

Introduced by Senator McGuireFebruary 18, 2022

An act to add Section 1368.3 to the Health and Safety Code, and to add Section 10125.3 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1337, as introduced, McGuire. Coordinated specialty care for first-episode psychosis.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on and after January 1, 2023, to provide coverage for coordinated specialty care (CSC) services for the treatment of first-episode psychosis, which is described by the bill as a team-based service delivery method composed of specified treatment modalities and affiliated activities including, but not limited to, case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities. The bill would require the CSC services provided to be consistent with the Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation, developed by the National Institute of Mental Health. The bill would

specify the membership of the CSC team and applicable training and supervision requirements. The bill would require the health care service plan or health insurer to use specified billing procedures for the services provided by the CSC team.

The bill would require the Department of Managed Health Care and the Department of Insurance, as appropriate, in collaboration with the State Department of Health Care Services, to create a working group to establish guidelines, including, but not limited to, inclusion and exclusion criteria for individuals eligible to receive CSC services, and caseload and geographic boundary parameters for the treatment team. The bill would provide that its requirements would not apply to a nongrandfathered individual health care service plan contract or health insurance policy, or group health care service plan contract or health insurance policy covering 50 or fewer employees, if the appropriate department determines that compliance with any or all of those requirements would require the state to assume the cost and provide payments to enrollees or insureds to defray the cost of providing services described in the bill, pursuant to specified federal law.

Because a 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. Section 1368.3 is added to the Health and Safety
- 2 Code, to read:
- 3 1368.3. (a) The following definitions apply for purposes of
- 4 this section:
- 5 (1) "CSC" means coordinated specialty care.
- 6 (2) "CSC manual" or "manual" means the Coordinated Specialty
- 7 Care for First Episode Psychosis Manual II: Implementation (CSC
- 8 manual) developed by the National Institute of Mental Health.

1 (3) “Department” means the Department of Managed Health
2 Care.

3 (4) “FEP” means first-episode psychosis.

4 (5) “HCPCS” means the Healthcare Common Procedure Coding
5 System.

6 (6) “SEE” means supported education and employment.

7 (b) A health care service plan contract issued, amended, or
8 renewed on and after January 1, 2023, shall provide coverage for
9 coordinated specialty care services for the treatment of first-episode
10 psychosis, which is a team-based service delivery method
11 composed of the following treatment modalities and affiliated
12 activities:

13 (1) Case management. Case management assists individuals
14 with problem solving, offering solutions to address practical
15 problems, and coordinating social services across multiple areas
16 of need. Case management involves frequent in-person contact
17 between the clinician and the individual and their family, with
18 sessions occurring in clinic, community, and home settings.

19 (2) Family support and education. Family education and support
20 teaches relatives or others providing support about psychosis and
21 its treatment and strengthens their capacity to aid in the individual’s
22 recovery. To the greatest extent possible, and consistent with
23 decisionmaking. For individuals less than 18 years of age,
24 participation of a family member or guardian is strongly
25 recommended.

26 (3) Pharmacotherapy and medication management.
27 Pharmacotherapy and medication management approaches that
28 are evidence-based guide medication selection and dosing for
29 individuals with FEP. Pharmacotherapy typically begins with a
30 low dose of a single antipsychotic medication and involves
31 monitoring for psychopathology, side effects, and attitudes towards
32 medication at every visit. Special emphasis should be given to
33 cardiometabolic risk factors such as smoking, weight gain,
34 hypertension, dyslipidemia, and prediabetes.

35 (4) Individual and group psychotherapy. Psychotherapy for FEP
36 is based upon cognitive and behavioral treatment principles and
37 emphasizes resilience training, illness and wellness management,
38 and general coping skills. Treatment consists of core and
39 supplemental modules and is tailored to each individual’s needs.
40 Individuals and psychotherapists work one-on-one, and in groups,

1 meeting weekly or biweekly, with the duration and frequency of
2 sessions personalized for each individual.

3 (5) Supported education and employment. Supported education
4 and employment services facilitate the individual's return to work
5 or school, as well as attainment of expected vocational and
6 educational milestones. SEE emphasizes rapid placement in the
7 individual's desired work or school setting and provides active
8 and sustained coaching and support to ensure the individual's
9 success. An SEE specialist strives to integrate vocational and
10 mental health services, is the CSC team liaison with outside
11 educators and employers, and frequently works with the individual
12 in the community to enhance school or job performance.

