

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 introduced, 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. 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.

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

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

28 (i) Medically necessary basic health care services, as defined
29 in subdivision (b) of Section 1345 and Section 1300.67 of Title
30 28 of the California Code of Regulations.

31 (ii) The health benefits mandated to be covered by the plan
32 pursuant to statutes enacted before December 31, 2011, as
33 described in the following sections: Sections 1367.002, 1367.06,
34 and 1367.35 (preventive services for children); Section 1367.25
35 (prescription drug coverage for contraceptives); Section 1367.45
36 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51
37 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section
38 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for

laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

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

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

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

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

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

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance

1 with the Paul Wellstone and Pete Domenici Mental Health Parity
2 and Addiction Equity Act of 2008 (Public Law 110-343), and all
3 rules, regulations, or guidance issued pursuant to Section 2726 of
4 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (2) A Medicare supplement plan.

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

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

29 (k) 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 (l) This section does not obligate the state to incur costs for the
33 coverage of benefits that are not essential health benefits as defined
34 in this section.

35 (m) 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 (n) (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 (o) For purposes of this section, the following definitions apply:

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

38 (2) (A) “Health benefits,” unless otherwise required to be
39 defined pursuant to federal rules, regulations, or guidance issued
40 pursuant to Section 1302(b) of PPACA, means health care items

1 or services for the diagnosis, cure, mitigation, treatment, or
2 prevention of illness, injury, disease, or a health condition,
3 including a behavioral health condition.

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

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

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

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

16 10112.27. (a) An individual or small group health insurance
17 policy issued, amended, or renewed on or after January 1, 2017,
18 shall include, at a minimum, coverage for essential health benefits
19 pursuant to the federal Patient Protection and Affordable Care Act
20 (PPACA) and as outlined in this section. This section shall
21 exclusively govern the benefits a health insurer must cover as
22 essential health benefits. For purposes of this section, “essential
23 health benefits” means all of the following:

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

32 (2) (A) ~~The~~ *For plan years on or before the 2027 plan year,*
33 health benefits covered by the Kaiser Foundation Health Plan
34 Small Group HMO 30 plan (federal health product identification
35 number 40513CA035) as this plan was offered during the first
36 quarter of 2014, as follows, regardless of whether the benefits are
37 specifically referenced in the plan contract or evidence of coverage
38 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 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
10 (alpha-fetoprotein testing); Section 1367.6 (breast cancer
11 screening); Section 1367.61 (prosthetics for laryngectomy); Section
12 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive
13 surgery); Section 1367.635 (mastectomies); Section 1367.64
14 (prostate cancer); Section 1367.65 (mammography); Section
15 1367.66 (cervical cancer); Section 1367.665 (cancer screening
16 tests); 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) If there are any conflicts or omissions in the plan identified
2 in subparagraph (A) as compared with the requirements for health
3 benefits under Chapter 2.2 (commencing with Section 1340) of
4 Division 2 of the Health and Safety Code that were enacted before
5 December 31, 2011, the requirements of Chapter 2.2 (commencing
6 with Section 1340) of Division 2 of the Health and Safety Code
7 shall control, 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 not be in conflict with
11 Chapter 2.2 (commencing with Section 1340) of Division 2 of the
12 Health and Safety Code.

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

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

31 (4) With respect to pediatric vision care, the same health benefits
32 for pediatric vision care covered under the Federal Employees
33 Dental and Vision Insurance Program vision plan with the largest
34 national enrollment as of the first quarter of 2014. The pediatric
35 vision care services covered pursuant to this paragraph shall be in
36 addition to, and shall not replace, any vision services covered under
37 the plan identified in paragraph (2).

38 (5) With respect to pediatric oral care, the same health benefits
39 for pediatric oral care covered under the dental benefit received
40 by children under the Medi-Cal program as of 2014, including the

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

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

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

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

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

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

35 (g) This section does not exempt a health insurer or a health
36 insurance policy from meeting other applicable requirements of
37 law.

38 (h) This section does not prohibit a policy from covering
39 additional benefits, including, but not limited to, spiritual care

1 services that are tax deductible under Section 213 of the Internal
2 Revenue Code.

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

4 (1) A policy that provides excepted benefits as described in
5 Sections 2722 and 2791 of the federal Public Health Service Act
6 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

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

12 (k) 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 (l) This section does not obligate the state to incur costs for the
16 coverage of benefits that are not essential health benefits as defined
17 in this section.

18 (m) 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 (n) (1) The commissioner may adopt emergency regulations
22 implementing this section. The commissioner, on a one-time basis,
23 may 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 authorized
39 by this subdivision shall be deemed an emergency and necessary
40 for the immediate preservation of the public peace, health, safety,

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

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

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

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

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

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

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

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

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

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

O