care service plan contract and specialized health insurance policy that provides pediatric oral care benefits ~~through the Exchange~~ *in the small group market through the SHOP or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* to also comply with minimum medical loss ratios and provide an annual rebate, as specified.

Existing law requires the Department of Managed Health Care and the Department of Insurance to promulgate regulations applicable to health care service plans and specified health insurers, respectively, to ensure that enrollees and insureds have the opportunity to access needed health care services in a timely manner, and to ensure adequacy of numbers of professional providers and institutional providers. Existing law requires health care service plans and health insurance policies to file specified rate information with the Department of Managed Health Care and the Department of Insurance, respectively, at least 60 days before implementing a rate change.

This bill would specify that those provisions would also apply to specialized health care service plans and specialized health insurance policies that provide pediatric oral care benefits through the ~~Exchange~~ *SHOP or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone*. Because a willful violation of the bill's provisions by a health care service plan would be a crime, this 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.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

~~SECTION 1. Section 1367.003 of the Health and Safety Code is amended to read:~~

~~1367.003. (a) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts, shall provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:~~

~~(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.~~

~~(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.~~

~~(b) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:~~

~~(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.~~

~~(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.~~

~~(c) Every specialized health care service plan contract described in Section 1311(d)(2)(B)(ii) of PPACA, as defined in Section 1367.005, (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) providing pediatric oral care benefits in the small group or individual market through the Exchange, shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the specialized health care service plan on the costs for reimbursement for services provided to enrollees under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after~~

~~accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than 75 percent.~~

~~(d) Every specialized health care service plan contract described in subdivision (c) shall maintain a minimum medical loss ratio of 75 percent.~~

~~(e) (1) The total amount of an annual rebate required under subdivision (a) shall be calculated in an amount equal to the product of the following:~~

~~(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).~~

~~(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.~~

~~(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.~~

~~(f) (1) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.~~

~~(2) The director may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.~~

~~(g) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.~~

~~(h) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.~~

~~(i) Nothing in this section shall be construed to apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.~~

~~(j) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).~~

~~SEC. 2.~~

SECTION 1. Section 1367.005 of the Health and Safety Code is amended to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services

and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

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

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,

1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

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

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

(5) (A) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary

orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. This subparagraph shall not apply to a health care service plan contract that is a qualified health plan, as defined in Section 100501 of the Government Code, that is offered, marketed, or sold through the *Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the* Exchange if a specialized health care service plan contract described in subdivision (c) is offered, marketed, or sold through the ~~Exchange. Notwithstanding subdivision (f) of Section 100503 of the Government Code, a qualified health plan that excludes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of PPACA shall not be offered, marketed, or sold outside of the Exchange.~~ *SHOP or the small group market outside the Exchange.*

(B) The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).~~-~~

~~(C) Cost sharing that is imposed as a result of a specialized health care service plan contract described in subdivision (c) shall be coordinated with that cost sharing which is associated with the qualified health plan identified in subparagraph (A), so that the total cost sharing for a combined qualified health plan and specialized health care service plan pursuant to this paragraph does not exceed the total cost sharing for a qualified health plan that includes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of the PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)). The plans shall develop a method for coordinating and tracking cost sharing that limits the burden on the subscriber.~~

(C) Notwithstanding subparagraph (A), it is the intent of the Legislature that all of the benefits described in Section 1302(b) of PPACA be included as essential health benefits whether obtained through a qualified health plan, or through a combination of a qualified health plan and a specialized health care service plan as described in subdivision (c). It is the intent of the Legislature that pediatric essential health benefits purchased separately are only essential health benefits for pediatric enrollees, to the extent permitted by PPACA.

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

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan contract.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.

(c) (1) A specialized health care service plan contract described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that is offered through the ~~Exchange~~ *SHOP pursuant to Section 100502 of the Government Code or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* shall, at a minimum, include coverage of the health benefits described in subparagraph (A) of paragraph (5) of subdivision (a).

