

Introduced by Senator MitchellFebruary 18, 2014

An act to amend Sections 1367.005 and 1367.25 of the Health and Safety Code, and to amend Sections 10112.27 and 10123.196 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

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

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various reforms to the health insurance market. Among other things, PPACA requires a nongrandfathered group health plan and a health insurance issuer offering group or individual insurance coverage to provide coverage for and not impose cost sharing requirements for certain preventive services, including those preventive care and screenings for women provided in specified guidelines. PPACA requires those plans and issuers to provide coverage without cost-sharing for all federal Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider, except as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits to provide coverage for a variety of federal Food and Drug Administration (FDA)

approved prescription contraceptive methods designated by the plan or insurer, except as specified. Existing law authorizes a religious employer, as defined, to request a contract or policy without coverage of FDA approved contraceptive methods that are contrary to the employer's religious tenets and, if so requested, requires a contract or policy to be provided without that coverage. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which are defined to include the health benefits covered by particular benchmark plans.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2015, to provide coverage for all FDA approved contraceptive drugs, devices, and products in each contraceptive category outlined by the FDA, as well as sterilization procedures and contraceptive education and counseling, and would prohibit a plan or insurer from engaging in unreasonable medical management, as defined, in providing that coverage. The bill would specify that these benefits are included within the definition of essential health benefits for contracts and policies issued, amended, or renewed on or after January 1, 2015. The bill would prohibit a nongrandfathered plan contract or health insurance policy from imposing any cost-sharing requirements with respect to this coverage, except as specified. The bill would also prohibit a plan or insurer from requiring a prescription to trigger coverage of FDA approved over-the-counter contraceptive methods and supplies. The bill would retain the provision authorizing a religious employer to request a contract or policy without coverage of FDA approved contraceptive methods that are contrary to the employer's religious tenets. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. The Legislature hereby finds and declares all of
2 the following:

3 (a) California has a long history of expanding timely access to
4 birth control to prevent unintended pregnancy.

5 (b) The federal Patient Protection and Affordable Care Act
6 includes a contraceptive coverage guarantee as part of a broader
7 requirement for health insurance carriers and plans to cover key
8 preventive care services without out-of-pocket costs for patients.

9 (c) The Legislature intends to build on existing state and federal
10 law to ensure greater contraceptive coverage equity and timely
11 access to all Federal Food and Drug Administration approved
12 methods of birth control for all individuals covered by health care
13 service plan contracts and health insurance policies in California.

14 SEC. 2. Section 1367.005 of the Health and Safety Code is
15 amended to read:

16 1367.005. (a) An individual or small group health care service
17 plan contract issued, amended, or renewed on or after January 1,
18 2014, shall, at a minimum, include coverage for essential health
19 benefits pursuant to PPACA and as outlined in this section. For
20 purposes of this section, “essential health benefits” means all of
21 the following:

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

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

36 (i) Medically necessary basic health care services, as defined
37 in subdivision (b) of Section 1345 and in Section 1300.67 of Title
38 28 of the California Code of Regulations.

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

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

27 (iv) The health benefits covered by the plan that are not
28 otherwise required to be covered under this chapter, to the extent
29 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
30 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
31 California Code of Regulations.

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

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

39 (C) Notwithstanding subparagraph (B) or any other provision
40 of this section, the home health services benefits covered under

1 the plan identified in subparagraph (A) shall be deemed to not be
2 in conflict with this chapter.

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

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

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

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

35 (b) *With respect to an individual or group health care service*
36 *plan contract issued, amended, or renewed on or after January 1,*
37 *2015, except for a specialized health care service plan contract,*
38 *“essential health benefits” also includes the benefits required to*
39 *be covered under subdivision (b) of Section 1367.25.*

40 (b)

1 (c) Treatment limitations imposed on health benefits described
 2 in ~~this section~~ *subdivision (a)* shall be no greater than the treatment
 3 limitations imposed by the corresponding plans identified in
 4 subdivision (a), subject to the requirements set forth in paragraph
 5 (2) of subdivision (a).

6 ~~(e)~~
 7 (d) Except as provided in subdivision ~~(d)~~ (e), nothing in this
 8 section shall be construed to permit a health care service plan to
 9 make substitutions for the benefits required to be covered under
 10 this section, regardless of whether those substitutions are actuarially
 11 equivalent.

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

22 ~~(e)~~
 23 (f) No health care service plan, or its agent, solicitor, or
 24 representative, shall issue, deliver, renew, offer, market, represent,
 25 or sell any product, contract, or discount arrangement as compliant
 26 with the essential health benefits requirement in federal law, unless
 27 it meets all of the requirements of this section.