13 (6) Coordination with primary care. Coordination with primary
14 care means that team members maintain close contact with primary
15 care providers to ensure optimal medical treatment for risk factors
16 related to comorbid medical conditions.

17 (7) Outreach and recruitment activities. Outreach and
18 recruitment activities are designed to facilitate the outreach and
19 referral process and are responsible for initial assessments of an
20 enrollee's potential eligibility for the program. This process should
21 identify potential referring entities, including, but not limited to,
22 mental health facilities, health systems, emergency departments,
23 primary care practitioners, educational institutions, professional
24 organizations, family organizations, consumer organizations, social
25 service programs, substance use disorder programs, criminal justice
26 systems, and places of worship. The outreach and referral process
27 should implement and maintain systems to track all the outreach
28 activities and referrals.

29 (c) The treatment modalities and affiliated activities described
30 in subdivision (b) shall be performed by a team that consists of
31 the following members, provided that there may be flexibility in
32 the actual composition of the team members, as the team structure
33 is described in the CSC manual:

- 34 (1) A team leader who is a licensed clinician.
- 35 (2) An individualized placement and support specialist.
- 36 (3) A skills trainer who is a licensed clinician.
- 37 (4) A psychiatrist.
- 38 (5) A certified peer support specialist with lived experience with
39 a mental illness.
- 40 (6) An outreach and referral specialist.

1 (7) Other team members, as appropriate, based on the team
2 structure of existing CSC programs throughout the country that
3 adhere to appropriate fidelity measures and have demonstrated
4 sustained positive outcomes using an alternative or supplemented
5 team structure.

6 (d) The treatment modalities and affiliated activities described
7 in subdivision (b), as performed by the team members described
8 in subdivision (c), shall be consistent with the performance and
9 fidelity measures identified in Appendix 12: Resources for Fidelity,
10 described in the CSC manual, provided that there shall be flexibility
11 in determining adherence to Appendix 12.

12 (e) The team members described in subdivision (c) shall undergo
13 training consistent with the recommendations of Section III and
14 Appendices 4 to 9, inclusive, of the of the CSC manual, provided
15 that the team may incorporate supplemental training methods
16 identified by the scientific and research communities developed
17 subsequent to the release of the manual.

18 (f) The team members described in subdivision (c) shall undergo
19 supervision consistent with the recommendations of Section IV
20 and Appendices 10 and 11 of the of the CSC manual, provided
21 that the team may incorporate supplemental supervision methods
22 identified by the scientific and research communities developed
23 subsequent to the release of the manual.

24 (g) (1) The department, in collaboration with the Department
25 of Insurance and the State Department of Health Care Services,
26 shall create a working group to establish guidelines regarding the
27 all of the following:

28 (A) The inclusion and exclusion criteria for individuals to be
29 eligible for the treatment modalities and affiliated activities
30 identified and described in subdivision (b), as performed by the
31 team described in subdivision (c), provided that the working group
32 shall take into consideration the criteria identified in Appendix 2
33 of the CSC manual but disregard the stipulation of Appendix 2
34 that requires an individual receiving CSC to have the ability to
35 understand and speak English.

36 (B) The caseload and geographic boundary parameters for the
37 team described in subdivision (c), which shall take into account
38 the ideal recommended caseload and geographic boundaries
39 identified in the CSC manual along with population density and

1 other factors that may make the recommended caseloads and
2 geographic boundaries impractical.

3 (C) The benchmarks, including time parameters, for individuals
4 receiving CSC services, that will determine when it is appropriate
5 for those individuals to transition to alternative treatment regimens.

6 (D) The possibility of utilizing telehealth beyond what is
7 currently required or permitted by statute or regulation, solely for
8 use in delivering CSC services.

9 (2) The working group described in paragraph (1) shall have
10 the following membership:

11 (A) A staff representative of the department.

12 (B) A staff representative of the State Department of Health
13 Care Services.

14 (C) A psychiatrist with knowledge of FEP and CSC, provided
15 that a psychiatrist with experience in participating in CSC shall
16 be given precedence over psychiatrists without experience in
17 participating in CSC.

