

AMENDED IN ASSEMBLY JUNE 24, 2013  
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**

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**Introduced by Assembly Member Pan**

December 3, 2012

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An act to amend ~~Sections 1367.005 and~~ *Section* 1385.02 of, and to add Sections 1367.013 and 1367.37 to, the Health and Safety Code, and to amend ~~Sections 10112.27 and~~ *Section* 10181.2 of, and to add 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-~~  
*care benefits.*

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, marketed, or sold through the SHOP or the small group market outside the Exchange from covering those pediatric oral care benefits if the 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 SHOP or the small group market outside the Exchange to include coverage of those pediatric oral care benefits. 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 in the small group market through the SHOP or the small group market outside the Exchange,~~ *benefits*, 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 *a* specialized health care service ~~plans~~ *plan* and specialized health insurance ~~policies~~ *policy* that ~~provide~~ *provides* pediatric oral care ~~benefits through the SHOP or the small group market outside the Exchange,~~ *benefits*, 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:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

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

3 1367.005. (a) An individual or small group health care service  
4 plan contract issued, amended, or renewed on or after January 1,  
5 2014, shall, at a minimum, include coverage for essential health  
6 benefits pursuant to PPACA and as outlined in this section. For  
7 purposes of this section, “essential health benefits” means all of  
8 the following:

9 (1) Health benefits within the categories identified in Section  
10 1302(b) of PPACA: ambulatory patient services, emergency  
11 services, hospitalization, maternity and newborn care, mental health  
12 and substance use disorder services, including behavioral health  
13 treatment, prescription drugs, rehabilitative and habilitative services  
14 and devices, laboratory services, preventive and wellness services  
15 and chronic disease management, and pediatric services, including  
16 oral and vision care.

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

23 (i) Medically necessary basic health care services, as defined  
24 in subdivision (b) of Section 1345 and in Section 1300.67 of Title  
25 28 of the California Code of Regulations.

26 (ii) The health benefits mandated to be covered by the plan  
27 pursuant to statutes enacted before December 31, 2011, as  
28 described in the following sections: Sections 1367.002, 1367.06,  
29 and 1367.35 (preventive services for children); Section 1367.25  
30 (prescription drug coverage for contraceptives); Section 1367.45  
31 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51  
32 (diabetes); Section 1367.54 (alpha feto protein testing); Section  
33 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for  
34 laryngectomy); Section 1367.62 (maternity hospital stay); Section  
35 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies);  
36 Section 1367.64 (prostate cancer); Section 1367.65  
37 (mammography); Section 1367.66 (cervical cancer); Section  
38 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);  
39 Section 1367.68 (surgical procedures for jaw bones); Section  
40 1367.71 (anesthesia for dental); Section 1367.9 (conditions

1 attributable to diethylstilbestrol); Section 1368.2 (hospice care);  
2 Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency  
3 response ambulance or ambulance transport services); subdivision  
4 (b) of Section 1373 (sterilization operations or procedures); Section  
5 1373.4 (inpatient hospital and ambulatory maternity); Section  
6 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for  
7 HIV); Section 1374.72 (mental health parity); and Section 1374.73  
8 (autism/behavioral health treatment).

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

12 (iv) The health benefits covered by the plan that are not  
13 otherwise required to be covered under this chapter, to the extent  
14 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,  
15 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the  
16 California Code of Regulations.

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

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

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

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

38 (3) With respect to habilitative services, in addition to any  
39 habilitative services identified in paragraph (2), coverage shall  
40 also be provided as required by federal rules, regulations, and

1 guidance issued pursuant to Section 1302(b) of PPACA.  
2 Habilitative services shall be covered under the same terms and  
3 conditions applied to rehabilitative services under the plan contract.

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

11 (5) (A) With respect to pediatric oral care, the same health  
12 benefits for pediatric oral care covered under the dental plan  
13 available to subscribers of the Healthy Families Program in  
14 2011-12, including the provision of medically necessary  
15 orthodontic care provided pursuant to the federal Children's Health  
16 Insurance Program Reauthorization Act of 2009. This subparagraph  
17 shall not apply to a health care service plan contract that is a  
18 qualified health plan, as defined in Section 100501 of the  
19 Government Code, that is offered, marketed, or sold through the  
20 Small Business Health Options Program (SHOP), pursuant to  
21 subdivision (m) of Section 100502 of the Government Code, or  
22 the small group market outside the Exchange if a specialized health  
23 care service plan contract described in subdivision (c) is offered,  
24 marketed, or sold through the SHOP or the small group market  
25 outside the Exchange.

