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SENATE BILL

No. 1053

Introduced by Senator Mitchell

(Coauthors: Senators DeSaulnier, Evans, and Wolk)

(Coauthors: Assembly Members Ammiano, Garcia, Mullin, Skinner,
Ting, and Wieckowski)

February 18, 2014

An act to amend Section 1367.25 of the Health and Safety Code, to amend Section 10123.196 of the Insurance Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1053, as amended, Mitchell. Health care coverage: contraceptives.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various reforms to the health insurance market. Among other things, PPACA requires a nongrandfathered group health plan and a health insurance issuer offering group or individual insurance coverage to provide coverage, without imposing cost-sharing requirements, for certain preventive services, including those preventive care and screenings for women provided in specified guidelines. PPACA

requires those plans and issuers to provide coverage without cost sharing for all federal Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider, except as specified.

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 a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits to provide coverage for a variety of federal Food and Drug Administration (FDA) approved prescription contraceptive methods designated by the plan or insurer, except as specified. Existing law authorizes a religious employer, as defined, to request a contract or policy without coverage of ~~FDA-approved~~ *FDA-approved* contraceptive methods that are contrary to the employer's religious tenets and, if so requested, requires a contract or policy to be provided without that coverage. 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, which are defined to include the health benefits covered by particular benchmark plans.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive specified health care services, including family planning services, subject to certain utilization controls. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide coverage for women for all prescribed and ~~FDA approved~~ *FDA-approved* female contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related followup services. The bill would prohibit a nongrandfathered plan contract or health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage, but would authorize cost-sharing

for equivalent nonpreferred drugs, devices, or products unless, among other exceptions, the enrollee is a Medi-Cal beneficiary, coverage, as specified. The bill would include Medi-Cal managed plans, as specified, in the definition of a health care service plan for purposes of these provisions.

The bill would retain the provision authorizing a religious employer to request a contract or policy without coverage of ~~FDA approved~~ *FDA-approved* contraceptive methods that are contrary to the employer's religious tenets. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require utilization controls for family planning services for Medi-Cal managed care plans to be subject *to* the cost-sharing requirements described above.

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

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

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

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

- 1 SECTION 1. The Legislature hereby finds and declares all of
- 2 the following:
- 3 (a) California has a long history of expanding timely access to
- 4 birth control to prevent unintended pregnancy.
- 5 (b) The federal Patient Protection and Affordable Care Act
- 6 includes a contraceptive coverage guarantee as part of a broader
- 7 requirement for health insurance carriers and plans to cover key
- 8 preventive care services without out-of-pocket costs for patients.
- 9 (c) The Legislature intends to build on existing state and federal
- 10 law to promote gender equity and women's health and to ensure
- 11 greater contraceptive coverage equity and timely access to all
- 12 federal Food and Drug Administration approved methods of birth
- 13 control for women covered by health care service plan contracts
- 14 and health insurance policies in California.
- 15 (d) Medical management techniques such as denials, step
- 16 therapy, or prior authorization in public and private health care

1 coverage can impede access to the most effective contraceptive
2 methods.

3 SEC. 2. Section 1367.25 of the Health and Safety Code is
4 amended to read:

5 1367.25. (a) A group health care service plan contract, except
6 for a specialized health care service plan contract, that is issued,
7 amended, renewed, or delivered on or after January 1, 2000,
8 through December 31, 2015, inclusive, and an individual health
9 care service plan contract that is amended, renewed, or delivered
10 on or after January 1, 2000, through December 31, 2015, inclusive,
11 except for a specialized health care service plan contract, shall
12 provide coverage for the following, under general terms and
13 conditions applicable to all benefits:

14 (1) A health care service plan contract that provides coverage
15 for outpatient prescription drug benefits shall include coverage for
16 a variety of federal Food and Drug Administration (FDA) approved
17 prescription contraceptive methods designated by the plan. In the
18 event the patient’s participating provider, acting within his or her
19 scope of practice, determines that none of the methods designated
20 by the plan is medically appropriate for the patient’s medical or
21 personal history, the plan shall also provide coverage for another
22 FDA approved, medically appropriate prescription contraceptive
23 method prescribed by the patient’s provider.

24 (2) Benefits for an enrollee under this subdivision shall be the
25 same for an enrollee’s covered spouse and covered nonspouse
26 dependents.

27 (b) (1) ~~A group or individual~~ health care service plan contract,
28 except for a specialized health care service plan contract, that is
29 issued, amended, renewed, or delivered on or after January 1, 2016,
30 shall provide coverage for all of the following *services and*
31 *contraceptive methods* for women:

32 ~~(A) All FDA approved~~ *Except as provided in subparagraphs*
33 *(B) and (C) of paragraph (2), all FDA-approved* contraceptive
34 *drugs, devices, and other products for women, including all*
35 *FDA-approved contraceptive drugs, devices, and products available*
36 ~~over the counter,~~ *over-the-counter,* as prescribed by the enrollee’s
37 provider.

38 (B) Voluntary sterilization procedures.

39 (C) Patient education and counseling on contraception.

1 (D) Followup services related to the drugs, devices, products,
2 and procedures covered under this subdivision, including, but not
3 limited to, management of side effects, counseling for continued
4 adherence, and device *insertion and* removal.

