

AMENDED IN ASSEMBLY AUGUST 17, 2015

AMENDED IN ASSEMBLY JULY 16, 2015

AMENDED IN SENATE APRIL 20, 2015

SENATE BILL

No. 43

**Introduced by Senator Hernandez
(Coauthor: Senator Monning)**

December 5, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

SB 43, as amended, Hernandez. Health care coverage: essential health benefits.

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

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, defined to include rehabilitative and habilitative services and the health benefits covered by particular benchmark plans, including a certain plan offered during the first quarter of 2012. Existing law requires habilitative services to be covered under the same terms and conditions applied to rehabilitative services under the plan contract or policy, and defines habilitative services to mean medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functions and that are necessary to address a health condition. Existing law specifies that these provisions do not apply to specified plans, including grandfathered plans. Existing law authorizes the Department of Managed Health Care and the Department of Insurance to adopt emergency regulations implementing these provisions until March 1, 2016.

This bill would, for an individual or small group health care service plan contract or an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, prohibit limits on habilitative and rehabilitative services from being ~~combined~~, ~~revise the definition of “habilitative services” to conform to federal regulations;~~ *combined* and would define essential health benefits to include the health benefits covered by particular benchmark plans as of the first quarter of 2014, as specified. *The bill, for plan years commencing on or after January 1, 2016, would revise the definition of “habilitative services” to conform to federal regulations.* The bill would authorize the Department of Managed Health Care and the Department of Insurance to adopt emergency regulations implementing amendments made to the above-described provisions during the 2015–16 Regular Session of the Legislature until July 1, 2018.

Because a willful violation of the bill’s requirements 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.

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. Section 1367.005 of the Health and Safety Code,
2 as amended by Section 7 of Chapter 572 of the Statutes of 2014,
3 is amended to read:

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

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

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

24 (i) Medically necessary basic health care services, as defined
25 in subdivision (b) of Section 1345 and in Section 1300.67 of Title
26 28 of the California Code of Regulations.

27 (ii) The health benefits mandated to be covered by the plan
28 pursuant to statutes enacted before December 31, 2011, as
29 described in the following sections: Sections 1367.002, 1367.06,
30 and 1367.35 (preventive services for children); Section 1367.25

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

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

23 (iv) The health benefits covered by the plan that are not
24 otherwise required to be covered under this chapter, to the extent
25 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
26 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
27 California Code of Regulations.

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

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

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

39 (D) For purposes of this section, the Paul Wellstone and Pete
40 Domenici Mental Health Parity and Addiction Equity Act of 2008

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

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

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

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

31 (b) Treatment limitations imposed on health benefits described
32 in this section shall be no greater than the treatment limitations
33 imposed by the corresponding plans identified in subdivision (a),
34 subject to the requirements set forth in paragraph (2) of subdivision
35 (a).

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

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

10 (e) No health care service plan, or its agent, solicitor, or
11 representative, shall issue, deliver, renew, offer, market, represent,
12 or sell any product, contract, or discount arrangement as compliant
13 with the essential health benefits requirement in federal law, unless
14 it meets all of the requirements of this section.

15 (f) This section shall apply regardless of whether the plan
16 contract is offered inside or outside the California Health Benefit
17 Exchange created by Section 100500 of the Government Code.

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

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

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

26 (1) A specialized health care service plan contract.

27 (2) A Medicare supplement plan.

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

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

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

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

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

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

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

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

19 *(3) The initial adoption of emergency regulations implementing*
20 *amendments to this section made during the 2015–16 Regular*
21 *Session of the Legislature and the readoption of emergency*
22 *regulations authorized by this subdivision shall be deemed an*
23 *emergency and necessary for the immediate preservation of the*
24 *public peace, health, safety, or general welfare. The initial*
25 *emergency regulations and the readoption of emergency*
26 *regulations authorized by this section shall be submitted to the*
27 *Office of Administrative Law for filing with the Secretary of State*
28 *and each shall remain in effect for no more than 180 days, by*
29 *which time final regulations may be adopted.*

30 ~~(3)~~

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

34 ~~(4)~~

35 (5) This subdivision shall become inoperative on ~~March 1, 2016.~~
36 *January 1, 2017.*

37 (p) For purposes of this section, the following definitions shall
38 apply:

39 (1) ~~“Habilitation”~~ *(A) For plan years commencing on or after*
40 *January 1, 2014, and on or before December 31, 2015,*

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

14 (B) For plan years commencing on or after January 1, 2016,
15 “habilitative services” means health care services and devices
16 that help a person keep, learn, or improve skills and functioning
17 for daily living. Examples include therapy for a child who is not
18 walking or talking at the expected age. These services may include
19 physical and occupational therapy, speech-language pathology,
20 and other services for people with disabilities in a variety of
21 inpatient or outpatient settings, or both. Habilitative services shall
22 be covered under the same terms and conditions applied to
23 rehabilitative services under the plan contract.