(2) ~~A~~ *Beginning on January 1, 2015, a* specialized health care service plan contract described in paragraph (1) shall not be regarded as providing excepted benefits under either the Public Health Service Act or PPACA, for the purpose of determining the applicability of Sections 2701 to 2706, inclusive, and ~~Sections 2708 and 2711~~ *Section 2708* of the Public Health Service Act, added by Section 1201 of PPACA, relating to the following:

(A) The prohibition of preexisting condition exclusions or other discrimination based on health status.

(B) Fair health insurance premiums.

(C) Guaranteed availability of coverage.

(D) Guaranteed renewability of coverage.

(E) Prohibition against discrimination against individual participants and beneficiaries on the basis of health status.

(F) Nondiscrimination in health care.

(G) Prohibition of excessive waiting periods~~, annual limits, and lifetime limits~~.

(3) Beginning on January 1, 2014, a specialized health care service plan contract described in paragraph (1) shall not be regarded as providing excepted benefits under either the Public Health Service Act or PPACA, for the purpose of determining the applicability of Section 2711 of the Public Health Service Act, added by Section 1201 of PPACA.

(4) A specialized health care service plan contract described in paragraph (1) shall waive the applicable dental out-of-pocket maximum upon notification from a qualified health plan on behalf

of an enrollee that the applicable out-of-pocket maximum under the qualified health plan has been satisfied. Beginning on January 1, 2015, the combined out-of-pocket maximums for dental and qualified health plans shall not exceed those limits established in Section 1302(c) of PPACA. The plans shall develop a method for coordinating and tracking progress toward satisfying the out-of-pocket maximum limitation that limits the burden on subscribers and enrollees. This paragraph shall be implemented only to the extent permitted by PPACA.

(d) Pediatric vision and oral care benefits described in paragraphs (4) and (5) of subdivision (a) shall be provided for individuals up to ~~26~~ *22* years of age, to the extent permitted under PPACA. Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

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

(f) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(g) No health care service plan, or its agent, solicitor, or representative, shall issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it includes coverage of the health benefits described in subdivision (a), including the benefits described in subparagraph (A) of paragraph (5) of subdivision (a), and meets the requirements of subdivisions (d), (e), and (f).

(h) Except as otherwise provided in this section, this section shall apply regardless of whether the plan contract is offered inside or outside the Exchange.

(i) Nothing in this section shall be construed to exempt a plan or a plan contract from meeting other applicable requirements of law.

(j) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(k) Nothing in this section shall be implemented in a manner that conflicts with a requirement of PPACA.

(*l*) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(m) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

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

(o) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

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

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.

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

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

(1) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(2) "Habilitative services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

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

(5) "SHOP" means the Small Business Health Options Business established pursuant to subdivision (m) of Section 100502 of the Government Code.

~~(5)~~

(6) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

~~SEC. 3.~~

SEC. 2. Section 1367.013 is added to the Health and Safety Code, to read:

1367.013. ~~A~~ *(a) Beginning on January 1, 2014, a* specialized health care service plan contract described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits through the ~~Exchange~~ *Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* shall be subject to Sections 1367, 1367.03, and ~~1342, and Article 6.2 (commencing with Section 1385.01)~~ *1342*.

(b) Beginning on January 1, 2015, a specialized health care service plan contract described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits through the SHOP or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone, shall be subject to Article 6.2 (commencing with Section 1385.01).

SEC. 3. Section 1367.37 is added to the Health and Safety Code, to read:

1367.37. (a) (1) Notwithstanding Section 1367.003, beginning on January 1, 2015, every specialized health care service plan contract described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)), as defined in Section 1367.005, providing pediatric oral care benefits in the small group market through the Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone, shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the specialized health care service plan on the costs for reimbursement for services provided to enrollees under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal

and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than 75 percent.

(2) Every specialized health care service plan contract described in this subdivision shall maintain a minimum medical loss ratio of 75 percent.

