

AMENDED IN SENATE APRIL 23, 2025

SENATE BILL

No. 62

Introduced by Senator Menjivar

January 9, 2025

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

LEGISLATIVE COUNSEL'S DIGEST

SB 62, as amended, Menjivar. Health care coverage: essential health benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service ~~plans~~. *plans and makes a willful violation of the act a crime*. Existing law requires the Department of Insurance to regulate health insurers. 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, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.

This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. ~~The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.~~ *The bill would require, commencing January*

1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: ~~no~~-yes.

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

1 SECTION 1. It is the intent of the Legislature to review
2 California's essential health benefits benchmark plan and establish
3 a new benchmark plan for the 2027 plan year.

4 SEC. 2. Section 1367.005 of the Health and Safety Code is
5 amended 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 include, at a minimum, coverage for essential health
9 benefits pursuant to the federal Patient Protection and Affordable
10 Care Act (PPACA) and as outlined in this section. For purposes
11 of this section, "essential health benefits" means all of the
12 following:

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

21 (2) (A) ~~For plan years on or before the 2027 plan year, The~~
22 health benefits covered by the Kaiser Foundation Health Plan

1 Small Group HMO 30 plan (federal health product identification
2 number 40513CA035) as this plan was offered during the first
3 quarter of 2014, as follows, regardless of whether the benefits are
4 specifically referenced in the evidence of coverage or plan contract
5 for that plan:

6 (i) Medically necessary basic health care services, as defined
7 in subdivision (b) of Section 1345 and Section 1300.67 of Title
8 28 of the California Code of Regulations.

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

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

35 (iv) The health benefits covered by the plan that are not
36 otherwise required to be covered under this chapter, to the extent
37 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
38 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
39 California Code of Regulations.

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

3 (B) If there are any conflicts or omissions in the plan identified
4 in subparagraph (A) as compared with the requirements for health
5 benefits under this chapter that were enacted prior to December
6 31, 2011, the requirements of this chapter shall be controlling,
7 except as otherwise specified in this section.

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

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

22 (E) *Commencing January 1, 2027, if the United States*
23 *Department of Health and Human Services approves a new*
24 *essential health benefits benchmark plan for the State of California*
25 *pursuant to submissions to the department made on behalf of the*
26 *state in 2025 for this purpose, the benchmark plan described in*
27 *subparagraph (A) shall additionally include all of the following*
28 *benefits:*

29 (i) *Services to evaluate, diagnose, and treat infertility that*
30 *include all of the following:*

31 (I) *Artificial insemination.*

32 (II) *Three attempts to retrieve gametes.*

33 (III) *Three attempts to create embryos.*

34 (IV) *Three rounds of pretransfer testing.*

35 (V) *Cryopreservation of gametes and embryos.*

36 (VI) *Two years of storage for cryopreserved embryos.*

37 (VII) *Unlimited storage for cryopreserved gametes.*

38 (VIII) *Unlimited embryo transfers.*

39 (IX) *Two vials of donor sperm.*

40 (X) *Ten donor eggs.*

1 *(XI) Surrogacy coverage for the services described above.*

2 *(XII) Health testing of the surrogate for each attempted round*
3 *of covered services.*

4 *(ii) All of the following durable medical equipment:*

5 *(I) Mobility devices, including, but not limited to, walkers and*
6 *manual and power wheelchairs and scooters.*

7 *(II) Augmented communications devices, including, but not*
8 *limited to, speech generating devices, communications boards,*
9 *and computer applications.*

10 *(III) Continuous positive airway pressure machines.*

11 *(IV) Portable oxygen.*

12 *(V) Hospital beds.*

13 *(iii) (I) An annual hearing exam.*

14 *(II) One hearing aid per ear every three years.*

15 (3) With respect to habilitative services, in addition to any
16 habilitative services and devices identified in paragraph (2),
17 coverage shall also be provided as required by federal rules,
18 regulations, and guidance issued pursuant to Section 1302(b) of
19 PPACA. Habilitative services and devices shall be covered under
20 the same terms and conditions applied to rehabilitative services
21 and devices under the plan contract. Limits on habilitative and
22 rehabilitative services and devices shall not be combined.