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

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

32 (3) “PPACA” means the federal Patient Protection and
33 Affordable Care Act (Public Law 111-148), as amended by the
34 federal Health Care and Education Reconciliation Act of 2010
35 (Public Law 111-152), and any rules, regulations, or guidance
36 issued thereunder.

37 (4) “Small group health care service plan contract” means a
38 group health care service plan contract issued to a small employer,
39 as defined in Section 1357.500.

1 (q) This section shall remain in effect only until January 1, 2017,
2 and as of that date is repealed, unless a later enacted statute, that
3 is enacted before January 1, 2017, deletes or extends that date.

4 SEC. 2. Section 1367.005 is added to the Health and Safety
5 Code, to read:

6 1367.005. (a) An individual or small group health care service
7 plan contract issued, amended, or renewed on or after January 1,
8 2017, shall, at a minimum, include coverage for essential health
9 benefits pursuant to PPACA and as outlined in this section. For
10 purposes of this section, “essential health benefits” means all of
11 the following:

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

20 (2) (A) The health benefits covered by the Kaiser Foundation
21 Health Plan Small Group HMO 30 plan (federal health product
22 identification number 40513CA035) as this plan was offered during
23 the first quarter of 2014, as follows, regardless of whether the
24 benefits are specifically referenced in the evidence of coverage or
25 plan contract for that plan:

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

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

1 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);
2 Section 1367.68 (surgical procedures for jaw bones); Section
3 1367.71 (anesthesia for dental); Section 1367.9 (conditions
4 attributable to diethylstilbestrol); Section 1368.2 (hospice care);
5 Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency
6 response ambulance or ambulance transport services); subdivision
7 (b) of Section 1373 (sterilization operations or procedures); Section
8 1373.4 (inpatient hospital and ambulatory maternity); Section
9 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for
10 HIV); Section 1374.72 (mental health parity); and Section 1374.73
11 (autism/behavioral health treatment).

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

15 (iv) The health benefits covered by the plan that are not
16 otherwise required to be covered under this chapter, to the extent
17 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
18 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
19 California Code of Regulations.

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

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

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

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

1 (3) With respect to habilitative services, in addition to any
2 habilitative services *and devices* identified in paragraph (2),
3 coverage shall also be provided as required by federal rules,
4 regulations, and guidance issued pursuant to Section 1302(b) of
5 PPACA. Habilitative services *and devices* shall be covered under
6 the same terms and conditions applied to rehabilitative services
7 *and devices* under the plan contract. Limits on habilitative and
8 rehabilitative services *and devices* shall not be combined.

9 (4) With respect to pediatric vision care, the same health benefits
10 for pediatric vision care covered under the Federal Employees
11 Dental and Vision Insurance Program vision plan with the largest
12 national enrollment as of the first quarter of 2014. The pediatric
13 vision care benefits covered pursuant to this paragraph shall be in
14 addition to, and shall not replace, any vision services covered under
15 the plan identified in paragraph (2).

16 (5) With respect to pediatric oral care, the same health benefits
17 for pediatric oral care covered under the dental benefit received
18 by children under the Medi-Cal program as of 2014, including the
19 provision of medically necessary orthodontic care provided
20 pursuant to the federal Children’s Health Insurance Program
21 Reauthorization Act of 2009. The pediatric oral care benefits
22 covered pursuant to this paragraph shall be in addition to, and shall
23 not replace, any dental or orthodontic services covered under the
24 plan identified in paragraph (2).

25 (b) Treatment limitations imposed on health benefits described
26 in this section shall be no greater than the treatment limitations
27 imposed by the corresponding plans identified in subdivision (a),
28 subject to the requirements set forth in paragraph (2) of subdivision
29 (a).

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

35 (d) To the extent permitted under Section 1302 of PPACA and
36 any rules, regulations, or guidance issued pursuant to that section,
37 and to the extent that substitution would not create an obligation
38 for the state to defray costs for any individual, a plan may substitute
39 its prescription drug formulary for the formulary provided under
40 the plan identified in subdivision (a) as long as the coverage for

1 prescription drugs complies with the sections referenced in clauses
2 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision
3 (a) that apply to prescription drugs.