5 (2) (A) Except for a grandfathered health plan, ~~and subject to~~
6 ~~subparagraph (B)~~, a health care service plan subject to this
7 subdivision shall not impose a deductible, coinsurance, copayment,
8 or any other cost-sharing requirement on the coverage provided
9 pursuant to this subdivision. *Cost sharing shall not be imposed on*
10 *any Medi-Cal beneficiary.*

11 ~~(B) A health care service plan may cover a generic or preferred~~
12 ~~drug, device, or product without cost sharing and impose cost~~
13 ~~sharing for equivalent nonpreferred drugs, devices, or products,~~
14 ~~except that cost sharing shall not be imposed on any Medi-Cal~~
15 ~~beneficiary. However, if a generic or preferred version of a drug,~~
16 ~~device, or product is not available, or is deemed medically~~
17 ~~inadvisable by the enrollee's provider, a health care service plan~~
18 ~~shall provide coverage for the nonpreferred drug, device, or product~~
19 ~~without cost sharing.~~

20 (B) *Where the FDA has approved one or more therapeutic*
21 *equivalents of a contraceptive drug, device, or product, a health*
22 *care service plan is not required to cover all of those*
23 *therapeutically equivalent versions in accordance with this*
24 *subdivision, as long as at least one is covered without cost sharing*
25 *in accordance with this subdivision.*

26 (C) *If a covered therapeutic equivalent of a drug, device, or*
27 *product is not available, or is deemed medically inadvisable by*
28 *the enrollee's provider, a health care service plan shall provide*
29 *coverage, subject to a plan's utilization management procedures,*
30 *for the prescribed contraceptive drug, device, or product without*
31 *cost sharing. Any request by a contracting provider shall be*
32 *responded to by the health care service plan in compliance with*
33 *the Knox-Keene Health Care Service Plan Act of 1975, as set forth*
34 *in this chapter and, as applicable, with the plan's Medi-Cal*
35 *managed care contract.*

36 (3) Except as otherwise authorized under this section, a health
37 care service plan shall not impose any restrictions or delays on the
38 coverage required under this subdivision.

1 (4) Benefits for an enrollee under this subdivision shall be the
2 same for an enrollee's covered spouse and covered nonspouse
3 dependents.

4 (5) For purposes of paragraphs (2) and (3) of this subdivision,
5 "health care service plan" shall include Medi-Cal managed care
6 plans that contract with the State Department of Health Care
7 Services pursuant to Chapter 7 (commencing with Section 14000)
8 and Chapter 8 (commencing with Section 14200) of Part 3 of
9 Division 9 of the Welfare and Institutions Code.

10 (c) Notwithstanding any other provision of this section, a
11 religious employer may request a health care service plan contract
12 without coverage for FDA approved contraceptive methods that
13 are contrary to the religious employer's religious tenets. If so
14 requested, a health care service plan contract shall be provided
15 without coverage for contraceptive methods.

16 (1) For purposes of this section, a "religious employer" is an
17 entity for which each of the following is true:

18 (A) The inculcation of religious values is the purpose of the
19 entity.

20 (B) The entity primarily employs persons who share the
21 religious tenets of the entity.

22 (C) The entity serves primarily persons who share the religious
23 tenets of the entity.

24 (D) The entity is a nonprofit organization as described in
25 Section ~~6033(a)(2)(A) i or iii~~, *6033(a)(3)(A)(i) or (iii)* of the Internal
26 Revenue Code of 1986, as amended.

27 (2) Every religious employer that invokes the exemption
28 provided under this section shall provide written notice to
29 prospective enrollees prior to enrollment with the plan, listing the
30 contraceptive health care services the employer refuses to cover
31 for religious reasons.

32 (d) Nothing in this section shall be construed to exclude
33 coverage for contraceptive supplies as prescribed by a provider,
34 acting within his or her scope of practice, for reasons other than
35 contraceptive purposes, such as decreasing the risk of ovarian
36 cancer or eliminating symptoms of menopause, or for contraception
37 that is necessary to preserve the life or health of an enrollee.

38 (e) Nothing in this section shall be construed to deny or restrict
39 in any way the department's authority to ensure plan compliance

1 with this chapter when a plan provides coverage for contraceptive
2 drugs, devices, and products.

3 (f) Nothing in this section shall be construed to require an
4 individual or group health care service plan contract to cover
5 experimental or investigational treatments.

6 (g) For purposes of this section, the following definitions apply:

7 (1) “Grandfathered health plan” has the meaning set forth in
8 Section 1251 of PPACA.

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

14 (3) With respect to health care service plan contracts issued,
15 amended, or renewed on or after January 1, 2016, “provider” means
16 an individual who is certified or licensed pursuant to Division 2
17 (commencing with Section 500) of the Business and Professions
18 Code, or an initiative act referred to in that division, or Division
19 2.5 (commencing with Section 1797) *of this code*.

20 SEC. 3. Section 10123.196 of the Insurance Code is amended
21 to read:

22 10123.196. (a) An individual or group policy of disability
23 insurance issued, amended, renewed, or delivered on or after
24 January 1, 2000, through December 31, 2015, inclusive, that
25 provides coverage for hospital, medical, or surgical expenses, shall
26 provide coverage for the following, under the same terms and
27 conditions as applicable to all benefits:

28 (1) A disability insurance policy that provides coverage for
29 outpatient prescription drug benefits shall include coverage for a
30 variety of federal Food and Drug Administration (FDA) approved
31 prescription contraceptive methods, as designated by the insurer.
32 If an insured’s health care provider determines that none of the
33 methods designated by the disability insurer is medically
34 appropriate for the insured’s medical or personal history, the insurer
35 shall, in the alternative, provide coverage for some other FDA
36 approved prescription contraceptive method prescribed by the
37 patient’s health care provider.