(b) (1) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The director may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(c) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

SEC. 4. Section 1385.02 of the Health and Safety Code is amended to read:

1385.02. This article shall apply to health care service plan contracts offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract, other than one providing pediatric oral care benefits through the ~~Exchange,~~ *Small Business Health Options Program, pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* as described in Section 1367.013; a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1); a health care service plan contract offered in the

Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health care service plan contract offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code); a health care service plan conversion contract offered pursuant to Section 1373.6; or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article ~~10.5~~ *11.5* (commencing with Section 1399.801).

~~SEC. 5. Section 10112.25 of the Insurance Code is amended to read:~~

~~10112.25. (a) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, but not including specialized health insurance policies, shall provide an annual rebate to each insured under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for clinical services provided to insureds under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:~~

~~(1) With respect to a health insurer offering coverage in the large group market, 85 percent.~~

~~(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.~~

~~(b) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:~~

~~(1) With respect to a health insurer offering coverage in the large group market, 85 percent.~~

~~(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.~~

~~(c) Every specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA, as defined in Section 10112.27, (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) providing pediatric oral care benefits in the small group or individual market through the Exchange, shall provide an annual rebate to each insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for services provided to insureds under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than 75 percent.~~

~~(d) Every specialized health insurance policy described in subdivision (c) shall maintain a minimum medical loss ratio of 75 percent.~~

~~(e) (1) The total amount of an annual rebate required under subdivision (a) shall be calculated in an amount equal to the product of the following:~~

~~(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).~~

~~(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.~~

~~(2) A health insurer shall provide any rebate owing to an insured no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.~~

~~(f) (1) The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.~~

~~(2) The commissioner may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5~~

~~(commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.~~

~~(g) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.~~

~~(h) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.~~

~~(i) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).~~

~~SEC. 6.~~

SEC. 5. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. This section shall exclusively govern what benefits a health insurer must cover

as essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

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

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

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

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient

hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

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

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

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

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

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

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

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

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

(5) (A) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. This subparagraph shall not apply to a health insurance policy that is a qualified health plan, as defined in Section 100501 of the Government Code, that is offered, marketed, or sold through the *Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the* Exchange if a specialized health insurance policy described in subdivision (c) is offered, marketed, or sold through the ~~Exchange. Notwithstanding subdivision (f) of Section 100503 of the Government Code, a qualified health plan that excludes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) shall not be offered, marketed, or sold outside of the Exchange.~~ *SHOP or the small group market outside the Exchange.*

(B) The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).-

~~(C) Cost sharing that is imposed as a result of a specialized health insurance policy described in subdivision (c) shall be coordinated with that cost sharing which is associated with the qualified health plan identified in subparagraph (A), so that the~~

~~total cost sharing for a combined qualified health plan and specialized health insurance policy pursuant to this paragraph does not exceed the total cost sharing for a qualified health plan that includes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of PPACA. The insurer and qualified health plan shall develop a method for coordinating and tracking cost-sharing that limits the burden on the policyholder.~~

(C) Notwithstanding subparagraph (A), it is the intent of the Legislature that all of the benefits described in Section 1302(b) of PPACA be included as essential health benefits whether obtained through a qualified health plan, or a combination of a qualified health plan and a specialized health insurance policy as described in subdivision (c). It is the intent of the Legislature that pediatric essential health benefits purchased separately are only essential for pediatric insureds, to the extent permitted by PPACA.

(b) Subdivision (a) shall not apply to any of the following:-

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

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

(c) (1) A specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that is offered through the ~~Exchange~~ *SHOP or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* shall, at a minimum, include coverage of the health benefits described in subparagraph (A) of paragraph (5) of subdivision (a).-

(2) ~~A~~ *Beginning on January 1, 2015, a* specialized health insurance policy described in paragraph (1) providing pediatric oral care benefits shall not be regarded as providing excepted benefits under either the Public Health Service Act or PPACA, for the purpose of determining the applicability of Sections 2701 to 2706, inclusive, and ~~Sections 2708 and 2711~~ *Section 2708* of the Public Health Service Act, added by Section 1201 of PPACA, relating to the following:

(A) The prohibition of preexisting condition exclusions or other discrimination based on health status.

(B) Fair health insurance premiums.

(C) Guaranteed availability of coverage.