18 (D) A mental health clinician with knowledge of FEP and CSC,
19 provided that a mental health clinician with experience in
20 participating in CSC shall be given precedence over clinicians
21 without experience in participating in CSC.

22 (E) A professional with experience in providing supportive
23 services, particularly supported education and supported
24 employment.

25 (F) A representative appointed by a state, regional, or local
26 mental health advocacy group or appointed by a collection of state,
27 regional, or local mental health advocacy groups.

28 (G) An individual who has lived experience with psychosis, or
29 a family member of an individual who has lived experience with
30 psychosis.

31 (H) Three representatives appointed by health care service plans
32 that issue individual or group health care service plan contracts in
33 this state.

34 (3) The working group described in paragraph (1) and (2) shall
35 convene no later than March 1, 2023, and shall convene at least
36 once per month until the guidelines identified in paragraph (1) are
37 finalized; however, the guidelines shall be completed within one
38 year the workgroup first convenes.

1 (4) Within 60 days after the guidelines identified in paragraph
2 (1) are finalized pursuant to paragraph (3), the department shall
3 adopt implementing regulations.

4 (h) The department, by regulation, may update the treatment
5 modalities and affiliated activities identified and described in
6 subdivision (a) and (b), the team structure described in subdivision
7 (c), the outcome and fidelity measures described in subdivision
8 (d), the training requirements described in subdivision (e), and the
9 supervision requirements described in subdivision (f) in a manner
10 consistent with the objectives of this part.

11 (i) A health care service plan shall use a single, monthly case
12 rate paid as a monthly per-member-per-month rate that reimburses
13 the team described in subdivision (c) for the full range of CSC
14 services described in subdivision (a) and (b) for any individual
15 meeting the target criteria who is receiving services for the full
16 CSC model that month.

17 (1) The health care service plan shall bill services under this
18 subdivision using the Healthcare Common Procedure Coding
19 System (HCPCS) T1024 billing code for team management, with
20 the HK modifier code for specialized mental health programs for
21 high-risk populations, provided that the minimum monthly services
22 shall include all of the following:

23 (A) At least two face-to-face visits or telehealth contacts from
24 a team member.

25 (B) One collateral contact via an electronic modality, including,
26 but not limited to, telephone, email, a phone-based application, or
27 telehealth.

28 (C) One team staff meeting discussion with the full team,
29 including the licensed professionals on the team;

30 (D) Provision of additional services during early stages of
31 treatment as well as any time an individual experiences periods of
32 destabilization, as medically necessary.

33 (E) The team shall continue providing medically necessary
34 services beyond the minimum monthly service requirements, as
35 needed.

36 (2) A daily encounter rate, which shall be billed under the
37 HCPCS T1024 billing code for team management, for each
38 encounter that the patient receives the treatment modalities and
39 affiliated activities described in subdivisions (a) and (b) through
40 the team described in subdivision (c) for less intensive service

1 delivery, provided that the health care service plan may require
2 that the team described in subdivision (c) provide documentation
3 that the billable activity occurred and that no other additional
4 services were medically necessary due to the individual being
5 hospitalized or being stabilized and not requiring the minimum
6 service provision, or there was another reason, as documented in
7 the medical record, so long as the request for the documentation
8 and the review of the documentation complies with this section
9 and the nonquantitative treatment limitation requirements for the
10 federal Mental Health Parity and Addiction Equity Act, in 45
11 C.F.R. 146.136(c)(4).

12 (3) The department shall adopt regulations that update the billing
13 and reimbursement methodology described in this subdivision, as
14 necessary.

15 (j) (1) An individual or group health care service plan contract
16 issued renewed, or amended on or after January 1, 2023, shall
17 provide coverage of the supported education and employment
18 services identified in paragraph (5) of subdivision (a) and described
19 in paragraph (5) of subdivision (b) for individuals who have
20 transitioned to an alternate treatment regimen that no longer meets
21 the specifications of CSC, and those services shall be billed and
22 reimbursed separately and distinctly from the payment structures
23 identified in subdivision (i).

24 (2) The department, in collaboration with the State Department
25 of Health Care Services, shall adopt regulations that establish a
26 billing and reimbursement methodology for coverage of the
27 supported education and employment services described in
28 paragraph (1).