38 (2) Coverage with respect to an insured under this subdivision
39 shall be identical for an insured’s covered spouse and covered
40 nonspouse dependents.

1 (b) (1) A group or individual policy of disability insurance,
2 except for a specialized health insurance policy, that is issued,
3 amended, renewed, or delivered on or after January 1, 2016, shall
4 provide coverage for all of the following *services and contraceptive*
5 *methods* for women:

6 (A) ~~All FDA-approved~~ *Except as provided in subparagraphs*
7 *(B) and (C) of paragraph (2), all FDA-approved* contraceptive
8 drugs, devices, and *other* products for women, including *all*
9 *FDA-approved contraceptive* drugs, devices, and products available
10 ~~over the counter, over-the-counter,~~ as prescribed by the insured's
11 provider.

12 (B) Voluntary sterilization procedures.

13 (C) Patient education and counseling on contraception.

14 (D) Followup services related to the drugs, devices, products,
15 and procedures covered under this subdivision, including, but not
16 limited to, management of side effects, counseling for continued
17 adherence, and device *insertion and* removal.

18 (2) (A) Except for a grandfathered health plan, ~~and subject to~~
19 ~~subparagraph (B),~~ a disability insurer subject to this subdivision
20 shall not impose a deductible, coinsurance, copayment, or any
21 other cost-sharing requirement on the coverage provided pursuant
22 to this subdivision.

23 ~~(B) A disability insurer may cover a generic or preferred drug,~~
24 ~~device, or product without cost sharing and impose cost sharing~~
25 ~~for an equivalent nonpreferred drug, device, or product. However,~~
26 ~~if a generic or preferred version of a drug, device, or product is~~
27 ~~not available, or is deemed medically inadvisable by the insured's~~
28 ~~provider, a disability insurer shall provide coverage for the~~
29 ~~nonpreferred drug, device, or product without cost sharing.~~

30 (B) *Where the FDA has approved one or more therapeutic*
31 *equivalents of a contraceptive drug, device, or product, a disability*
32 *insurer is not required to cover all of those therapeutically*
33 *equivalent versions in accordance with this subdivision, as long*
34 *as at least one is covered without cost sharing in accordance with*
35 *this subdivision.*

36 (C) *If a covered therapeutic equivalent of a drug, device, or*
37 *product is not available, or is deemed medically inadvisable by*
38 *the insured's provider, a disability insurer shall provide coverage,*
39 *subject to an insurer's utilization management procedures, for the*
40 *prescribed contraceptive drug, device, or product without cost*

1 *sharing. Any request by a contracting provider shall be responded*
2 *to by the disability insurer in compliance with Section 10123.191.*

3 (3) Except as otherwise authorized under this section, an insurer
4 shall not impose any restrictions or delays on the coverage required
5 under this subdivision.

6 (4) Coverage with respect to an insured under this subdivision
7 shall be identical for an insured’s covered spouse and covered
8 nonspouse dependents.

9 (c) Nothing in this section shall be construed to deny or restrict
10 in any way any existing right or benefit provided under law or by
11 contract.

12 (d) Nothing in this section shall be construed to require an
13 individual or group disability insurance policy to cover
14 experimental or investigational treatments.

15 (e) Notwithstanding any other provision of this section, a
16 religious employer may request a disability insurance policy
17 without coverage for contraceptive methods that are contrary to
18 the religious employer’s religious tenets. If so requested, a
19 disability insurance policy shall be provided without coverage for
20 contraceptive methods.

21 (1) For purposes of this section, a “religious employer” is an
22 entity for which each of the following is true:

23 (A) The inculcation of religious values is the purpose of the
24 entity.

25 (B) The entity primarily employs persons who share the religious
26 tenets of the entity.

27 (C) The entity serves primarily persons who share the religious
28 tenets of the entity.

29 (D) The entity is a nonprofit organization pursuant to Section
30 ~~6033(a)(2)(A)(i) or (iii)~~ 6033(a)(3)(A)(i) or (iii) of the Internal
31 Revenue Code of 1986, as amended.

32 (2) Every religious employer that invokes the exemption
33 provided under this section shall provide written notice to any
34 prospective employee once an offer of employment has been made,
35 and prior to that person commencing that employment, listing the
36 contraceptive health care services the employer refuses to cover
37 for religious reasons.

38 (f) Nothing in this section shall be construed to exclude coverage
39 for contraceptive supplies as prescribed by a provider, acting within
40 his or her scope of practice, for reasons other than contraceptive

1 purposes, such as decreasing the risk of ovarian cancer or
2 eliminating symptoms of menopause, or for contraception that is
3 necessary to preserve the life or health of an insured.

4 (g) This section shall only apply to disability insurance policies
5 or contracts that are defined as health benefit plans pursuant to
6 subdivision (a) of Section 10198.6, except that for accident only,
7 specified disease, or hospital indemnity coverage, coverage for
8 benefits under this section shall apply to the extent that the benefits
9 are covered under the general terms and conditions that apply to
10 all other benefits under the policy or contract. Nothing in this
11 section shall be construed as imposing a new benefit mandate on
12 accident only, specified disease, or hospital indemnity insurance.

13 (h) For purposes of this section, the following definitions apply:

14 (1) “Grandfathered health plan” has the meaning set forth in
15 Section 1251 of PPACA.

