# ASSEMBLY BILL No. 910

**Introduced by Assembly Member Karnette**

February 22, 2007

An act to amend Sections 3587, 3751, and 3752.5 of the Family Code, to amend Section 1373 of the Health and Safety Code, and to amend Sections 10277 and 10278 of the Insurance Code, relating to disabled persons.

## LEGISLATIVE COUNSEL'S DIGEST

AB 910, as introduced, Karnette. Disabled persons: support and health care coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), 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. Under existing law, a plan and a health insurer are required to provide that coverage for a dependent child who attains a limiting age specified in the plan or policy shall not terminate if the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or a physical handicap and chiefly dependent upon the subscriber or insured for support.

This bill would change the first criterion, requiring a health care service plan and a health insurer to provide that coverage of a dependent child shall not terminate upon attaining the limiting age if the child is and continues to be incapable of self-sustaining employment by reason of mental disability, including, but not limited to, mental illness or a physical disability or a combination of those disabilities. The bill would

require the plan and insurer to notify the subscriber or insured 60 days before the dependent child attains the limiting age and to continue coverage pending its determination as to whether the child meets the criteria for coverage after attaining the limiting age. The bill would also require after a change in carriers, that the new plan or insurer accept the prior carrier's determination that a dependent child satisfies the criteria for continued coverage unless the director of the department or the Insurance Commissioner finds otherwise.

Because the bill would specify additional requirements under the Knox-Keene Act, the willful violation of which would be a crime, it would impose a state-mandated local program.

(2) Existing law requires parents to maintain a child of any age who is incapacitated from earning a living and without sufficient means. Existing law also requires health insurance coverage, as defined, for a supported child to be included in a court's order for support if that insurance is available at no cost or at reasonable cost to the parents and that the obligor and obligee in a support order inform each other of the availability of health insurance coverage.

This bill would require a court to direct the parents of a child who is incapacitated from earning a living and without sufficient means to consider entering into a stipulated agreement for the child's support after attaining 18 years of age. The bill would also require a support order to direct the parent providing health insurance coverage for a supported child to seek continuation coverage for the child upon his or her attaining the limiting age under the coverage if the child is incapable of self-sustaining employment and otherwise meets the criteria described in paragraph (1). The bill would require the obligor and obligee to provide information about the availability of health insurance coverage for a child who meets that criteria for the duration of the child's lifetime.

(3) 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. Section 3587 of the Family Code is amended to read:

3587. *(a) Notwithstanding any other provision of law, the court shall direct the parents of a child who is incapacitated from earning a living and without sufficient means to consider entering into a stipulated agreement for the continuation of child support after the child attains 18 years of age or for the payment of support of such an adult child. The stipulated agreement may designate particular savings or investments or require the purchase of life insurance as a means of funding the support, and the support may be in the amount and may be made in payments as agreed upon by the parents. The parents shall consider structuring the stipulated agreement to maintain the child's eligibility for government benefits.*

*(b)* Notwithstanding any other provision of law, the court has the authority to approve a stipulated agreement by the parents to pay for the support of an adult child or for the continuation of child support after a child attains the age of 18 years and to make a support order to effectuate the agreement.

*(c) This section shall not relieve the parents of any other obligation they may have to support their child who is incapacitated from earning a living and without sufficient means, including, but not limited to, their duty under Section 3910, and shall not affect any remedy such a child may have to enforce those obligations.*

SEC. 2. Section 3751 of the Family Code is amended to read:

3751. (a) (1) Support orders issued or modified pursuant to this chapter shall include a provision requiring the child support obligor to keep the agency designated under Title IV-D of the Social Security Act (42 U.S.C. Sec. 651 et seq.) informed of whether the obligor has health insurance coverage at reasonable cost and, if so, the health insurance policy information.