29 (k) This section does not apply to a nongrandfathered individual
30 health care service plan contract or a nongrandfathered group
31 health care service plan contract covering 50 or fewer employees,
32 if the department determines that compliance with the section, in
33 whole or part, will require the state to assume the cost and provide
34 payments to enrollees to defray the cost of the services, pursuant
35 to 42 U.S.C. SEC. 18031(d)(3)(B)(ii).

36 SEC. 2. Section 10125.3 is added to the Insurance Code, to
37 read:

38 10125.3. (a) The following definitions apply for purposes of
39 this section:

40 (1) "CSC" means coordinated specialty care.

1 (2) “CSC manual” or “manual” means the Coordinated Specialty
2 Care for First Episode Psychosis Manual II: Implementation (CSC
3 manual) developed by the National Institute of Mental Health.

4 (3) “Department” means the Department of Insurance.

5 (4) “FEP” means first-episode psychosis.

6 (5) “HCPCS” means the Healthcare Common Procedure Coding
7 System.

8 (6) “SEE” means supported education and employment.

9 (b) A health insurance policy issued, amended, or renewed on
10 and after January 1, 2023, shall provide coverage for coordinated
11 specialty care services for the treatment of first-episode psychosis,
12 which is a team-based service delivery method composed of the
13 following treatment modalities and affiliated activities:

14 (1) Case management. Case management assists individuals
15 with problem solving, offering solutions to address practical
16 problems, and coordinating social services across multiple areas
17 of need. Case management involves frequent in-person contact
18 between the clinician and the individual and their family, with
19 sessions occurring in clinic, community, and home settings.

20 (2) Family support and education. Family education and support
21 teaches relatives or others providing support about psychosis and
22 its treatment and strengthens their capacity to aid in the individual’s
23 recovery. To the greatest extent possible, and consistent with the
24 individual’s preferences, supportive persons are included in all
25 phases of treatment planning and decisionmaking. For individuals
26 less than 18 years of age, participation of a family member or
27 guardian is strongly recommended.

28 (3) Pharmacotherapy and medication management.
29 Pharmacotherapy and medication management approaches that
30 are evidence-based guide medication selection and dosing for
31 individuals with FEP. Pharmacotherapy typically begins with a
32 low dose of a single antipsychotic medication and involves
33 monitoring for psychopathology, side effects, and attitudes towards
34 medication at every visit. Special emphasis should be given to
35 cardiometabolic risk factors such as smoking, weight gain,
36 hypertension, dyslipidemia, and prediabetes.

37 (4) Individual and group psychotherapy. Psychotherapy for FEP
38 is based upon cognitive and behavioral treatment principles and
39 emphasizes resilience training, illness and wellness management,
40 and general coping skills. Treatment consists of core and

1 supplemental modules and is tailored to each individual's needs.
2 Individuals and psychotherapists work one-on-one, and in groups,
3 meeting weekly or biweekly, with the duration and frequency of
4 sessions personalized for each individual.

5 (5) Supported education and employment. Supported education
6 and employment services facilitate the individual's return to work
7 or school, as well as attainment of expected vocational and
8 educational milestones. SEE emphasizes rapid placement in the
9 individual's desired work or school setting and provides active
10 and sustained coaching and support to ensure the individual's
11 success. An SEE specialist strives to integrate vocational and
12 mental health services, is the CSC team liaison with outside
13 educators and employers, and frequently works with the individual
14 in the community to enhance school or job performance.

15 (6) Coordination with primary care. Coordination with primary
16 care means that team members maintain close contact with primary
17 care providers to ensure optimal medical treatment for risk factors
18 related to comorbid medical conditions.

19 (7) Outreach and recruitment activities. Outreach and
20 recruitment activities are designed to facilitate the outreach and
21 referral process and are responsible for initial assessments of an
22 insured's potential eligibility for the program. This process should
23 identify potential referring entities, including, but not limited to,
24 mental health facilities, health systems, emergency departments,
25 primary care practitioners, educational institutions, professional
26 organizations, family organizations, consumer organizations, social
27 service programs, substance use disorder programs, criminal justice
28 systems, and places of worship. The outreach and referral process
29 should implement and maintain systems to track all the outreach
30 activities and referrals.