28 ~~(f)~~
 29 (g) This section shall apply regardless of whether the plan
 30 contract is offered inside or outside the California Health Benefit
 31 Exchange created by Section 100500 of the Government Code.

32 ~~(g)~~
 33 (h) Nothing in this section shall be construed to exempt a plan
 34 or a plan contract from meeting other applicable requirements of
 35 law.

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

1 ~~(i)~~

2 (j) Subdivision (a) shall not apply to any of the following:

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

4 (2) A Medicare supplement plan.

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

8 ~~(j)~~

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

11 ~~(k)~~

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

14 ~~(l) An~~

15 (m) *Except for the benefits required under subdivision (b), an*
16 essential health benefit is required to be provided under this section
17 only to the extent that federal law does not require the state to
18 defray the costs of the benefit.

19 ~~(m)~~

20 (n) Nothing in this section shall obligate the state to incur costs
21 for the coverage of benefits that are not essential health benefits
22 as defined in this section.

23 ~~(n)~~

24 (o) A plan is not required to cover, under this section, changes
25 to health benefits that are the result of statutes enacted on or after
26 December 31, 2011, *except for the benefits required under*
27 *subdivision (b).*

28 ~~(o)~~

29 (p) (1) The department may adopt emergency regulations
30 implementing this section. The department may, on a one-time
31 basis, readopt any emergency regulation authorized by this section
32 that is the same as, or substantially equivalent to, an emergency
33 regulation previously adopted under this section.

34 (2) The initial adoption of emergency regulations implementing
35 this section and the readoption of emergency regulations authorized
36 by this subdivision shall be deemed an emergency and necessary
37 for the immediate preservation of the public peace, health, safety,
38 or general welfare. The initial emergency regulations and the
39 readoption of emergency regulations authorized by this section
40 shall be submitted to the Office of Administrative Law for filing

1 with the Secretary of State and each shall remain in effect for no
2 more than 180 days, by which time final regulations may be
3 adopted.

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

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

8 ~~(p)~~

9 (q) For purposes of this section, the following definitions shall
10 apply:

11 (1) “Habilitative services” means medically necessary health
12 care services and health care devices that assist an individual in
13 partially or fully acquiring or improving skills and functioning and
14 that are necessary to address a health condition, to the maximum
15 extent practical. These services address the skills and abilities
16 needed for functioning in interaction with an individual’s
17 environment. Examples of health care services that are not
18 habilitative services include, but are not limited to, respite care,
19 day care, recreational care, residential treatment, social services,
20 custodial care, or education services of any kind, including, but
21 not limited to, vocational training. Habilitative services shall be
22 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.

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

3 1367.25. (a) ~~Every~~A group health care service plan contract,
4 except for a specialized health care service plan contract, that is
5 issued, amended, renewed, or delivered on or after January 1, 2000,
6 and ~~every~~ *an* individual health care service plan contract that is
7 amended, renewed, or delivered on or after January 1, 2000, except
8 for a specialized health care service plan contract, shall provide
9 coverage for the following, under general terms and conditions
10 applicable to all benefits:

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

22 (2) Outpatient prescription benefits for an enrollee *under this*
23 *subdivision* shall be the same for an enrollee’s covered spouse and
24 covered nonspouse dependents.

25 (b) (1) *A group or individual health care service plan contract,*
26 *except for a specialized health care service plan contract, that is*
27 *issued, amended, renewed, or delivered on or after January 1,*
28 *2015, shall provide coverage for all FDA approved contraceptive*
29 *drugs, devices, and products in each contraceptive category*
30 *outlined by the FDA, as well as sterilization procedures and*
31 *contraceptive education and counseling. A health care service*
32 *plan shall not engage in unreasonable medical management in*
33 *providing the coverage required by this subdivision.*

34 (2) *A nongrandfathered group or individual health care service*
35 *plan contract subject to this subdivision shall not impose a*
36 *deductible, coinsurance, copayment, or any other cost-sharing*
37 *requirement on the coverage provided pursuant to this subdivision.*

38 (3) *Notwithstanding paragraph (2), a plan may cover a generic*
39 *drug without cost sharing and impose cost sharing for equivalent*
40 *branded drugs. If a generic version of a drug is not available, a*

1 *plan shall provide coverage for the brand name drug in accordance*
2 *with the requirements of this subdivision. In addition, a plan shall*
3 *accommodate an enrollee for whom a generic drug would be*
4 *medically inappropriate under this subdivision, as determined by*
5 *the enrollee’s participating provider in consultation with the*
6 *enrollee, by having a mechanism for waiving the otherwise*
7 *applicable cost sharing for the branded version.*

