SENATE BILL No. 1053

Introduced by Senator Mitchell

February 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:

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

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

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

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

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

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. 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 and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

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

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

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 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) Where 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 with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

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

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

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

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

~~(b)~~

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

~~(c)~~

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

~~(d)~~

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

~~(e)~~

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

~~(f)~~

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

~~(g)~~

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

~~(h)~~

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

~~(i)~~

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

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

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

~~(j)~~

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

~~(k)~~

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

~~*(l)* An~~

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

~~(m)~~

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

~~(n)~~

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

~~(o)~~

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

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

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

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

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

~~(p)~~

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

(1) "Habilitative services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. 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.

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

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

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

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

(b) (1) A group or individual health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2015, shall 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. A health care service plan shall not engage in unreasonable medical management in providing the coverage required by this subdivision.

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

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

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

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

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

(6) Outpatient drug benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

~~(b)~~

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

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

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

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

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

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

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

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

~~(c)~~

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

~~(d)~~

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

~~(e)~~

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

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

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "Nongrandfathered individual or group health care service plan contract" means a health care service plan contract that is not a grandfathered health plan.

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

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

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

SEC. 4. 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, 2014, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. This section shall exclusively govern what 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 and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

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

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

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 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 Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, 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 Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted prior to December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code 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 Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

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

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

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

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

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

~~(b)~~

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

~~(c)~~

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

~~(d)~~

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

~~(e)~~

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

~~(f)~~

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

~~(g)~~

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

~~(h)~~

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

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

~~(i)~~

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

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

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

~~(j)~~

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

~~(k)~~

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

~~*(l)* An~~

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

~~(m)~~

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

~~(n)~~

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

~~(o)~~

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

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety,

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

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

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

~~(p)~~

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

~~(q)~~

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

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

(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 insurance policy" means a group health care service insurance policy issued to a small employer, as defined in Section 10700.

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

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

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

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

(b) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2015, shall 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. A disability insurer shall not engage in unreasonable medical management in providing the coverage required by this subdivision.

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

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

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

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

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

~~(b)~~

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

~~(c)~~

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

~~(d)~~

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

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

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

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

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

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

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

~~(e)~~

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

~~(f)~~

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

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

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

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

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

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

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

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

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