31 (c) The treatment modalities and affiliated activities described
32 in subdivision (a) shall be performed by a team that consists of the
33 following members, provided that there may be flexibility in the
34 actual composition of the team members, as the team structure is
35 described in the CSC manual:

- 36 (1) A team leader who is a licensed clinician.
- 37 (2) An individualized placement and support specialist.
- 38 (3) A skills trainer who is a licensed clinician.
- 39 (4) A psychiatrist.

1 (5) A certified peer support specialist with lived experience with
2 a mental illness.

3 (6) An outreach and referral specialist.

4 (7) Other team members, as appropriate, based on the team
5 structure of existing CSC programs throughout the country that
6 adhere to appropriate fidelity measures and have demonstrated
7 sustained positive outcomes using an alternative or supplemented
8 team structure.

9 (d) The treatment modalities and affiliated activities described
10 in subdivision (b), as performed by the team members described
11 in subdivision (c), shall be consistent with the performance and
12 fidelity measures identified in Appendix 12: Resources for Fidelity,
13 described in the CSC manual, provided that there shall be flexibility
14 in determining adherence to Appendix 12.

15 (e) The team members described in subdivision (c) shall undergo
16 training consistent with the recommendations of Section III and
17 Appendices 4 to 9, inclusive, of the of the CSC manual, provided
18 that the team may incorporate supplemental training methods
19 identified by the scientific and research communities developed
20 subsequent to the release of the manual.

21 (f) The team members described in subdivision (c) shall undergo
22 supervision consistent with the recommendations of Section IV
23 and Appendices 10 and 11 of the of the CSC manual, provided
24 that the team may incorporate supplemental supervision methods
25 identified by the scientific and research communities developed
26 subsequent to the release of the manual.

27 (g) (1) The department, in collaboration with the Department
28 of Managed Health Care and the State Department of Health Care
29 Services, shall create a working group to establish guidelines
30 regarding the all of the following:

31 (A) The inclusion and exclusion criteria for individuals to be
32 eligible for the treatment modalities and affiliated activities
33 identified and described in subdivision (a) and (b), as performed
34 by the team described in subdivision (c), provided that the working
35 group shall take into consideration the criteria identified in
36 Appendix 2 of the CSC manual but disregard the stipulation of
37 Appendix 2 that requires an individual receiving CSC to have the
38 ability to understand and speak English.

39 (B) The caseload and geographic boundary parameters for the
40 team described in subdivision (c), which shall take into account

1 the ideal recommended caseload and geographic boundaries
2 identified in the CSC manual along with population density and
3 other factors that may make the recommended caseloads and
4 geographic boundaries impractical.

5 (C) The benchmarks, including time parameters, for individuals
6 receiving CSC services, that will determine when it is appropriate
7 for those individuals to transition to alternative treatment regimens.

8 (D) The possibility of utilizing telehealth beyond what is
9 currently required or permitted by statute or regulation, solely for
10 use in delivering CSC services.

11 (2) The working group described in paragraph (1) shall have
12 the following membership:

13 (A) A staff representative of the department.

14 (B) A staff representative of the State Department of Health
15 Care Services.

16 (C) A psychiatrist with knowledge of FEP and CSC, provided
17 that a psychiatrist with experience in participating in CSC shall
18 be given precedence over psychiatrists without experience in
19 participating in CSC.

20 (D) A mental health clinician with knowledge of FEP and CSC,
21 provided that a mental health clinician with experience in
22 participating in CSC shall be given precedence over clinicians
23 without experience in participating in CSC.

24 (E) A professional with experience in providing supportive
25 services, particularly supported education and supported
26 employment.

27 (F) A representative appointed by a state, regional, or local
28 mental health advocacy group or appointed by a collection of state,
29 regional, or local mental health advocacy groups.

30 (G) An individual who has lived experience with psychosis, or
31 a family member of an individual who has lived experience with
32 psychosis.

33 (H) Three representatives appointed by health insurers that issue
34 individual or group health insurance policies in this state.

35 (3) The working group described in paragraph (1) paragraph
36 (2) shall convene no later than March 1, 2023, and shall convene
37 at least once per month until the guidelines identified in paragraph
38 (1) are finalized; however, the guidelines shall be completed within
39 one year the workgroup first convenes.