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

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

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

- 40 (1) A specialized health care service plan contract.

1 ~~(2) A Medicare supplement plan contract.~~

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

5 ~~(e) (1) A specialized health care service plan contract described~~  
6 ~~in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec.~~  
7 ~~18031(d)(2)(B)(ii)) that is offered through the SHOP pursuant to~~  
8 ~~Section 100502 of the Government Code or the small group market~~  
9 ~~outside the Exchange, whether or not it is bundled with a qualified~~  
10 ~~health plan or standing alone, shall, at a minimum, include~~  
11 ~~coverage of the health benefits described in subparagraph (A) of~~  
12 ~~paragraph (5) of subdivision (a).~~

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

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

22 ~~(B) Fair health insurance premiums.~~

23 ~~(C) Guaranteed availability of coverage.~~

24 ~~(D) Guaranteed renewability of coverage.~~

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

27 ~~(F) Nondiscrimination in health care.~~

28 ~~(G) Prohibition of excessive waiting periods.~~

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

35 ~~(4) A specialized health care service plan contract described in~~  
36 ~~paragraph (1) shall waive the applicable dental out-of-pocket~~  
37 ~~maximum upon notification from a qualified health plan on behalf~~  
38 ~~of an enrollee that the applicable out-of-pocket maximum under~~  
39 ~~the qualified health plan has been satisfied. Beginning on January~~  
40 ~~1, 2015, the combined out-of-pocket maximums for dental and~~

1 qualified health plans shall not exceed those limits established in  
2 Section 1302(e) of PPACA. The plans shall develop a method for  
3 coordinating and tracking progress toward satisfying the  
4 out-of-pocket maximum limitation that limits the burden on  
5 subscribers and enrollees. This paragraph shall be implemented  
6 only to the extent permitted by PPACA.

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

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

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

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

- 1 ~~(i) Nothing in this section shall be construed to exempt a plan~~  
2 ~~or a plan contract from meeting other applicable requirements of~~  
3 ~~law.~~
- 4 ~~(j) 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 ~~(k) Nothing in this section shall be implemented in a manner~~  
9 ~~that conflicts with a requirement of PPACA.~~
- 10 ~~(l) This section shall be implemented only to the extent essential~~  
11 ~~health benefits are required pursuant to PPACA.~~
- 12 ~~(m) An essential health benefit is required to be provided under~~  
13 ~~this section only to the extent that federal law does not require the~~  
14 ~~state to defray the costs of the benefit.~~
- 15 ~~(n) Nothing in this section shall obligate the state to incur costs~~  
16 ~~for the coverage of benefits that are not essential health benefits~~  
17 ~~as defined in this section.~~
- 18 ~~(o) A plan is not required to cover, under this section, changes~~  
19 ~~to health benefits that are the result of statutes enacted on or after~~  
20 ~~December 31, 2011.~~
- 21 ~~(p) (1) The department may adopt emergency regulations~~  
22 ~~implementing this section. The department may, on a one-time~~  
23 ~~basis, readopt any emergency regulation authorized by this section~~  
24 ~~that is the same as, or substantially equivalent to, an emergency~~  
25 ~~regulation previously adopted under this section.~~
- 26 ~~(2) The initial adoption of emergency regulations implementing~~  
27 ~~this section and the readoption of emergency regulations authorized~~  
28 ~~by this subdivision shall be deemed an emergency and necessary~~  
29 ~~for the immediate preservation of the public peace, health, safety,~~  
30 ~~or general welfare. The initial emergency regulations and the~~  
31 ~~readoption of emergency regulations authorized by this section~~  
32 ~~shall be submitted to the Office of Administrative Law for filing~~  
33 ~~with the Secretary of State and each shall remain in effect for no~~  
34 ~~more than 180 days, by which time final regulations may be~~  
35 ~~adopted.~~
- 36 ~~(3) The director shall consult with the Insurance Commissioner~~  
37 ~~to ensure consistency and uniformity in the development of~~  
38 ~~regulations under this subdivision.~~
- 39 ~~(4) This subdivision shall become inoperative on March 1, 2016.~~

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

3 (1) “Exchange” means the California Health Benefit Exchange  
 4 created by Section 100500 of the Government Code.