(2) In any case in which an amount is set for current support, the court shall require that health insurance coverage for a supported child shall be maintained by either or both parents if that insurance is available at no cost or at reasonable cost to the parent. Health insurance coverage shall be rebuttably presumed to be reasonable in cost if it is employment-related group health

insurance or other group health insurance, regardless of the service delivery mechanism. The actual cost of the health insurance to the obligor shall be considered in determining whether the cost of insurance is reasonable. If the court determines that the cost of health insurance coverage is not reasonable, the court shall state its reasons on the record.

(b) If the court determines that health insurance coverage is not available at no or reasonable cost, the court's order for support shall contain a provision that specifies that health insurance coverage shall be obtained if it becomes available at no or reasonable cost. Upon health insurance coverage at no or reasonable cost becoming available to a parent, the parent shall apply for that coverage.

*(c) The court's order for support shall require the parent providing health insurance coverage for a supported child to seek continuation of coverage for the child upon attainment of the limiting age for a dependent child under the health insurance coverage if the child meets the criteria specified under Section 1373 of the Health and Safety Code or Section 10277 or 10278 of the Insurance Code and that health insurance coverage is available at no cost or at reasonable cost to the parent.*

SEC. 3. Section 3752.5 of the Family Code is amended to read:

3752.5. *(a)* A child support order issued or modified pursuant to this division shall include a provision requiring the child support obligor to keep the obligee informed of whether the obligor has health insurance made available through the obligor's employer or has other group health insurance and, if so, the health insurance policy information. The support obligee under a child support order shall inform the support obligor of whether the obligee has health insurance made available through the employer or other group health insurance and, if so, the health insurance policy information.

*(b) A child support order issued or modified pursuant to this division shall include a provision requiring the child support obligor and obligee to provide the information described in subdivision (a) for a child who meets the criteria for continuation of health insurance coverage upon attaining the limiting age pursuant to Section 1373 of the Health and Safety Code or Section 10277 or 10278 of the Insurance Code and shall continue to provide this information during the child's lifetime.*

*(c)* The Judicial Council shall modify the form of the order for health insurance coverage (family law) to notify child support obligors of the requirements of this section and of Section 3752.

SEC. 4. Section 1373 of the Health and Safety Code is amended to read:

1373. (a) A plan contract may not provide an exception for other coverage if the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or ~~medicaid~~ *Medicaid* benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

Each plan contract shall be interpreted not to provide an exception for the Medi-Cal or ~~medicaid~~ *Medicaid* benefits.

A plan contract shall not provide an exemption for enrollment because of an applicant's entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or ~~medicaid~~ *Medicaid* benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to the Medi-Cal or ~~medicaid~~ *Medicaid* benefits.

(b) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual's reason for sterilization.

As used in this section, "sterilization operations or procedures" shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization

form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed for adoption. No plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of, or children placed for adoption with, a subscriber or spouse covered as required by this subdivision.

(d) *(1)* Every plan contract that provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide ~~in substance~~ that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to ~~be both (1) incapable~~ *meet both of the following criteria:*

*(A) Incapable* of self-sustaining employment by reason of ~~mental retardation~~ *a mental disability, including, but not limited to, mental illness* or *a* physical ~~handicap and (2) chiefly~~ *disability or a combination of those disabilities.*

*(B) Chiefly* dependent upon the subscriber for support and maintenance~~, provided~~.

*(2) The plan shall notify the subscriber that the dependent child's coverage will terminate upon attainment of the limiting age unless the subscriber submits* proof of the ~~incapacity~~ *disability* and dependency ~~is furnished~~ to the plan ~~by the member within 31 days of the request for the information by the plan or group plan contractholder and subsequently as may be required by the plan or group plan contractholder,~~ *within 30 days of the date of receipt of the notification. The plan shall send this notification to the subscriber 60 days prior to the date the child attains the limiting age. The plan shall determine whether the dependent child meets the criteria specified in paragraph (1) before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination.*

*(3) The plan may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under this subdivision* but not more frequently than annually

after the two-year period following the child's attainment of the limiting age.