23 (4) With respect to pediatric vision care, the same health benefits
24 for pediatric vision care covered under the Federal Employees
25 Dental and Vision Insurance Program vision plan with the largest
26 national enrollment as of the first quarter of 2014. The pediatric
27 vision care benefits covered pursuant to this paragraph shall be in
28 addition to, and shall not replace, any vision services covered under
29 the plan identified in paragraph (2).

30 (5) With respect to pediatric oral care, the same health benefits
31 for pediatric oral care covered under the dental benefit received
32 by children under the Medi-Cal program as of 2014, including the
33 provision of medically necessary orthodontic care provided
34 pursuant to the federal Children's Health Insurance Program
35 Reauthorization Act of 2009. The pediatric oral care benefits
36 covered pursuant to this paragraph shall be in addition to, and shall
37 not replace, any dental or orthodontic services covered under the
38 plan identified in paragraph (2).

39 (b) Treatment limitations imposed on health benefits described
40 in this section shall be no greater than the treatment limitations

1 imposed by the corresponding plans identified in subdivision (a),
2 subject to the requirements set forth in paragraph (2) of subdivision
3 (a).

4 (c) Except as provided in subdivision (d), this section does not
5 permit a health care service plan to make substitutions for the
6 benefits required to be covered under this section, regardless of
7 whether those substitutions are actuarially equivalent.

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

17 (e) A health care service plan, or its agent, solicitor, or
18 representative, shall not issue, deliver, renew, offer, market,
19 represent, or sell any product, contract, or discount arrangement
20 as compliant with the essential health benefits requirement in
21 federal law, unless it meets all of the requirements of this section.

22 (f) This section applies regardless of whether the plan contract
23 is offered inside or outside the California Health Benefit Exchange
24 created by Section 100500 of the Government Code.

25 (g) This section does not exempt a plan or a plan contract from
26 meeting other applicable requirements of law.

27 (h) This section does not prohibit a plan contract from covering
28 additional benefits, including, but not limited to, spiritual care
29 services that are tax deductible under Section 213 of the Internal
30 Revenue Code.

31 (i) Subdivision (a) does not apply to any of the following:

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

33 (2) A Medicare supplement plan.

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

37 (j) This section shall not be implemented in a manner that
38 conflicts with a requirement of PPACA.

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

4 (l) This section does not obligate the state to incur costs for the
5 coverage of benefits that are not essential health benefits as defined
6 in this section.

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

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

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

25 (3) The initial adoption of emergency regulations implementing
26 this section made during the 2015–16 Regular Session of the
27 Legislature 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 (4) The director shall consult with the Insurance Commissioner
37 to ensure consistency and uniformity in the development of
38 regulations under this subdivision.

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

40 (o) For purposes of this section, the following definitions apply:

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

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

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

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

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

SEC. 3. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. This section shall exclusively govern the benefits a health insurer must cover as essential health benefits. For purposes of this section, “essential health benefits” means all of the following:

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

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) ~~For plan years on or before the 2027 plan year, The~~
5 health benefits covered by the Kaiser Foundation Health Plan
6 Small Group HMO 30 plan (federal health product identification
7 number 40513CA035) as this plan was offered during the first
8 quarter of 2014, as follows, regardless of whether the benefits are
9 specifically referenced in the plan contract or evidence of coverage
10 for that plan:

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

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

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

4 (iv) The health benefits covered by the plan that are not
5 otherwise required to be covered under Chapter 2.2 (commencing
6 with Section 1340) of Division 2 of the Health and Safety Code,
7 to the extent otherwise required pursuant to Sections 1367.18,
8 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
9 and Safety Code, and Section 1300.67.24 of Title 28 of the
10 California Code of Regulations.