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

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

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

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

31 (5) “SHOP” means the Small Business Health Options Business  
 32 established pursuant to subdivision (m) of Section 100502 of the  
 33 Government Code.

34 (6) “Small group health care service plan contract” means a  
 35 group health care service plan contract issued to a small employer,  
 36 as defined in Section 1357.500.

37 SEC. 2.

38 SECTION 1. Section 1367.013 is added to the Health and Safety  
 39 Code, to read:

1 1367.013. (a) Beginning on January 1, 2014, a specialized  
2 health care service plan contract described in Section  
3 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii))  
4 that provides pediatric oral care ~~benefits through the Small~~  
5 ~~Business Health Options Program (SHOP), pursuant to subdivision~~  
6 ~~(m) of Section 100502 of the Government Code, or the small group~~  
7 ~~market outside the Exchange, benefits~~, whether or not it is bundled  
8 with a qualified health plan or standing alone, shall be subject to  
9 Sections ~~1367, 1367.03, and 1342. 1367 and 1367.03.~~

10 (b) Beginning on January 1, 2015, a specialized health care  
11 service plan contract described in Section 1311(d)(2)(B)(ii) of  
12 PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric  
13 oral care ~~benefits through the SHOP or the small group market~~  
14 ~~outside the Exchange, benefits~~, whether or not it is bundled with  
15 a qualified health plan or standing alone, shall be subject to Article  
16 6.2 (commencing with Section 1385.01).

17 ~~SEC. 3.~~

18 *SEC. 2.* Section 1367.37 is added to the Health and Safety  
19 Code, to read:

20 1367.37. (a) (1) Notwithstanding Section 1367.003, beginning  
21 on January 1, 2015, every specialized health care service plan  
22 contract described in Section 1311(d)(2)(B)(ii) of PPACA (42  
23 U.S.C. Sec. 18031(d)(2)(B)(ii)), as defined in Section 1367.005,  
24 providing pediatric oral care ~~benefits in the small group market~~  
25 ~~through the Small Business Health Options Program (SHOP),~~  
26 ~~pursuant to subdivision (m) of Section 100502 of the Government~~  
27 ~~Code, or the small group market outside the Exchange, benefits,~~  
28 whether or not it is bundled with a qualified health plan or standing  
29 alone, shall provide an annual rebate to each enrollee under that  
30 coverage, on a pro rata basis, if the ratio of the amount of premium  
31 revenue expended by the specialized health care service plan on  
32 the costs for reimbursement for services provided to enrollees  
33 under that coverage and for activities that improve dental care  
34 quality to the total amount of premium revenue, excluding federal  
35 and state taxes and licensing or regulatory fees, and after  
36 accounting for payments or receipts for risk adjustment, risk  
37 corridors, and reinsurance, is less than 75 percent.

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

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

8 (2) The director may also adopt emergency regulations in  
 9 accordance with the Administrative Procedure Act (Chapter 3.5  
 10 (commencing with Section 11340) of Part 1 of Division 3 of Title  
 11 2 of the Government Code) when it is necessary to implement the  
 12 applicable provisions of this section and to address specific  
 13 conflicts between state and federal law that prevent implementation  
 14 of federal law and guidance pursuant to Section 2718 of the federal  
 15 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial  
 16 adoption of the emergency regulations shall be deemed to be an  
 17 emergency and necessary for the immediate preservation of the  
 18 public peace, health, safety, or general welfare.

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

22 ~~SEC. 4.~~

23 *SEC. 3.* Section 1385.02 of the Health and Safety Code is  
 24 amended to read:

25 1385.02. This article shall apply to health care service plan  
 26 contracts offered in the individual or group market in California.  
 27 However, this article shall not apply to a specialized health care  
 28 service plan contract, other than one providing pediatric oral care  
 29 ~~benefits through the Small Business Health Options Program,~~  
 30 ~~pursuant to subdivision (m) of Section 100502 of the Government~~  
 31 ~~Code, or the small group market outside the Exchange, benefits,~~  
 32 whether or not it is bundled with a qualified health plan or standing  
 33 alone, as described in Section 1367.013; a Medicare supplement  
 34 contract subject to Article 3.5 (commencing with Section 1358.1);  
 35 a health care service plan contract offered in the Medi-Cal program  
 36 (Chapter 7 (commencing with Section 14000) of Part 3 of Division  
 37 9 of the Welfare and Institutions Code); a health care service plan  
 38 contract offered in the Healthy Families Program (Part 6.2  
 39 (commencing with Section 12693) of Division 2 of the Insurance  
 40 Code), the Access for Infants and Mothers Program (Part 6.3