*(4) If the subscriber changes carriers to another plan or to a health insurer, the new plan or insurer shall continue to provide coverage for the dependent child unless it demonstrates to the director's satisfaction, if a health care service plan, or to the Insurance Commissioner's satisfaction, if a health insurer, that the child no longer satisfies the criteria in paragraph (1).*

(e) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for both an employee and one or more covered persons dependent upon the employee and provides for an extension of the coverage for any period following a termination of employment of the employee shall also provide that this extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective bargaining agreement.

(f) A group contract shall not discriminate against handicapped persons or against groups containing handicapped persons. Nothing in this subdivision shall preclude reasonable provisions in a plan contract against liability for services or reimbursement of the handicap condition or conditions relating thereto, as may be allowed by rules of the director.

(g) Every group contract shall set forth the terms and conditions under which subscribers and enrollees may remain in the plan in the event the group ceases to exist, the group contract is terminated or an individual subscriber leaves the group, or the enrollees' eligibility status changes.

(h) (1) A health care service plan or specialized health care service plan may provide for coverage of, or for payment for, professional mental health services, or vision care services, or for the exclusion of these services. If the terms and conditions include coverage for services provided in a general acute care hospital or an acute psychiatric hospital as defined in Section 1250 and do not restrict or modify the choice of providers, the coverage shall extend to care provided by a psychiatric health facility as defined in Section 1250.2 operating pursuant to licensure by the State Department of Mental Health. A health care service plan that offers outpatient mental health services but does not cover these services

in all of its group contracts shall communicate to prospective group contractholders as to the availability of outpatient coverage for the treatment of mental or nervous disorders.

(2) No plan shall prohibit the member from selecting any psychologist who is licensed pursuant to the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code), any optometrist who is the holder of a certificate issued pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code or, upon referral by a physician and surgeon licensed pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code), (i) any marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, (ii) any licensed clinical social worker who is the holder of a license under Section 4996 of the Business and Professions Code, (iii) any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, or (iv) any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, to perform the particular services covered under the terms of the plan, and the certificate holder is expressly authorized by law to perform these services.

(3) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional mental health services beyond his or her field or fields of competence as established by his or her education, training and experience.

(4) For the purposes of this section, "marriage and family therapist" means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions ~~which~~ *that* is equivalent to the instruction required for licensure on January 1, 1981.

(5) Nothing in this section shall be construed to allow a member to select and obtain mental health or psychological or vision care services from a certificate or license holder who is not directly affiliated with or under contract to the health care service plan or specialized health care service plan to which the member belongs. All health care service plans and individual practice associations that offer mental health benefits shall make reasonable efforts to make available to their members the services of licensed psychologists. However, a failure of a plan or association to comply with the requirements of the preceding sentence shall not constitute a misdemeanor.

(6) As used in this subdivision, "individual practice association" means an entity as defined in subsection (5) of Section 1307 of the federal Public Health Service Act (42 U.S.C. Sec. 300e-1~~, subsec.~~ (5)).

(7) Health care service plan coverage for professional mental health services may include community residential treatment services that are alternatives to inpatient care and that are directly affiliated with the plan or to which enrollees are referred by providers affiliated with the plan.

(i) If the plan utilizes arbitration to settle disputes, the plan contracts shall set forth the type of disputes subject to arbitration, the process to be utilized, and how it is to be initiated.

(j) A plan contract that provides benefits that accrue after a certain time of confinement in a health care facility shall specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requisite to the commencement of benefits.

SEC. 5. Section 10277 of the Insurance Code is amended to read:

10277. *(a)* A group ~~hospital, medical or surgical expense~~ *health* insurance policy ~~delivered or issued for delivery in this state more than 120 days after the effective date of this section, which~~ *that* provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall also provide ~~in substance~~ that attainment of ~~such~~ *the* limiting age shall not operate to terminate the coverage of ~~such~~ *the* child while the child is and continues to ~~be both (a) incapable~~ *meet both of the following criteria:*

*(1) Incapable* of self-sustaining employment by reason of *a* mental ~~retardation~~ *disability, including, but not limited to, mental illness* or *a* physical ~~handicap and (b) chiefly~~ *disability or a combination of those disabilities.*

*(2) Chiefly* dependent upon the employee or member for support and maintenance~~, provided~~.