4 (e) No health care service plan, or its agent, solicitor, or
5 representative, shall issue, deliver, renew, offer, market, represent,
6 or sell any product, contract, or discount arrangement as compliant
7 with the essential health benefits requirement in federal law, unless
8 it meets all of the requirements of this section.

9 (f) This section shall apply regardless of whether the plan
10 contract is offered inside or outside the California Health Benefit
11 Exchange created by Section 100500 of the Government Code.

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

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

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

20 (1) A specialized health care service plan contract.

21 (2) A Medicare supplement plan.

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

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

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

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

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

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

38 (o) (1) The department may adopt emergency regulations
39 implementing this section. The department may, on a one-time
40 basis, readopt any emergency regulation authorized by this section

1 that is the same as, or substantially equivalent to, an emergency
2 regulation previously adopted under this section.

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

13 (3) The initial adoption of emergency regulations implementing
14 this section made during the 2015–16 Regular Session of the
15 Legislature and the readoption of emergency regulations authorized
16 by this subdivision shall be deemed an emergency and necessary
17 for the immediate preservation of the public peace, health, safety,
18 or general welfare. The initial emergency regulations and the
19 readoption of emergency regulations authorized by this section
20 shall be submitted to the Office of Administrative Law for filing
21 with the Secretary of State and each shall remain in effect for no
22 more than 180 days, by which time final regulations may be
23 adopted.

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

27 (5) This subdivision shall become inoperative on July 1, 2018.

28 (p) For purposes of this section, the following definitions shall
29 apply:

30 (1) “Habilitative services” means health care services and
31 devices that help a person keep, learn, or improve skills and
32 functioning for daily living. Examples include therapy for a child
33 who is not walking or talking at the expected age. These services
34 may include physical and occupational therapy, speech-language
35 pathology, and other services for people with disabilities in a
36 variety of inpatient or outpatient settings, or both. Habilitative
37 services shall be covered under the same terms and conditions
38 applied to rehabilitative services under the plan contract.

39 (2) (A) “Health benefits,” unless otherwise required to be
40 defined pursuant to federal rules, regulations, or guidance issued

1 pursuant to Section 1302(b) of PPACA, means health care items
2 or services for the diagnosis, cure, mitigation, treatment, or
3 prevention of illness, injury, disease, or a health condition,
4 including a behavioral health condition.

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

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

12 (4) “Small group health care service plan contract” means a
13 group health care service plan contract issued to a small employer,
14 as defined in Section 1357.500.

15 SEC. 3. Section 10112.27 of the Insurance Code, as amended
16 by Section 14 of Chapter 572 of the Statutes of 2014, is amended
17 to read:

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

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

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

39 (i) Medically necessary basic health care services, as defined
40 in subdivision (b) of Section 1345 of the Health and Safety Code

1 and in Section 1300.67 of Title 28 of the California Code of
2 Regulations.

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

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

30 (iv) The health benefits covered by the plan that are not
31 otherwise required to be covered under Chapter 2.2 (commencing
32 with Section 1340) of Division 2 of the Health and Safety Code,
33 to the extent otherwise required pursuant to Sections 1367.18,
34 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
35 and Safety Code, and Section 1300.67.24 of Title 28 of the
36 California Code of Regulations.

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

1 (B) Where there are any conflicts or omissions in the plan
2 identified in subparagraph (A) as compared with the requirements
3 for health benefits under Chapter 2.2 (commencing with Section
4 1340) of Division 2 of the Health and Safety Code that were
5 enacted prior to December 31, 2011, the requirements of Chapter
6 2.2 (commencing with Section 1340) of Division 2 of the Health
7 and Safety Code shall be controlling, except as otherwise specified
8 in this section.

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

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

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

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

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

1 pursuant to the federal Children’s Health Insurance Program
2 Reauthorization Act of 2009. The pediatric oral care benefits
3 covered pursuant to this paragraph shall be in addition to, and shall
4 not replace, any dental or orthodontic services covered under the
5 plan identified in paragraph (2).

6 (b) Treatment limitations imposed on health benefits described
7 in this section shall be no greater than the treatment limitations
8 imposed by the corresponding plans identified in subdivision (a),
9 subject to the requirements set forth in paragraph (2) of subdivision
10 (a).