16 (2) “PPACA” means the federal Patient Protection and
17 Affordable Care Act (Public Law 111-148), as amended by the
18 federal Health Care and Education Reconciliation Act of 2010
19 (Public Law 111-152), and any rules, regulations, or guidance
20 issued thereunder.

21 (3) With respect to policies of disability insurance issued,
22 amended, or renewed on or after January 1, 2016, “health care
23 provider” means an individual who is certified or licensed pursuant
24 to Division 2 (commencing with Section 500) of the Business and
25 Professions Code, or an initiative act referred to in that division,
26 or Division 2.5 (commencing with Section 1797) of the Health
27 and Safety Code.

28 SEC. 4. Section 14132 of the Welfare and Institutions Code is
29 amended to read:

30 14132. The following is the schedule of benefits under this
31 chapter:

32 (a) Outpatient services are covered as follows:
33 Physician, hospital or clinic outpatient, surgical center,
34 respiratory care, optometric, chiropractic, psychology, podiatric,
35 occupational therapy, physical therapy, speech therapy, audiology,
36 acupuncture to the extent federal matching funds are provided for
37 acupuncture, and services of persons rendering treatment by prayer
38 or healing by spiritual means in the practice of any church or
39 religious denomination insofar as these can be encompassed by

1 federal participation under an approved plan, subject to utilization
2 controls.

3 (b) (1) Inpatient hospital services, including, but not limited
4 to, physician and podiatric services, physical therapy and
5 occupational therapy, are covered subject to utilization controls.

6 (2) For Medi-Cal fee-for-service beneficiaries, emergency
7 services and care that are necessary for the treatment of an
8 emergency medical condition and medical care directly related to
9 the emergency medical condition. This paragraph shall not be
10 construed to change the obligation of Medi-Cal managed care
11 plans to provide emergency services and care. For the purposes of
12 this paragraph, “emergency services and care” and “emergency
13 medical condition” shall have the same meanings as those terms
14 are defined in Section 1317.1 of the Health and Safety Code.

15 (c) Nursing facility services, subacute care services, and services
16 provided by any category of intermediate care facility for the
17 developmentally disabled, including podiatry, physician, nurse
18 practitioner services, and prescribed drugs, as described in
19 subdivision (d), are covered subject to utilization controls.
20 Respiratory care, physical therapy, occupational therapy, speech
21 therapy, and audiology services for patients in nursing facilities
22 and any category of intermediate care facility for the
23 developmentally disabled are covered subject to utilization controls.

24 (d) (1) Purchase of prescribed drugs is covered subject to the
25 Medi-Cal List of Contract Drugs and utilization controls.

26 (2) Purchase of drugs used to treat erectile dysfunction or any
27 off-label uses of those drugs are covered only to the extent that
28 federal financial participation is available.

29 (3) (A) To the extent required by federal law, the purchase of
30 outpatient prescribed drugs, for which the prescription is executed
31 by a prescriber in written, nonelectronic form on or after April 1,
32 2008, is covered only when executed on a tamper resistant
33 prescription form. The implementation of this paragraph shall
34 conform to the guidance issued by the federal Centers for Medicare
35 and Medicaid Services but shall not conflict with state statutes on
36 the characteristics of tamper resistant prescriptions for controlled
37 substances, including Section 11162.1 of the Health and Safety
38 Code. The department shall provide providers and beneficiaries
39 with as much flexibility in implementing these rules as allowed
40 by the federal government. The department shall notify and consult

1 with appropriate stakeholders in implementing, interpreting, or
2 making specific this paragraph.

3 (B) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department may take the actions specified in subparagraph (A)
6 by means of a provider bulletin or notice, policy letter, or other
7 similar instructions without taking regulatory action.

8 (4) (A) (i) For the purposes of this paragraph, nonlegend has
9 the same meaning as defined in subdivision (a) of Section
10 14105.45.

11 (ii) Nonlegend acetaminophen-containing products, with the
12 exception of children's acetaminophen-containing products,
13 selected by the department are not covered benefits.

14 (iii) Nonlegend cough and cold products selected by the
15 department are not covered benefits. This clause shall be
16 implemented on the first day of the first calendar month following
17 90 days after the effective date of the act that added this clause,
18 or on the first day of the first calendar month following 60 days
19 after the date the department secures all necessary federal approvals
20 to implement this section, whichever is later.

21 (iv) Beneficiaries under the Early and Periodic Screening,
22 Diagnosis, and Treatment Program shall be exempt from clauses
23 (ii) and (iii).

24 (B) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department may take the actions specified in subparagraph (A)
27 by means of a provider bulletin or notice, policy letter, or other
28 similar instruction without taking regulatory action.

29 (e) Outpatient dialysis services and home hemodialysis services,
30 including physician services, medical supplies, drugs and
31 equipment required for dialysis, are covered, subject to utilization
32 controls.

33 (f) Anesthesiologist services when provided as part of an
34 outpatient medical procedure, nurse anesthetist services when
35 rendered in an inpatient or outpatient setting under conditions set
36 forth by the director, outpatient laboratory services, and X-ray
37 services are covered, subject to utilization controls. Nothing in
38 this subdivision shall be construed to require prior authorization
39 for anesthesiologist services provided as part of an outpatient
40 medical procedure or for portable X-ray services in a nursing

1 facility or any category of intermediate care facility for the
2 developmentally disabled.

3 (g) Blood and blood derivatives are covered.