*(b) The insurer shall notify the employee or member that the dependent child's coverage will terminate upon attainment of the limiting age unless the employee or member submits* proof of ~~such incapacity~~ *the disability* and dependency ~~is furnished~~ to the insurer ~~by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age~~. *within 30 days of the date of receipt of the notification. The insurer shall send this notification to the employee or member 60 days prior to the date the child attains the limiting age. The insurer shall determine whether the dependent child meets the criteria specified in subdivision (a) before the child attains the limiting age. If the insurer fails to make the determination by that date, it shall continue coverage of the child pending its determination.*

~~Group hospital, medical or surgical expense insurance policies currently approved by the commissioner which are delivered or issued for delivery more than 120 days after the effective date of this section shall be automatically construed to be in compliance with this section and need not be refiled or reprinted. Such policies submitted to the commissioner for approval on and after the effective date of this section shall contain provisions in compliance with this section.~~

*(c) The insurer may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under subdivision (a), but not more frequently than annually after the two-year period following the child's attainment of the limiting age.*

*(d) If the employee or member changes carriers to another insurer or to a health care service plan, the new insurer or plan shall continue to provide coverage for the dependent child unless it demonstrates to the commissioner's satisfaction, if a health insurer, or to the satisfaction of the Director of Managed Health*

*Care, if a health care service plan, that the child no longer satisfies the criteria in subdivision (a).*

SEC. 6. Section 10278 of the Insurance Code is amended to read:

10278. *(a)* An individual ~~hospital, medical or surgical expense~~ *health* insurance policy ~~delivered or issued for delivery in this state more than 120 days after the effective date of this section, which~~ *that* provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall also provide ~~in substance~~ that attainment of ~~such~~ *the* limiting age shall not operate to terminate the coverage of ~~such~~ *the* child while the child is and continues to ~~be both (a) incapable~~ *meet both of the following criteria:*

*(1) Incapable* of self-sustaining employment by reason of *a* mental ~~retardation~~ *disability, including, but not limited to, mental illness* or *a* physical ~~handicap and (b) chiefly~~ *disability or a combination of those disabilities.*

*(2) Chiefly* dependent upon the policyholder or subscriber for support and ~~miantenance, provided~~ *maintenance.*

*(b) The insurer shall notify the policyholder or subscriber that the dependent child's coverage will terminate upon attainment of the limiting age unless the policyholder or subscriber submits* proof of ~~such incapacity~~ *the disability* and dependency ~~is furnished~~ to the insurer ~~by the policyholder within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age~~ *within 30 days of the date of receipt of the notification. The insurer shall send this notification to the policyholder or subscriber 60 days prior to the date the child attains the limiting age. The insurer shall determine whether the dependent child meets the criteria specified in subdivision (a) before the child attains the limiting age. If the insurer fails to make the determination by that date, it shall continue coverage of the child pending its determination.*

~~Individual hospital, medical or surgical expense insurance policies currently approved by the commissioner which are delivered or issued for delivery more than 120 days after the effective date of this section shall be automatically construed to be in compliance with this section and need not be refiled or~~

~~reprinted. Such policies submitted to the commissioner for approval on and after the effective date of this section shall contain provisions in compliance with this section.~~

*(c) The insurer may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under subdivision (a), but not more frequently than annually after the two-year period following the child's attainment of the limiting age.*

*(d) If the subscriber or policyholder changes carriers to another insurer or to a health care service plan, the new insurer or plan shall continue to provide coverage for the dependent child unless it demonstrates to the commissioner's satisfaction, if a health insurer, or to the satisfaction of the Director of Managed Health Care, if a health care service plan, that the child no longer satisfies the criteria in subdivision (a).*

SEC. 7. 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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