(D) Guaranteed renewability of coverage.

(E) Prohibition against discrimination against individual participants and beneficiaries on the basis of health status.

(F) Nondiscrimination in health care.

(G) Prohibition of excessive waiting periods~~, annual limits, and lifetime limits~~.

(3) Beginning on January 1, 2014, a specialized health insurance policy described in paragraph (1) providing pediatric oral care benefits shall not be regarded as providing excepted benefits under either the Public Health Service Act or PPACA, for the purpose of determining the applicability of Section 2711 of the Public Health Service Act, added by Section 1201 of PPACA.

(4) A specialized health insurance policy described in paragraph (1) shall waive the applicable dental out-of-pocket maximum upon notification from a qualified health plan on behalf of an insured that the applicable out-of-pocket maximum under the qualified health plan has been satisfied. Beginning on January 1, 2015, the combined out-of-pocket maximums for dental and qualified health plans shall not exceed those limits established in Section 1302(c) of PPACA. Insurers shall develop a method for coordinating and tracking progress toward satisfying the out-of-pocket maximum limitation that limits the burden on policyholders and insureds. This paragraph shall only be implemented to the extent permitted by PPACA.

(d) Pediatric vision and oral care benefits described in paragraphs (4) and (5) of subdivision (a) shall be provided for individuals up to ~~26~~ *22* years of age, to the extent permitted under PPACA. Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

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

(f) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation

for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(g) No health insurer, or its agent, producer, or representative, shall issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it includes coverage of the health benefits described in subdivision (a), including the benefits described in subparagraph (A) of paragraph (5) of subdivision (a), and meets the requirements of subdivisions (d), (e), and (f). This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(h) Except as otherwise provided in this section, this section shall apply regardless of whether the policy is offered inside or outside the Exchange.

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

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

(k) Nothing in this section shall be implemented in a manner that conflicts with a requirement of PPACA.

(*l*) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(m) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

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

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

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

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

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

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

(r) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(2) "Habilitative services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but

not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

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

(5) "SHOP" means the Small Business Health Options Program established pursuant to subdivision (m) of Section 100502 of the Government Code.

~~(5)~~

(6) "Small group health insurance policy" means a group health care service insurance policy issued to a small employer, as defined in Section 10753.

~~SEC. 7.~~

SEC. 6. Section 10112.35 is added to the Insurance Code, to read:

10112.35. ~~A~~ *(a) Beginning on January 1, 2014, a* specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits through the ~~Exchange~~ *Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* shall be subject to Section 10133.5 ~~and Article 4.5 (commencing with Section 10181.1)~~.

(b) Beginning on January 1, 2015, a specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits through the SHOP or the small group market outside the Exchange, whether or not it is bundled with a qualified health

plan or standing alone, shall be subject to Article 4.5 (commencing with Section 10181).

SEC. 7. Section 10123.56 is added to the Insurance Code, to read:

10123.56. (a) (1) Notwithstanding Section 10112.25, beginning on January 1, 2015, every specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)), as defined in Section 10112.27, providing pediatric oral care benefits in the small group market through the Small Business Health Options Program (SHOP), pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone, shall provide an annual rebate to each insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for services provided to insureds under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than 75 percent.

(2) Every specialized health insurance policy described in this subdivision shall maintain a minimum medical loss ratio of 75 percent.

(b) (1) The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The commissioner may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial

adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(c) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

SEC. 8. Section 10181.2 of the Insurance Code is amended to read:

10181.2. This article shall apply to health insurance policies offered in the individual or group market in California. However, this article shall not apply to a specialized health insurance policy, other than one providing pediatric oral care benefits through the ~~Exchange,~~ *Small Business Health Options Program, pursuant to subdivision (m) of Section 100502 of the Government Code, or the small group market outside the Exchange, whether or not it is bundled with a qualified health plan or standing alone,* as described in Section 10112.35; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

SEC. 9. 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.

SEC. 10. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to update state law consistent with federal requirements at the earliest possible time, it is necessary that this bill take effect immediately.

O