4 (h) (1) Emergency and essential diagnostic and restorative
5 dental services, except for orthodontic, fixed bridgework, and
6 partial dentures that are not necessary for balance of a complete
7 artificial denture, are covered, subject to utilization controls. The
8 utilization controls shall allow emergency and essential diagnostic
9 and restorative dental services and prostheses that are necessary
10 to prevent a significant disability or to replace previously furnished
11 prostheses which are lost or destroyed due to circumstances beyond
12 the beneficiary's control. Notwithstanding the foregoing, the
13 director may by regulation provide for certain fixed artificial
14 dentures necessary for obtaining employment or for medical
15 conditions that preclude the use of removable dental prostheses,
16 and for orthodontic services in cleft palate deformities administered
17 by the department's California Children Services Program.

18 (2) For persons 21 years of age or older, the services specified
19 in paragraph (1) shall be provided subject to the following
20 conditions:

21 (A) Periodontal treatment is not a benefit.

22 (B) Endodontic therapy is not a benefit except for vital
23 pulpotomy.

24 (C) Laboratory processed crowns are not a benefit.

25 (D) Removable prosthetics shall be a benefit only for patients
26 as a requirement for employment.

27 (E) The director may, by regulation, provide for the provision
28 of fixed artificial dentures that are necessary for medical conditions
29 that preclude the use of removable dental prostheses.

30 (F) Notwithstanding the conditions specified in subparagraphs
31 (A) to (E), inclusive, the department may approve services for
32 persons with special medical disorders subject to utilization review.

33 (3) Paragraph (2) shall become inoperative July 1, 1995.

34 (i) Medical transportation is covered, subject to utilization
35 controls.

36 (j) Home health care services are covered, subject to utilization
37 controls.

38 (k) Prosthetic and orthotic devices and eyeglasses are covered,
39 subject to utilization controls. Utilization controls shall allow
40 replacement of prosthetic and orthotic devices and eyeglasses

1 necessary because of loss or destruction due to circumstances
2 beyond the beneficiary's control. Frame styles for eyeglasses
3 replaced pursuant to this subdivision shall not change more than
4 once every two years, unless the department so directs.

5 Orthopedic and conventional shoes are covered when provided
6 by a prosthetic and orthotic supplier on the prescription of a
7 physician and when at least one of the shoes will be attached to a
8 prosthesis or brace, subject to utilization controls. Modification
9 of stock conventional or orthopedic shoes when medically
10 indicated, is covered subject to utilization controls. When there is
11 a clearly established medical need that cannot be satisfied by the
12 modification of stock conventional or orthopedic shoes,
13 custom-made orthopedic shoes are covered, subject to utilization
14 controls.

15 Therapeutic shoes and inserts are covered when provided to
16 beneficiaries with a diagnosis of diabetes, subject to utilization
17 controls, to the extent that federal financial participation is
18 available.

19 (l) Hearing aids are covered, subject to utilization controls.
20 Utilization controls shall allow replacement of hearing aids
21 necessary because of loss or destruction due to circumstances
22 beyond the beneficiary's control.

23 (m) Durable medical equipment and medical supplies are
24 covered, subject to utilization controls. The utilization controls
25 shall allow the replacement of durable medical equipment and
26 medical supplies when necessary because of loss or destruction
27 due to circumstances beyond the beneficiary's control. The
28 utilization controls shall allow authorization of durable medical
29 equipment needed to assist a disabled beneficiary in caring for a
30 child for whom the disabled beneficiary is a parent, stepparent,
31 foster parent, or legal guardian, subject to the availability of federal
32 financial participation. The department shall adopt emergency
33 regulations to define and establish criteria for assistive durable
34 medical equipment in accordance with the rulemaking provisions
35 of the Administrative Procedure Act (Chapter 3.5 (commencing
36 with Section 11340) of Part 1 of Division 3 of Title 2 of the
37 Government Code).

38 (n) Family planning services are covered, subject to utilization
39 controls. However, for Medi-Cal managed care plans, *any*

1 utilization controls shall be subject to ~~paragraphs (2) and (3) of~~
2 ~~subdivision (b) of~~ Section 1367.25 of the Health and Safety Code.

3 (o) Inpatient intensive rehabilitation hospital services, including
4 respiratory rehabilitation services, in a general acute care hospital
5 are covered, subject to utilization controls, when either of the
6 following criteria are met:

7 (1) A patient with a permanent disability or severe impairment
8 requires an inpatient intensive rehabilitation hospital program as
9 described in Section 14064 to develop function beyond the limited
10 amount that would occur in the normal course of recovery.

11 (2) A patient with a chronic or progressive disease requires an
12 inpatient intensive rehabilitation hospital program as described in
13 Section 14064 to maintain the patient's present functional level as
14 long as possible.

15 (p) (1) Adult day health care is covered in accordance with
16 Chapter 8.7 (commencing with Section 14520).

17 (2) Commencing 30 days after the effective date of the act that
18 added this paragraph, and notwithstanding the number of days
19 previously approved through a treatment authorization request,
20 adult day health care is covered for a maximum of three days per
21 week.

22 (3) As provided in accordance with paragraph (4), adult day
23 health care is covered for a maximum of five days per week.

24 (4) As of the date that the director makes the declaration
25 described in subdivision (g) of Section 14525.1, paragraph (2)
26 shall become inoperative and paragraph (3) shall become operative.

27 (q) (1) Application of fluoride, or other appropriate fluoride
28 treatment as defined by the department, and other prophylaxis
29 treatment for children 17 years of age and under are covered.