1 (commencing with Section 12695) of Division 2 of the Insurance  
2 Code), the California Major Risk Medical Insurance Program (Part  
3 6.5 (commencing with Section 12700) of Division 2 of the  
4 Insurance Code), or the Federal Temporary High Risk Pool (Part  
5 6.6 (commencing with Section 12739.5) of Division 2 of the  
6 Insurance Code); a health care service plan conversion contract  
7 offered pursuant to Section 1373.6; or a health care service plan  
8 contract offered to a federally eligible defined individual under  
9 Article 4.6 (commencing with Section 1366.35) or Article 11.5  
10 (commencing with Section 1399.801).

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

13 ~~10112.27. (a) An individual or small group health insurance~~  
14 ~~policy issued, amended, or renewed on or after January 1, 2014,~~  
15 ~~shall, at a minimum, include coverage for essential health benefits~~  
16 ~~pursuant to PPACA and as outlined in this section. This section~~  
17 ~~shall exclusively govern what benefits a health insurer must cover~~  
18 ~~as essential health benefits. For purposes of this section, “essential~~  
19 ~~health benefits” means all of the following:~~

20 ~~(1) Health benefits within the categories identified in Section~~  
21 ~~1302(b) of PPACA: ambulatory patient services, emergency~~  
22 ~~services, hospitalization, maternity and newborn care, mental health~~  
23 ~~and substance use disorder services, including behavioral health~~  
24 ~~treatment, prescription drugs, rehabilitative and habilitative services~~  
25 ~~and devices, laboratory services, preventive and wellness services~~  
26 ~~and chronic disease management, and pediatric services, including~~  
27 ~~oral and vision care.~~

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

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

38 ~~(ii) The health benefits mandated to be covered by the plan~~  
39 ~~pursuant to statutes enacted before December 31, 2011, as~~  
40 ~~described in the following sections of the Health and Safety Code:~~

1 Sections 1367.002, 1367.06, and 1367.35 (preventive services for  
 2 children); Section 1367.25 (prescription drug coverage for  
 3 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46  
 4 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha  
 5 fetoprotein testing); Section 1367.6 (breast cancer screening);  
 6 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62  
 7 (maternity hospital stay); Section 1367.63 (reconstructive surgery);  
 8 Section 1367.635 (mastectomies); Section 1367.64 (prostate  
 9 cancer); Section 1367.65 (mammography); Section 1367.66  
 10 (cervical cancer); Section 1367.665 (cancer screening tests);  
 11 Section 1367.67 (osteoporosis); Section 1367.68 (surgical  
 12 procedures for jaw bones); Section 1367.71 (anesthesia for dental);  
 13 Section 1367.9 (conditions attributable to diethylstilbestrol);  
 14 Section 1368.2 (hospice care); Section 1370.6 (cancer clinical  
 15 trials); Section 1371.5 (emergency response ambulance or  
 16 ambulance transport services); subdivision (b) of Section 1373  
 17 (sterilization operations or procedures); Section 1373.4 (inpatient  
 18 hospital and ambulatory maternity); Section 1374.56  
 19 (phenylketonuria); Section 1374.17 (organ transplants for HIV);  
 20 Section 1374.72 (mental health parity); and Section 1374.73  
 21 (autism/behavioral health treatment).

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

25 (iv) The health benefits covered by the plan that are not  
 26 otherwise required to be covered under Chapter 2.2 (commencing  
 27 with Section 1340) of Division 2 of the Health and Safety Code,  
 28 to the extent otherwise required pursuant to Sections 1367.18,  
 29 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health  
 30 and Safety Code, and Section 1300.67.24 of Title 28 of the  
 31 California Code of Regulations.

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

35 (B) Where there are any conflicts or omissions in the plan  
 36 identified in subparagraph (A) as compared with the requirements  
 37 for health benefits under Chapter 2.2 (commencing with Section  
 38 1340) of Division 2 of the Health and Safety Code that were  
 39 enacted prior to December 31, 2011, the requirements of Chapter  
 40 2.2 (commencing with Section 1340) of Division 2 of the Health

1 and Safety Code shall be controlling, except as otherwise specified  
2 in this section.