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

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

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

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

36 (E) *Commencing January 1, 2027, if the United States*
37 *Department of Health and Human Services approves a new*
38 *essential health benefits benchmark plan for the State of California*
39 *pursuant to submissions to the department made on behalf of the*
40 *state in 2025 for this purpose, the benchmark plan described in*

1 *subparagraph (A) shall additionally include all of the following*
2 *benefits:*

3 *(i) Services to evaluate, diagnose, and treat infertility that*
4 *include all of the following:*

5 *(I) Artificial insemination.*

6 *(II) Three attempts to retrieve gametes.*

7 *(III) Three attempts to create embryos.*

8 *(IV) Three rounds of pretransfer testing.*

9 *(V) Cryopreservation of gametes and embryos.*

10 *(VI) Two years of storage for cryopreserved embryos.*

11 *(VII) Unlimited storage for cryopreserved gametes.*

12 *(VIII) Unlimited embryo transfers.*

13 *(IX) Two vials of donor sperm.*

14 *(X) Ten donor eggs.*

15 *(XI) Surrogacy coverage for the services described above.*

16 *(XII) Health testing of the surrogate for each attempted round*
17 *of covered services.*

18 *(ii) All of the following durable medical equipment:*

19 *(I) Mobility devices, including, but not limited to, walkers and*
20 *manual and power wheelchairs and scooters.*

21 *(II) Augmented communications devices, including, but not*
22 *limited to, speech generating devices, communications boards,*
23 *and computer applications.*

24 *(III) Continuous positive airway pressure machines.*

25 *(IV) Portable oxygen.*

26 *(V) Hospital beds.*

27 *(iii) (I) An annual hearing exam.*

28 *(II) One hearing aid per ear every three years.*

29 *(3) With respect to habilitative services, in addition to any*
30 *habilitative services and devices identified in paragraph (2),*
31 *coverage shall also be provided as required by federal rules,*
32 *regulations, or guidance issued pursuant to Section 1302(b) of*
33 *PPACA. Habilitative services and devices shall be covered under*
34 *the same terms and conditions applied to rehabilitative services*
35 *and devices under the policy. Limits on habilitative and*
36 *rehabilitative services and devices shall not be combined.*

37 *(4) With respect to pediatric vision care, the same health benefits*
38 *for pediatric vision care covered under the Federal Employees*
39 *Dental and Vision Insurance Program vision plan with the largest*
40 *national enrollment as of the first quarter of 2014. The pediatric*

1 vision care services covered pursuant to this paragraph shall be in
2 addition to, and shall not replace, any vision services covered under
3 the plan identified in paragraph (2).

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

13 (b) Treatment limitations imposed on health benefits described
14 in this section shall be no greater than the treatment limitations
15 imposed by the corresponding plans identified in subdivision (a),
16 subject to the requirements set forth in paragraph (2) of subdivision
17 (a).

18 (c) Except as provided in subdivision (d), this section does not
19 permit a health insurer to make substitutions for the benefits
20 required to be covered under this section, regardless of whether
21 those substitutions are actuarially equivalent.

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

31 (e) A health insurer, or its agent, producer, or representative,
32 shall not issue, deliver, renew, offer, market, represent, or sell any
33 product, policy, or discount arrangement as compliant with the
34 essential health benefits requirement in federal law, unless it meets
35 all of the requirements of this section. This subdivision shall be
36 enforced in the same manner as Section 790.03, including through
37 the means specified in Sections 790.035 and 790.05.

38 (f) This section applies regardless of whether the policy is
39 offered inside or outside the California Health Benefit Exchange
40 created by Section 100500 of the Government Code.

1 (g) This section does not exempt a health insurer or a health
2 insurance policy from meeting other applicable requirements of
3 law.

4 (h) This section does not prohibit a policy from covering
5 additional benefits, including, but not limited to, spiritual care
6 services that are tax deductible under Section 213 of the Internal
7 Revenue Code.

8 (i) Subdivision (a) does not apply to any of the following:

9 (1) A policy that provides excepted benefits as described in
10 Sections 2722 and 2791 of the federal Public Health Service Act
11 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

15 (j) This section shall not be implemented in a manner that
16 conflicts with a requirement of PPACA.

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

20 (l) This section does not obligate the state to incur costs for the
21 coverage of benefits that are not essential health benefits as defined
22 in this section.

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

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

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

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

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

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

17 (o) This section does not impose on health insurance policies
18 the cost sharing or network limitations of the plans identified in
19 subdivision (a) except to the extent otherwise required to comply
20 with this code, including this section, and as otherwise applicable
21 to all health insurance policies offered to individuals and small
22 groups.

23 (p) For purposes of this section, the following definitions apply:

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

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

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

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

6 (4) “Small group health insurance policy” means a group health
7 insurance policy issued to a small employer, as defined in
8 subdivision (q) of Section 10753.

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