30 (2) All dental hygiene services provided by a registered dental
31 hygienist, registered dental hygienist in extended functions, and
32 registered dental hygienist in alternative practice licensed pursuant
33 to Sections 1753, 1917, 1918, and 1922 of the Business and
34 Professions Code may be covered as long as they are within the
35 scope of Denti-Cal benefits and they are necessary services
36 provided by a registered dental hygienist, registered dental
37 hygienist in extended functions, or registered dental hygienist in
38 alternative practice.

39 (r) (1) Paramedic services performed by a city, county, or
40 special district, or pursuant to a contract with a city, county, or

1 special district, and pursuant to a program established under Article
2 3 (commencing with Section 1480) of Chapter 2.5 of Division 2
3 of the Health and Safety Code by a paramedic certified pursuant
4 to that article, and consisting of defibrillation and those services
5 specified in subdivision (3) of Section 1482 of the article.

6 (2) All providers enrolled under this subdivision shall satisfy
7 all applicable statutory and regulatory requirements for becoming
8 a Medi-Cal provider.

9 (3) This subdivision shall be implemented only to the extent
10 funding is available under Section 14106.6.

11 (s) In-home medical care services are covered when medically
12 appropriate and subject to utilization controls, for beneficiaries
13 who would otherwise require care for an extended period of time
14 in an acute care hospital at a cost higher than in-home medical
15 care services. The director shall have the authority under this
16 section to contract with organizations qualified to provide in-home
17 medical care services to those persons. These services may be
18 provided to patients placed in shared or congregate living
19 arrangements, if a home setting is not medically appropriate or
20 available to the beneficiary. As used in this section, “in-home
21 medical care service” includes utility bills directly attributable to
22 continuous, 24-hour operation of life-sustaining medical equipment,
23 to the extent that federal financial participation is available.

24 As used in this subdivision, in-home medical care services
25 include, but are not limited to:

26 (1) ~~Level of care and cost of care~~ *Level-of-care and cost-of-care*
27 evaluations.

28 (2) Expenses, directly attributable to home care activities, for
29 materials.

30 (3) Physician fees for home visits.

31 (4) Expenses directly attributable to home care activities for
32 shelter and modification to shelter.

33 (5) Expenses directly attributable to additional costs of special
34 diets, including tube feeding.

35 (6) Medically related personal services.

36 (7) Home nursing education.

37 (8) Emergency maintenance repair.

38 (9) Home health agency personnel benefits which permit
39 coverage of care during periods when regular personnel are on
40 vacation or using sick leave.

- 1 (10) All services needed to maintain antiseptic conditions at
2 stoma or shunt sites on the body.
- 3 (11) Emergency and nonemergency medical transportation.
- 4 (12) Medical supplies.
- 5 (13) Medical equipment, including, but not limited to, scales,
6 gurneys, and equipment racks suitable for paralyzed patients.
- 7 (14) Utility use directly attributable to the requirements of home
8 care activities which are in addition to normal utility use.
- 9 (15) Special drugs and medications.
- 10 (16) Home health agency supervision of visiting staff which is
11 medically necessary, but not included in the home health agency
12 rate.
- 13 (17) Therapy services.
- 14 (18) Household appliances and household utensil costs directly
15 attributable to home care activities.
- 16 (19) Modification of medical equipment for home use.
- 17 (20) Training and orientation for use of life-support systems,
18 including, but not limited to, support of respiratory functions.
- 19 (21) Respiratory care practitioner services as defined in Sections
20 3702 and 3703 of the Business and Professions Code, subject to
21 prescription by a physician and surgeon.
- 22 Beneficiaries receiving in-home medical care services are entitled
23 to the full range of services within the Medi-Cal scope of benefits
24 as defined by this section, subject to medical necessity and
25 applicable utilization control. Services provided pursuant to this
26 subdivision, which are not otherwise included in the Medi-Cal
27 schedule of benefits, shall be available only to the extent that
28 federal financial participation for these services is available in
29 accordance with a home- and community-based services waiver.
- 30 (t) Home- and community-based services approved by the
31 United States Department of Health and Human Services are
32 covered to the extent that federal financial participation is available
33 for those services under the state plan or waivers granted in
34 accordance with Section 1315 or 1396n of Title 42 of the United
35 States Code. The director may seek waivers for any or all home-
36 and community-based services approvable under Section 1315 or
37 1396n of Title 42 of the United States Code. Coverage for those
38 services shall be limited by the terms, conditions, and duration of
39 the federal waivers.

1 (u) Comprehensive perinatal services, as provided through an
2 agreement with a health care provider designated in Section
3 14134.5 and meeting the standards developed by the department
4 pursuant to Section 14134.5, subject to utilization controls.

5 The department shall seek any federal waivers necessary to
6 implement the provisions of this subdivision. The provisions for
7 which appropriate federal waivers cannot be obtained shall not be
8 implemented. Provisions for which waivers are obtained or for
9 which waivers are not required shall be implemented
10 notwithstanding any inability to obtain federal waivers for the
11 other provisions. No provision of this subdivision shall be
12 implemented unless matching funds from Subchapter XIX
13 (commencing with Section 1396) of Chapter 7 of Title 42 of the
14 United States Code are available.

15 (v) Early and periodic screening, diagnosis, and treatment for
16 any individual under 21 years of age is covered, consistent with
17 the requirements of Subchapter XIX (commencing with Section
18 1396) of Chapter 7 of Title 42 of the United States Code.