8 *(4) Notwithstanding paragraph (1), a health care service plan*
9 *may impose reasonable quantity limits on the number of*
10 *contraceptive supplies an enrollee may receive at a given time*
11 *under this subdivision.*

12 *(5) A health care service plan shall not require a prescription*
13 *to trigger coverage of FDA approved over-the-counter*
14 *contraceptive methods and supplies under this subdivision.*

15 *(6) Outpatient drug benefits for an enrollee under this*
16 *subdivision shall be the same for an enrollee’s covered spouse*
17 *and covered nonspouse dependents.*

18 ~~(b)~~

19 *(c) Notwithstanding any other provision of this section, a*
20 *religious employer may request a health care service plan contract*
21 *without coverage for ~~federal Food and Drug Administration~~ FDA*
22 *approved contraceptive methods that are contrary to the religious*
23 *employer’s religious tenets. If so requested, a health care service*
24 *plan contract shall be provided without coverage for contraceptive*
25 *methods.*

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

28 *(A) The inculcation of religious values is the purpose of the*
29 *entity.*

30 *(B) The entity primarily employs persons who share the*
31 *religious tenets of the entity.*

32 *(C) The entity serves primarily persons who share the religious*
33 *tenets of the entity.*

34 *(D) The entity is a nonprofit organization as described in*
35 *Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of*
36 *1986, as amended.*

37 *(2) Every religious employer that invokes the exemption*
38 *provided under this section shall provide written notice to*
39 *prospective enrollees prior to enrollment with the plan, listing the*

1 contraceptive health care services the employer refuses to cover
2 for religious reasons.

3 (e)

4 (d) Nothing in this section shall be construed to exclude
5 coverage for ~~prescription~~ contraceptive supplies ordered by a health
6 care provider ~~with prescriptive authority~~, *acting within his or her*
7 *scope of practice*, for reasons other than contraceptive purposes,
8 such as decreasing the risk of ovarian cancer or eliminating
9 symptoms of menopause, or for ~~prescription~~ contraception that is
10 necessary to preserve the life or health of an enrollee.

11 (d)

12 (e) Nothing in this section shall be construed to deny or restrict
13 in any way the department’s authority to ensure plan compliance
14 with this chapter when a plan provides coverage for ~~prescription~~
15 drugs.

16 (e)

17 (f) Nothing in this section shall be construed to require an
18 individual or group health care service plan *contract* to cover
19 experimental or investigational treatments.

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

21 (1) “Grandfathered health plan” *has the meaning set forth in*
22 *Section 1251 of PPACA.*

23 (2) “Nongrandfathered individual or group health care service
24 plan contract” *means a health care service plan contract that is*
25 *not a grandfathered health plan.*

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

31 (4) *With respect to health care service plan contracts issued,*
32 *amended, or renewed on or after January 1, 2015, “provider”*
33 *means an individual who is certified or licensed pursuant to*
34 *Division 2 (commencing with Section 500) of the Business and*
35 *Professions Code, or an initiative act referred to in that division,*
36 *or Division 2.5 (commencing with Section 1797).*

37 (5) “Reasonable quantity limits” *means quantity limits placed*
38 *by a health care service plan on contraceptive supplies that would*
39 *not cause an undue burden or barrier to consistent, regular, and*
40 *effective use of the contraceptive method.*

1 (6) “Unreasonable medical management” means techniques
2 used by a health care service plan that deny, tier, or condition
3 enrollee access to an FDA approved contraceptive drug, device,
4 or product.

5 SEC. 4. Section 10112.27 of the Insurance Code is amended
6 to read:

7 10112.27. (a) An individual or small group health insurance
8 policy issued, amended, or renewed on or after January 1, 2014,
9 shall, at a minimum, include coverage for essential health benefits
10 pursuant to PPACA and as outlined in this section. This section
11 shall exclusively govern what benefits a health insurer must cover
12 as essential health benefits. For purposes of this section, “essential
13 health benefits” means all of the following:

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

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

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

32 (ii) The health benefits mandated to be covered by the plan
33 pursuant to statutes enacted before December 31, 2011, as
34 described in the following sections of the Health and Safety Code:
35 Sections 1367.002, 1367.06, and 1367.35 (preventive services for
36 children); Section 1367.25 (prescription drug coverage for
37 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46
38 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha
39 fetoprotein testing); Section 1367.6 (breast cancer screening);
40 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62

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

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

19 (iv) The health benefits covered by the plan that are not
20 otherwise required to be covered under Chapter 2.2 (commencing
21 with Section 1340) of Division 2 of the Health and Safety Code,
22 to the extent otherwise required pursuant to Sections 1367.18,
23 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
24 and Safety Code, and Section 1300.67.24 of Title 28 of the
25 California Code of Regulations.

