§ 1367.005. Individual or small group health care service plan to cover essential health benefits; Provisions

(a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. 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 2014, 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 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-fetoprotein 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) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

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

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance 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 and devices 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 and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.

(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 2014. 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 benefit received by children under the Medi-Cal program as of 2014, 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) Treatment limitations imposed on health benefits described in this section 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) Except as provided in subdivision (d), this section does not 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) 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) if 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) A health care service plan, or its agent, solicitor, or representative, shall not 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) This section applies 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) This section does not exempt a plan or a plan contract from meeting other applicable requirements of law.

(h) This section does not 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) Subdivision (a) does 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) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) 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.

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

(m) 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.

(n)(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 initial adoption of emergency regulations implementing this section made during the 2015-16 Regular Session of the Legislature 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.

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

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

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

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

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

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

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

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

HISTORY:

Added Stats 2015 ch 648 § 2 (SB 43), effective January 1, 2016, operative January 1, 2017. Amended Stats 2016 ch 86 § 177 (SB 1171), effective January 1, 2017; Stats 2021 ch 764 § 4 (SB 326), effective January 1, 2022.

§ 1367.006. Nongrandfathered individual and group health care service plans that cover essential health benefits; Limit on annual out-of-pocket expenses for covered essential health benefits

(a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.

(b)(1) For nongrandfathered health care service plan contracts in the individual or small group markets, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4.

(2) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care consistent with Section 1371.4. This limit shall only apply to essential health benefits, as defined in Section 1367.005, that are covered under the plan to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health care service plan contracts in the large group market.

(c)(1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g)(1)(A) Except as provided in paragraph (2), if a health care service plan contract for family coverage includes a deductible, an individual within a

family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(B) Except as provided in paragraph (2), if a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible, an individual within a family shall not have a deductible that is more than the deductible limit for individual coverage for that product.

(2)(A) If a health care service plan contract for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(B) If a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(h) For nongrandfathered health plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, "plan year" means the calendar year.

(i) "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.

HISTORY:

Added Stats 2013 ch 316 § 3 (SB 639), effective January 1, 2014. Amended Stats 2014 ch 71 § 84 (SB 1304), effective January 1, 2015, ch 572 § 8 (SB 959), effective January 1, 2015 (ch 572 prevails); Stats 2015 ch 641 § 1 (AB 1305), effective January 1, 2016.