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

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

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

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

31 (5) (A) With respect to pediatric oral care, the same health  
32 benefits for pediatric oral care covered under the dental plan  
33 available to subscribers of the Healthy Families Program in  
34 2011-12, including the provision of medically necessary  
35 orthodontic care provided pursuant to the federal Children's Health  
36 Insurance Program Reauthorization Act of 2009. This subparagraph  
37 shall not apply to a health insurance policy that is a qualified health  
38 plan, as defined in Section 100501 of the Government Code, that  
39 is offered, marketed, or sold through the Small Business Health  
40 Options Program (SHOP), pursuant to subdivision (m) of Section

1 100502 of the Government Code, or the small group market outside  
2 the Exchange if a specialized health insurance policy described in  
3 subdivision (e) is offered, marketed, or sold through the SHOP or  
4 the small group market outside the Exchange.

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

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

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

18 (1) A policy that provides excepted benefits as described in  
19 Sections 2722 and 2791 of the federal Public Health Service Act  
20 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

24 (e) (1) A specialized health insurance policy described in  
25 Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec.  
26 18031(d)(2)(B)(ii)) that is offered through the SHOP or the small  
27 group market outside the Exchange, whether or not it is bundled  
28 with a qualified health plan or standing alone, shall, at a minimum,  
29 include coverage of the health benefits described in subparagraph  
30 (A) of paragraph (5) of subdivision (a).

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

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

40 (B) Fair health insurance premiums.

1 ~~(C) Guaranteed availability of coverage.~~

2 ~~(D) Guaranteed renewability of coverage.~~

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

5 ~~(F) Nondiscrimination in health care.~~

6 ~~(G) Prohibition of excessive waiting periods.~~

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

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

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

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

37 ~~(f) To the extent permitted under Section 1302 of PPACA and~~  
38 ~~any rules, regulations, or guidance issued pursuant to that section,~~  
39 ~~and to the extent that substitution would not create an obligation~~  
40 ~~for the state to defray costs for any individual, an insurer may~~

1 ~~substitute its prescription drug formulary for the formulary~~  
2 ~~provided under the plan identified in subdivision (a) as long as the~~  
3 ~~coverage for prescription drugs complies with the sections~~  
4 ~~referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph~~  
5 ~~(2) of subdivision (a) that apply to prescription drugs.~~

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

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

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

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

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

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

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

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

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

39 ~~(p) (1) The commissioner may adopt emergency regulations~~  
40 ~~implementing this section. The commissioner may, on a one-time~~

1 basis, readopt any emergency regulation authorized by this section  
2 that is the same as, or substantially equivalent to, an emergency  
3 regulation previously adopted under this section.

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

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

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

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

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

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

29 ~~(2) "Habilitative services" means medically necessary health  
30 care services and health care devices that assist an individual in  
31 partially or fully acquiring or improving skills and functioning and  
32 that are necessary to address a health condition, to the maximum  
33 extent practical. These services address the skills and abilities  
34 needed for functioning in interaction with an individual's  
35 environment. Examples of health care services that are not  
36 habilitative services include, but are not limited to, respite care,  
37 day care, recreational care, residential treatment, social services,  
38 custodial care, or education services of any kind, including, but  
39 not limited to, vocational training. Habilitative services shall be~~

1 covered under the same terms and conditions applied to  
2 rehabilitative services under the policy.

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

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

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

16 (5) “SHOP” means the Small Business Health Options Program  
17 established pursuant to subdivision (m) of Section 100502 of the  
18 Government Code.

19 (6) “Small group health insurance policy” means a group health  
20 care service insurance policy issued to a small employer, as defined  
21 in Section 10753.

22 SEC. 6.

23 SEC. 4. Section 10112.35 is added to the Insurance Code, to  
24 read:

25 10112.35. (a) Beginning on January 1, 2014, a specialized  
26 health insurance policy described in Section 1311(d)(2)(B)(ii) of  
27 PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric  
28 oral care benefits through the Small Business Health Options  
29 Program (SHOP), pursuant to subdivision (m) of Section 100502  
30 of the Government Code, or the small group market outside the  
31 Exchange, *benefits*, whether or not it is bundled with a qualified  
32 health plan or standing alone, shall be subject to Section 10133.5.