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

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

24 (e) No health insurer, or its agent, producer, or representative,
25 shall issue, deliver, renew, offer, market, represent, or sell any
26 product, policy, or discount arrangement as compliant with the
27 essential health benefits requirement in federal law, unless it meets
28 all of the requirements of this section. This subdivision shall be
29 enforced in the same manner as Section 790.03, including through
30 the means specified in Sections 790.035 and 790.05.

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

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

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

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

2 (1) A policy that provides excepted benefits as described in
3 Sections 2722 and 2791 of the federal Public Health Service Act
4 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

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

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

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

21 (o) (1) The commissioner may adopt emergency regulations
22 implementing this section. The commissioner 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 initial adoption of emergency regulations implementing*
37 *this section made during the 2015–16 Regular Session of the*
38 *Legislature and the readoption of emergency regulations*
39 *authorized by this subdivision shall be deemed an emergency and*
40 *necessary for the immediate preservation of the public peace,*

1 *health, safety, or general welfare. The initial emergency*
2 *regulations and the readoption of emergency regulations*
3 *authorized by this section shall be submitted to the Office of*
4 *Administrative Law for filing with the Secretary of State and each*
5 *shall remain in effect for no more than 180 days, by which time*
6 *final regulations may be adopted.*

7 ~~(3)~~

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

12 ~~(4)~~

13 (5) This subdivision shall become inoperative on ~~March 1, 2016.~~
14 *January 1, 2017.*

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

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

23 ~~(1) “Habilitative—~~(A) *For plan years commencing on or after*
24 *January 1, 2014, and on or before December 31, 2015,*
25 *“habilitative services” means medically necessary health care*
26 *services and health care devices that assist an individual in partially*
27 *or fully acquiring or improving skills and functioning and that are*
28 *necessary to address a health condition, to the maximum extent*
29 *practical. These services address the skills and abilities needed for*
30 *functioning in interaction with an individual’s environment.*
31 *Examples of health care services that are not habilitative services*
32 *include, but are not limited to, respite care, day care, recreational*
33 *care, residential treatment, social services, custodial care, or*
34 *education services of any kind, including, but not limited to,*
35 *vocational training. Habilitative services shall be covered under*
36 *the same terms and conditions applied to rehabilitative services*
37 *under the policy.*

38 (B) *For plan years commencing on or after January 1, 2016,*
39 *“habilitative services” means health care services and devices*
40 *that help a person keep, learn, or improve skills and functioning*

1 *for daily living. Examples include therapy for a child who is not*
 2 *walking or talking at the expected age. These services may include*
 3 *physical and occupational therapy, speech-language pathology,*
 4 *and other services for people with disabilities in a variety of*
 5 *inpatient or outpatient settings, or both. Habilitative services shall*
 6 *be covered under the same terms and conditions applied to*
 7 *rehabilitative services under the policy.*

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

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

16 (3) “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 (4) “Small group health insurance policy” means a group health
 22 insurance policy issued to a small employer, as defined in Section
 23 10753.

24 (r) This section shall remain in effect only until January 1, 2017,
 25 and as of that date is repealed, unless a later enacted statute, that
 26 is enacted before January 1, 2017, deletes or extends that date.

27 SEC. 4. Section 10112.27 is added to the Insurance Code, to
 28 read:

29 10112.27. (a) An individual or small group health insurance
 30 policy issued, amended, or renewed on or after January 1, 2017,
 31 shall, at a minimum, include coverage for essential health benefits
 32 pursuant to PPACA and as outlined in this section. This section
 33 shall exclusively govern what benefits a health insurer must cover
 34 as essential health benefits. For purposes of this section, “essential
 35 health benefits” means all of the following:

36 (1) Health benefits within the categories identified in Section
 37 1302(b) of PPACA: ambulatory patient services, emergency
 38 services, hospitalization, maternity and newborn care, mental health
 39 and substance use disorder services, including behavioral health
 40 treatment, prescription drugs, rehabilitative and habilitative services

1 and devices, laboratory services, preventive and wellness services
2 and chronic disease management, and pediatric services, including
3 oral and vision care.