1 (4) Within 60 days after the guidelines identified in paragraph
2 (1) are finalized pursuant to paragraph (3), the department shall
3 adopt implementing regulations.

4 (h) The department, by regulation, may update the treatment
5 modalities and affiliated activities identified and described in
6 subdivision (a) and (b), the team structure described in subdivision
7 (c), the outcome and fidelity measures described in subdivision
8 (d), the training requirements described in subdivision (e), and the
9 supervision requirements described in subdivision (f) in a manner
10 consistent with the objectives of this part.

11 (i) A health insurer shall use a single, monthly case rate paid as
12 a monthly per-member-per-month rate that reimburses the team
13 described in subdivision (c) for the full range of CSC services
14 described in subdivision (a) and (b) for any individual meeting the
15 target criteria who is receiving services for the full CSC model
16 that month.

17 (1) The health insurer shall bill services under this subdivision
18 using the Healthcare Common Procedure Coding System (HCPCS)
19 T1024 billing code for team management, with the HK modifier
20 code for specialized mental health programs for high-risk
21 populations, provided that the minimum monthly services shall
22 include all of the following:

23 (A) At least two face-to-face visits or telehealth contacts from
24 a team member.

25 (B) One collateral contact via an electronic modality, including,
26 but not limited to, telephone, email, a phone-based application, or
27 telehealth.

28 (C) One team staff meeting discussion with the full team,
29 including the licensed professionals on the team;

30 (D) Provision of additional services during early stages of
31 treatment as well as any time an individual experiences periods of
32 destabilization, as medically necessary.

33 (E) The team shall continue providing medically necessary
34 services beyond the minimum monthly service requirements, as
35 needed.

36 (2) A daily encounter rate, which shall be billed under the
37 HCPCS T1024 billing code for team management, for each
38 encounter that the patient receives the treatment modalities and
39 affiliated activities described in subdivisions (a) and (b) through
40 the team described in subdivision (c) for less intensive service

1 delivery, provided that the insurer may require that the team
2 described in subdivision (c) provide documentation that the billable
3 activity occurred and that no other additional services were
4 medically necessary due to the individual being hospitalized or
5 being stabilized and not requiring the minimum service provision,
6 or there was another reason, as documented in the medical record,
7 so long as the request for the documentation and the review of the
8 documentation complies with this section and the nonquantitative
9 treatment limitation requirements for the federal Mental Health
10 Parity and Addiction Equity Act, in 45 C.F.R. 146.136(c)(4).

11 (3) The department shall adopt regulations that update the billing
12 and reimbursement methodology described in this subdivision, as
13 necessary.

14 (j) (1) An individual or group health insurance policy issued
15 renewed, or amended on or after January 1, 2023, shall provide
16 coverage of the supported education and employment services
17 identified in paragraph (2) of subdivision (a) and described in
18 paragraph (5) of subdivision (b) for individuals who have
19 transitioned to an alternate treatment regimen that no longer meets
20 the specifications of CSC, and those services shall be billed and
21 reimbursed separately and distinctly from the payment structures
22 identified in subdivision (i).

23 (2) The department, in collaboration with the State Department
24 of Health Care Services, shall adopt regulations that establish a
25 billing and reimbursement methodology for coverage of the
26 supported education and employment services described in
27 paragraph (1).

28 (k) This section does not apply to a nongrandfathered individual
29 health insurance policy or a nongrandfathered group health
30 insurance policy covering 50 or fewer employees, if the department
31 determines that compliance with the section, in whole or part, will
32 require the state to assume the cost and provide payments to
33 insureds to defray the cost of the services, pursuant to 42 U.S.C.
34 Sec. 18031(d)(3)(B)(ii).

35 SEC. 3. No reimbursement is required by this act pursuant to
36 Section 6 of Article XIII B of the California Constitution because
37 the only costs that may be incurred by a local agency or school
38 district will be incurred because this act creates a new crime or
39 infraction, eliminates a crime or infraction, or changes the penalty
40 for a crime or infraction, within the meaning of Section 17556 of

1 the Government Code, or changes the definition of a crime within
2 the meaning of Section 6 of Article XIII B of the California
3 Constitution.

O