19 (w) Hospice service which is Medicare-certified hospice service
20 is covered, subject to utilization controls. Coverage shall be
21 available only to the extent that no additional net program costs
22 are incurred.

23 (x) When a claim for treatment provided to a beneficiary
24 includes both services which are authorized and reimbursable
25 under this chapter, and services which are not reimbursable under
26 this chapter, that portion of the claim for the treatment and services
27 authorized and reimbursable under this chapter shall be payable.

28 (y) Home- and community-based services approved by the
29 United States Department of Health and Human Services for
30 beneficiaries with a diagnosis of AIDS or ARC, who require
31 intermediate care or a higher level of care.

32 Services provided pursuant to a waiver obtained from the
33 Secretary of the United States Department of Health and Human
34 Services pursuant to this subdivision, and which are not otherwise
35 included in the Medi-Cal schedule of benefits, shall be available
36 only to the extent that federal financial participation for these
37 services is available in accordance with the waiver, and subject to
38 the terms, conditions, and duration of the waiver. These services
39 shall be provided to individual beneficiaries in accordance with

1 the client’s needs as identified in the plan of care, and subject to
2 medical necessity and applicable utilization control.

3 The director may under this section contract with organizations
4 qualified to provide, directly or by subcontract, services provided
5 for in this subdivision to eligible beneficiaries. Contracts or
6 agreements entered into pursuant to this division shall not be
7 subject to the Public Contract Code.

8 (z) Respiratory care when provided in organized health care
9 systems as defined in Section 3701 of the Business and Professions
10 Code, and as an in-home medical service as outlined in subdivision
11 (s).

12 (aa) (1) There is hereby established in the department, a
13 program to provide comprehensive clinical family planning
14 services to any person who has a family income at or below 200
15 percent of the federal poverty level, as revised annually, and who
16 is eligible to receive these services pursuant to the waiver identified
17 in paragraph (2). This program shall be known as the Family
18 Planning, Access, Care, and Treatment (Family PACT) Program.

19 (2) The department shall seek a waiver in accordance with
20 Section 1315 of Title 42 of the United States Code, or a state plan
21 amendment adopted in accordance with Section
22 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code,
23 which was added to Section 1396a of Title 42 of the United States
24 Code by Section 2303(a)(2) of the federal Patient Protection and
25 Affordable Care Act (PPACA) (Public Law 111-148), for a
26 program to provide comprehensive clinical family planning
27 services as described in paragraph (8). Under the waiver, the
28 program shall be operated only in accordance with the waiver and
29 the statutes and regulations in paragraph (4) and subject to the
30 terms, conditions, and duration of the waiver. Under the state plan
31 amendment, which shall replace the waiver and shall be known as
32 the Family PACT successor state plan amendment, the program
33 shall be operated only in accordance with this subdivision and the
34 statutes and regulations in paragraph (4). The state shall use the
35 standards and processes imposed by the state on January 1, 2007,
36 including the application of an eligibility discount factor to the
37 extent required by the federal Centers for Medicare and Medicaid
38 Services, for purposes of determining eligibility as permitted under
39 Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States
40 Code. To the extent that federal financial participation is available,

1 the program shall continue to conduct education, outreach,
2 enrollment, service delivery, and evaluation services as specified
3 under the waiver. The services shall be provided under the program
4 only if the waiver and, when applicable, the successor state plan
5 amendment are approved by the federal Centers for Medicare and
6 Medicaid Services and only to the extent that federal financial
7 participation is available for the services. Nothing in this section
8 shall prohibit the department from seeking the Family PACT
9 successor state plan amendment during the operation of the waiver.

10 (3) Solely for the purposes of the waiver or Family PACT
11 successor state plan amendment and notwithstanding any other
12 provision of law, the collection and use of an individual's social
13 security number shall be necessary only to the extent required by
14 federal law.

15 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
16 and 24013, and any regulations adopted under these statutes shall
17 apply to the program provided for under this subdivision. No other
18 provision of law under the Medi-Cal program or the State-Only
19 Family Planning Program shall apply to the program provided for
20 under this subdivision.

21 (5) Notwithstanding Chapter 3.5 (commencing with Section
22 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
23 the department may implement, without taking regulatory action,
24 the provisions of the waiver after its approval by the federal Health
25 Care Financing Administration and the provisions of this section
26 by means of an all-county letter or similar instruction to providers.
27 Thereafter, the department shall adopt regulations to implement
28 this section and the approved waiver in accordance with the
29 requirements of Chapter 3.5 (commencing with Section 11340) of
30 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
31 six months after the effective date of the act adding this
32 subdivision, the department shall provide a status report to the
33 Legislature on a semiannual basis until regulations have been
34 adopted.

35 (6) In the event that the Department of Finance determines that
36 the program operated under the authority of the waiver described
37 in paragraph (2) or the Family PACT successor state plan
38 amendment is no longer cost effective, this subdivision shall
39 become inoperative on the first day of the first month following
40 the issuance of a 30-day notification of that determination in

1 writing by the Department of Finance to the chairperson in each
2 house that considers appropriations, the chairpersons of the
3 committees, and the appropriate subcommittees in each house that
4 considers the State Budget, and the Chairperson of the Joint
5 Legislative Budget Committee.