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

29 (B) Where there are any conflicts or omissions in the plan
30 identified in subparagraph (A) as compared with the requirements
31 for health benefits under Chapter 2.2 (commencing with Section
32 1340) of Division 2 of the Health and Safety Code that were
33 enacted prior to December 31, 2011, the requirements of Chapter
34 2.2 (commencing with Section 1340) of Division 2 of the Health
35 and Safety Code shall be controlling, except as otherwise specified
36 in this section.

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

1 in conflict with Chapter 2.2 (commencing with Section 1340) of
2 Division 2 of the Health and Safety Code.

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

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

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

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

35 *(b) With respect to an individual or group health insurance*
36 *policy issued, amended, or renewed on or after January 1, 2015,*
37 *except for a specialized health insurance policy, “essential health*
38 *benefits” also includes the benefits required to be covered under*
39 *subdivision (b) of Section 10123.196.*

40 (b)

1 (c) Treatment limitations imposed on health benefits described
2 in ~~this section~~ *subdivision (a)* shall be no greater than the treatment
3 limitations imposed by the corresponding plans identified in
4 subdivision (a), subject to the requirements set forth in paragraph
5 (2) of subdivision (a).

6 ~~(e)~~

7 (d) Except as provided in subdivision ~~(d)~~ (e), nothing in this
8 section shall be construed to permit a health insurer to make
9 substitutions for the benefits required to be covered under this
10 section, regardless of whether those substitutions are actuarially
11 equivalent.

12 ~~(e)~~

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

22 ~~(e)~~

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

30 ~~(f)~~

31 (g) 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)~~

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

38 ~~(h)~~

39 (i) This section shall not be construed to prohibit a policy from
40 covering additional benefits, including, but not limited to, spiritual

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

3 ~~(i)~~

4 (j) Subdivision (a) shall not apply to any of the following:

5 (1) A policy that provides excepted benefits as described in
6 Sections 2722 and 2791 of the federal Public Health Service Act
7 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

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

11 ~~(j)~~

12 (k) Nothing in this section shall be implemented in a manner
13 that conflicts with a requirement of PPACA.

14 ~~(k)~~

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

17 ~~(l) An~~

18 (m) *Except for the benefits required under subdivision (b), an*
19 *essential health benefit is required to be provided under this section*
20 *only to the extent that federal law does not require the state to*
21 *defray the costs of the benefit.*

22 ~~(m)~~

23 (n) Nothing in this section shall obligate the state to incur costs
24 for the coverage of benefits that are not essential health benefits
25 as defined in this section.

26 ~~(n)~~

27 (o) An insurer is not required to cover, under this section,
28 changes to health benefits that are the result of statutes enacted on
29 or after December 31, 2011, *except for the benefits required under*
30 *subdivision (b).*

31 ~~(o)~~

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

37 (2) The initial adoption of emergency regulations implementing
38 this section 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 (3) 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 (4) This subdivision shall become inoperative on March 1, 2016.

12 ~~(p)~~

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

19 ~~(q)~~

20 (r) For purposes of this section, the following definitions shall
21 apply:

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

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

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

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

8 (4) “Small group health insurance policy” means a group health
9 care service insurance policy issued to a small employer, as defined
10 in Section 10700.

11 SEC. 5. Section 10123.196 of the Insurance Code is amended
12 to read:

13 10123.196. (a) ~~Every~~*An individual and or* group policy of
14 disability insurance issued, amended, renewed, or delivered on or
15 after January 1, 2000, that provides coverage for hospital, medical,
16 or surgical expenses, shall provide coverage for the following,
17 under the same terms and conditions as applicable to all benefits:

18 (1) A disability insurance policy that provides coverage for
19 outpatient prescription drug benefits shall include coverage for a
20 variety of federal Food and Drug Administration (FDA) approved
21 prescription contraceptive methods, as designated by the insurer.
22 If an insured’s health care provider determines that none of the
23 methods designated by the disability insurer is medically
24 appropriate for the insured’s medical or personal history, the insurer
25 shall, in the alternative, provide coverage for some other FDA
26 approved prescription contraceptive method prescribed by the
27 patient’s health care provider.

28 (2) Outpatient prescription coverage with respect to an insured
29 *under this subdivision* shall be identical for an insured’s covered
30 spouse and covered nonspouse dependents.