4 (2) (A) The health benefits covered by the Kaiser Foundation
5 Health Plan Small Group HMO 30 plan (federal health product
6 identification number 40513CA035) as this plan was offered during
7 the first quarter of 2014, as follows, regardless of whether the
8 benefits are specifically referenced in the plan contract or evidence
9 of coverage for that plan:

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

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

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

1 (iv) The health benefits covered by the plan that are not
2 otherwise required to be covered under Chapter 2.2 (commencing
3 with Section 1340) of Division 2 of the Health and Safety Code,
4 to the extent otherwise required pursuant to Sections 1367.18,
5 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
6 and Safety Code, and Section 1300.67.24 of Title 28 of the
7 California Code of Regulations.

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

11 (B) Where there are any conflicts or omissions in the plan
12 identified in subparagraph (A) as compared with the requirements
13 for health benefits under Chapter 2.2 (commencing with Section
14 1340) of Division 2 of the Health and Safety Code that were
15 enacted prior to December 31, 2011, the requirements of Chapter
16 2.2 (commencing with Section 1340) of Division 2 of the Health
17 and Safety Code shall be controlling, except as otherwise specified
18 in this section.

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

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

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

1 *and devices* under the policy. Limits on habilitative and
2 rehabilitative services *and devices* shall not be combined.

3 (4) With respect to pediatric vision care, the same health benefits
4 for pediatric vision care covered under the Federal Employees
5 Dental and Vision Insurance Program vision plan with the largest
6 national enrollment as of the first quarter of 2014. The pediatric
7 vision care services covered pursuant to this paragraph shall be in
8 addition to, and shall not replace, any vision services covered under
9 the plan identified in paragraph (2).

10 (5) With respect to pediatric oral care, the same health benefits
11 for pediatric oral care covered under the dental benefit received
12 by children under Medi-Cal as of 2014, including the provision of
13 medically necessary orthodontic care provided pursuant to the
14 federal Children’s Health Insurance Program Reauthorization Act
15 of 2009. The pediatric oral care benefits covered pursuant to this
16 paragraph shall be in addition to, and shall not replace, any dental
17 or orthodontic services covered under the plan identified in
18 paragraph (2).

19 (b) Treatment limitations imposed on health benefits described
20 in this section shall be no greater than the treatment limitations
21 imposed by the corresponding plans identified in subdivision (a),
22 subject to the requirements set forth in paragraph (2) of subdivision
23 (a).

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

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

37 (e) No health insurer, or its agent, producer, or representative,
38 shall issue, deliver, renew, offer, market, represent, or sell any
39 product, policy, or discount arrangement as compliant with the
40 essential health benefits requirement in federal law, unless it meets

1 all of the requirements of this section. This subdivision shall be
2 enforced in the same manner as Section 790.03, including through
3 the means specified in Sections 790.035 and 790.05.

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

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

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

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

15 (1) A policy that provides excepted benefits as described in
16 Sections 2722 and 2791 of the federal Public Health Service Act
17 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

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

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

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

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

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

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

39 (2) The initial adoption of emergency regulations implementing
40 this section and the readoption of emergency regulations authorized

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

9 (3) The initial adoption of emergency regulations implementing
10 this section made during the 2015–16 Regular Session of the
11 Legislature and the readoption of emergency regulations authorized
12 by this subdivision shall be deemed an emergency and necessary
13 for the immediate preservation of the public peace, health, safety,
14 or general welfare. The initial emergency regulations and the
15 readoption of emergency regulations authorized by this section
16 shall be submitted to the Office of Administrative Law for filing
17 with the Secretary of State and each shall remain in effect for no
18 more than 180 days, by which time final regulations may be
19 adopted.

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

24 (5) This subdivision shall become inoperative on July 1, 2018.

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

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

33 (1) “Habilitative services” means health care services and
34 devices that help a person keep, learn, or improve skills and
35 functioning for daily living. Examples include therapy for a child
36 who is not walking or talking at the expected age. These services
37 may include physical and occupational therapy, speech-language
38 pathology, and other services for people with disabilities in a
39 variety of inpatient or outpatient settings, or both. Habilitative

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

3 (2) (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 (3) “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 (4) “Small group health insurance policy” means a group health
17 insurance policy issued to a small employer, as defined in Section
18 10753.

19 SEC. 5. No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution because
21 the only costs that may be incurred by a local agency or school
22 district will be incurred because this act creates a new crime or
23 infraction, eliminates a crime or infraction, or changes the penalty
24 for a crime or infraction, within the meaning of Section 17556 of
25 the Government Code, or changes the definition of a crime within
26 the meaning of Section 6 of Article XIII B of the California
27 Constitution.

28

29

30 **CORRECTIONS:**

31 **Amended House—Page 1.**

32

O