6 (7) If this subdivision ceases to be operative, all persons who
7 have received or are eligible to receive comprehensive clinical
8 family planning services pursuant to the waiver described in
9 paragraph (2) shall receive family planning services under the
10 Medi-Cal program pursuant to subdivision (n) if they are otherwise
11 eligible for Medi-Cal with no share of cost, or shall receive
12 comprehensive clinical family planning services under the program
13 established in Division 24 (commencing with Section 24000) either
14 if they are eligible for Medi-Cal with a share of cost or if they are
15 otherwise eligible under Section 24003.

16 (8) For purposes of this subdivision, “comprehensive clinical
17 family planning services” means the process of establishing
18 objectives for the number and spacing of children, and selecting
19 the means by which those objectives may be achieved. These
20 means include a broad range of acceptable and effective methods
21 and services to limit or enhance fertility, including contraceptive
22 methods, federal Food and Drug Administration approved
23 contraceptive drugs, devices, and supplies, natural family planning,
24 abstinence methods, and basic, limited fertility management.
25 Comprehensive clinical family planning services include, but are
26 not limited to, preconception counseling, maternal and fetal health
27 counseling, general reproductive health care, including diagnosis
28 and treatment of infections and conditions, including cancer, that
29 threaten reproductive capability, medical family planning treatment
30 and procedures, including supplies and followup, and
31 informational, counseling, and educational services.
32 Comprehensive clinical family planning services shall not include
33 abortion, pregnancy testing solely for the purposes of referral for
34 abortion or services ancillary to abortions, or pregnancy care that
35 is not incident to the diagnosis of pregnancy. Comprehensive
36 clinical family planning services shall be subject to utilization
37 control and include all of the following:

38 (A) Family planning related services and male and female
39 sterilization. Family planning services for men and women shall
40 include emergency services and services for complications directly

1 related to the contraceptive method, federal Food and Drug
2 Administration approved contraceptive drugs, devices, and
3 supplies, and followup, consultation, and referral services, as
4 indicated, which may require treatment authorization requests.

5 (B) All United States Department of Agriculture, federal Food
6 and Drug Administration approved contraceptive drugs, devices,
7 and supplies that are in keeping with current standards of practice
8 and from which the individual may choose.

9 (C) Culturally and linguistically appropriate health education
10 and counseling services, including informed consent, that include
11 all of the following:

- 12 (i) Psychosocial and medical aspects of contraception.
- 13 (ii) Sexuality.
- 14 (iii) Fertility.
- 15 (iv) Pregnancy.
- 16 (v) Parenthood.
- 17 (vi) Infertility.
- 18 (vii) Reproductive health care.
- 19 (viii) Preconception and nutrition counseling.
- 20 (ix) Prevention and treatment of sexually transmitted infection.
- 21 (x) Use of contraceptive methods, federal Food and Drug
22 Administration approved contraceptive drugs, devices, and
23 supplies.
- 24 (xi) Possible contraceptive consequences and followup.
- 25 (xii) Interpersonal communication and negotiation of
26 relationships to assist individuals and couples in effective
27 contraceptive method use and planning families.

28 (D) A comprehensive health history, updated at the next periodic
29 visit (between 11 and 24 months after initial examination) that
30 includes a complete obstetrical history, gynecological history,
31 contraceptive history, personal medical history, health risk factors,
32 and family health history, including genetic or hereditary
33 conditions.

34 (E) A complete physical examination on initial and subsequent
35 periodic visits.

36 (F) Services, drugs, devices, and supplies deemed by the federal
37 Centers for Medicare and Medicaid Services to be appropriate for
38 inclusion in the program.

39 (9) In order to maximize the availability of federal financial
40 participation under this subdivision, the director shall have the

1 discretion to implement the Family PACT successor state plan
2 amendment retroactively to July 1, 2010.

3 (ab) (1) Purchase of prescribed enteral nutrition products is
4 covered, subject to the Medi-Cal list of enteral nutrition products
5 and utilization controls.

6 (2) Purchase of enteral nutrition products is limited to those
7 products to be administered through a feeding tube, including, but
8 not limited to, a gastric, nasogastric, or jejunostomy tube.
9 Beneficiaries under the Early and Periodic Screening, Diagnosis,
10 and Treatment Program shall be exempt from this paragraph.

11 (3) Notwithstanding paragraph (2), the department may deem
12 an enteral nutrition product, not administered through a feeding
13 tube, including, but not limited to, a gastric, nasogastric, or
14 jejunostomy tube, a benefit for patients with diagnoses, including,
15 but not limited to, malabsorption and inborn errors of metabolism,
16 if the product has been shown to be neither investigational nor
17 experimental when used as part of a therapeutic regimen to prevent
18 serious disability or death.

19 (4) Notwithstanding Chapter 3.5 (commencing with Section
20 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
21 the department may implement the amendments to this subdivision
22 made by the act that added this paragraph by means of all-county
23 letters, provider bulletins, or similar instructions, without taking
24 regulatory action.

25 (5) The amendments made to this subdivision by the act that
26 added this paragraph shall be implemented June 1, 2011, or on the
27 first day of the first calendar month following 60 days after the
28 date the department secures all necessary federal approvals to
29 implement this section, whichever is later.

30 (ac) Diabetic testing supplies are covered when provided by a
31 pharmacy, subject to utilization controls.

32 SEC. 5. No reimbursement is required by this act pursuant to
33 Section 6 of Article XIII B of the California Constitution because
34 the only costs that may be incurred by a local agency or school
35 district will be incurred because this act creates a new crime or
36 infraction, eliminates a crime or infraction, or changes the penalty
37 for a crime or infraction, within the meaning of Section 17556 of
38 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.

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