31 *(b) (1) A group or individual policy of disability insurance,*
32 *except for a specialized health insurance policy, that is issued,*
33 *amended, renewed, or delivered on or after January 1, 2015, shall*
34 *provide coverage for all FDA approved contraceptive drugs,*
35 *devices, and products in each contraceptive category outlined by*
36 *the FDA, as well as sterilization procedures and contraceptive*
37 *education and counseling. A disability insurer shall not engage*
38 *in unreasonable medical management in providing the coverage*
39 *required by this subdivision.*

1 (2) A nongrandfathered group or individual policy of disability
2 insurance subject to this subdivision shall not impose a deductible,
3 coinsurance, copayment, or any other cost-sharing requirement
4 on the coverage provided pursuant to this subdivision.

5 (3) Notwithstanding paragraph (2), an insurer may cover a
6 generic drug without cost sharing and impose cost sharing for
7 equivalent branded drugs. If a generic version of a drug is not
8 available, an insurer shall provide coverage for the brand name
9 drug in accordance with the requirements of this subdivision. In
10 addition, an insurer shall accommodate an insured for whom a
11 generic drug would be medically inappropriate under this
12 subdivision, as determined by the insured's health care provider
13 in consultation with the insured, by having a mechanism for
14 waiving the otherwise applicable cost sharing for the branded
15 version.

16 (4) Notwithstanding paragraph (1), an insurer may impose
17 reasonable quantity limits on the number of contraceptive supplies
18 an insured may receive at a given time under this subdivision.

19 (5) An insurer shall not require a prescription to trigger
20 coverage of FDA approved over-the-counter contraceptive methods
21 and supplies under this subdivision.

22 (6) Outpatient drug coverage with respect to an insured under
23 this subdivision shall be identical for an insured's covered spouse
24 and covered nonspouse dependents.

25 ~~(b)~~

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

29 ~~(e)~~

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

33 ~~(d)~~

34 (e) Notwithstanding any other provision of this section, a
35 religious employer may request a disability insurance policy
36 without coverage for contraceptive methods that are contrary to
37 the religious employer's religious tenets. If so requested, a
38 disability insurance policy shall be provided without coverage for
39 contraceptive methods.

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

3 (A) The inculcation of religious values is the purpose of the
4 entity.

5 (B) The entity primarily employs persons who share the religious
6 tenets of the entity.

7 (C) The entity serves primarily persons who share the religious
8 tenets of the entity.

9 (D) The entity is a nonprofit organization pursuant to Section
10 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as
11 amended.

12 (2) Every religious employer that invokes the exemption
13 provided under this section shall provide written notice to any
14 prospective employee once an offer of employment has been made,
15 and prior to that person commencing that employment, listing the
16 contraceptive health care services the employer refuses to cover
17 for religious reasons.

18 (e)

19 (f) Nothing in this section shall be construed to exclude coverage
20 for ~~prescription~~ contraceptive supplies ordered by a health care
21 provider with prescriptive authority, *acting within his or her scope*
22 *of practice*, for reasons other than contraceptive purposes, such as
23 decreasing the risk of ovarian cancer or eliminating symptoms of
24 menopause, or for ~~prescription~~ contraception that is necessary to
25 preserve the life or health of an insured.

26 (f)

27 (g) This section shall only apply to disability insurance policies
28 or contracts that are defined as health benefit plans pursuant to
29 subdivision (a) of Section 10198.6, except that for accident only,
30 specified disease, or hospital indemnity coverage, coverage for
31 benefits under this section shall apply to the extent that the benefits
32 are covered under the general terms and conditions that apply to
33 all other benefits under the policy or contract. Nothing in this
34 section shall be construed as imposing a new benefit mandate on
35 accident only, specified disease, or hospital indemnity insurance.

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

37 (1) *“Grandfathered health plan” has the meaning set forth in*
38 *Section 1251 of PPACA.*

1 (2) “Nongrandfathered group or individual policy of disability
2 insurance” means a disability insurance policy that is not a
3 grandfathered health plan.

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

9 (4) With respect to policies of disability insurance issued,
10 amended, or renewed on or after January 1, 2015, “health care
11 provider” means an individual who is certified or licensed pursuant
12 to Division 2 (commencing with Section 500) of the Business and
13 Professions Code, or an initiative act referred to in that division,
14 or Division 2.5 (commencing with Section 1797) of the Health and
15 Safety Code.

16 (5) “Reasonable quantity limits” means quantity limits placed
17 by a disability insurer on contraceptive supplies that would not
18 cause an undue burden or barrier to consistent, regular, and
19 effective use of the contraceptive method.

20 (6) “Unreasonable medical management” means techniques
21 used by a disability insurer that deny, tier, or condition insured
22 access to an FDA approved contraceptive drug, device, or product.

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