33 (b) Beginning on January 1, 2015, a specialized health insurance  
34 policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C.  
35 Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits  
36 through the SHOP or the small group market outside the Exchange,  
37 *benefits*, whether or not it is bundled with a qualified health plan  
38 or standing alone, shall be subject to Article 4.5 (commencing with  
39 Section 10181).

1 ~~SEC. 7.~~

2 *SEC. 5.* Section 10123.56 is added to the Insurance Code, to  
3 read:

4 10123.56. (a) (1) Notwithstanding Section 10112.25,  
5 beginning on January 1, 2015, every specialized health insurance  
6 policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C.  
7 Sec. 18031(d)(2)(B)(ii)), as defined in Section 10112.27, providing  
8 pediatric oral care ~~benefits in the small group market through the~~  
9 ~~Small Business Health Options Program (SHOP), pursuant to~~  
10 ~~subdivision (m) of Section 100502 of the Government Code, or~~  
11 ~~the small group market outside the Exchange, benefits~~, whether  
12 or not it is bundled with a qualified health plan or standing alone,  
13 shall provide an annual rebate to each insured under that coverage,  
14 on a pro rata basis, if the ratio of the amount of premium revenue  
15 expended by the health insurer on the costs for reimbursement for  
16 services provided to insureds under that coverage and for activities  
17 that improve dental care quality to the total amount of premium  
18 revenue, excluding federal and state taxes and licensing or  
19 regulatory fees and after accounting for payments or receipts for  
20 risk adjustment, risk corridors, and reinsurance, is less than 75  
21 percent.

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

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

32 (2) The commissioner may also adopt emergency regulations  
33 in accordance with the Administrative Procedure Act (Chapter 3.5  
34 (commencing with Section 11340) of Part 1 of Division 3 of Title  
35 2 of the Government Code) when it is necessary to implement the  
36 applicable provisions of this section and to address specific  
37 conflicts between state and federal law that prevent implementation  
38 of federal law and guidance pursuant to Section 2718 of the federal  
39 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial  
40 adoption of the emergency regulations shall be deemed to be an

1 emergency and necessary for the immediate preservation of the  
2 public peace, health, safety, or general welfare.

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

7 ~~SEC. 8.~~

8 *SEC. 6.* Section 10181.2 of the Insurance Code is amended to  
9 read:

10 10181.2. This article shall apply to health insurance policies  
11 offered in the individual or group market in California. However,  
12 this article shall not apply to a specialized health insurance policy,  
13 other than one providing pediatric oral care ~~benefits through the~~  
14 ~~Small Business Health Options Program, pursuant to subdivision~~  
15 ~~(m) of Section 100502 of the Government Code, or the small group~~  
16 ~~market outside the Exchange, benefits~~, whether or not it is bundled  
17 with a qualified health plan or standing alone, as described in  
18 Section 10112.35; a Medicare supplement policy subject to Article  
19 6 (commencing with Section 10192.05); a health insurance policy  
20 offered in the Medi-Cal program (Chapter 7 (commencing with  
21 Section 14000) of Part 3 of Division 9 of the Welfare and  
22 Institutions Code); a health insurance policy offered in the Healthy  
23 Families Program (Part 6.2 (commencing with Section 12693)),  
24 the Access for Infants and Mothers Program (Part 6.3 (commencing  
25 with Section 12695)), the California Major Risk Medical Insurance  
26 Program (Part 6.5 (commencing with Section 12700)), or the  
27 Federal Temporary High Risk Pool (Part 6.6 (commencing with  
28 Section 12739.5)); a health insurance conversion policy offered  
29 pursuant to Section 12682.1; or a health insurance policy offered  
30 to a federally eligible defined individual under Chapter 9.5  
31 (commencing with Section 10900).

32 ~~SEC. 9.~~

33 *SEC. 7.* No reimbursement is required by this act pursuant to  
34 Section 6 of Article XIII B of the California Constitution because  
35 the only costs that may be incurred by a local agency or school  
36 district will be incurred because this act creates a new crime or  
37 infraction, eliminates a crime or infraction, or changes the penalty  
38 for a crime or infraction, within the meaning of Section 17556 of  
39 the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California  
2 Constitution.

3 ~~SEC. 10.~~

4 *SEC. 8.* This act is an urgency statute necessary for the  
5 immediate preservation of the public peace, health, or safety within  
6 the meaning of Article IV of the Constitution and shall go into  
7 immediate effect. The facts constituting the necessity are:

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

O