

ASSEMBLY BILL

No. 29

**Introduced by Assembly Member Price
(Coauthor: Assembly Member Swanson)**

December 1, 2008

An act to amend Section 1373 of the Health and Safety Code, and to amend Section 10277 of the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 29, as introduced, Price. Health care coverage.

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. Existing law requires that every health care service plan contract or group health insurance policy that provides for termination of coverage of a dependent child upon attainment of the limiting age for dependent children shall also provide that attainment of the limiting age shall not terminate the coverage of a child under certain conditions.

This bill would prohibit, with specified exceptions, the limiting age for dependent children covered by these health care service plan contracts and group health insurance policies from being less than 27 years of age. This bill would also authorize certain public employees and annuitants to elect to provide coverage to their dependents who would otherwise be ineligible for coverage by contributing the premium for that coverage.

Because this bill would specify additional requirements under the Knox-Keene Act, the willful violation of which would be a crime, this 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 1373 of the Health and Safety Code is
2 amended to read:

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

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

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

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

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

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

4 (c) Every plan contract that provides coverage to the spouse or
5 dependents of the subscriber or spouse shall grant immediate
6 accident and sickness coverage, from and after the moment of
7 birth, to each newborn infant of any subscriber or spouse covered
8 and to each minor child placed for adoption from and after the date
9 on which the adoptive child’s birth parent or other appropriate
10 legal authority signs a written document, including, but not limited
11 to, a health facility minor release report, a medical authorization
12 form, or a relinquishment form, granting the subscriber or spouse
13 the right to control health care for the adoptive child or, absent
14 this written document, on the date there exists evidence of the
15 subscriber’s or spouse’s right to control the health care of the child
16 placed for adoption. No plan may be entered into or amended if it
17 contains any disclaimer, waiver, or other limitation of coverage
18 relative to the coverage or insurability of newborn infants of, or
19 children placed for adoption with, a subscriber or spouse covered
20 as required by this subdivision.

21 (d) (1) Every plan contract that provides that coverage of a
22 dependent child of a subscriber shall terminate upon attainment
23 of the limiting age for dependent children specified in the plan,
24 shall also provide that attainment of the limiting age shall not
25 operate to terminate the coverage of the child while the child is
26 and continues to meet both of the following criteria:

27 (A) Incapable of self-sustaining employment by reason of a
28 physically or mentally disabling injury, illness, or condition.

29 (B) Chiefly dependent upon the subscriber for support and
30 maintenance.

31 (2) The plan shall notify the subscriber that the dependent child’s
32 coverage will terminate upon attainment of the limiting age unless
33 the subscriber submits proof of the criteria described in
34 subparagraphs (A) and (B) of paragraph (1) to the plan within 60
35 days of the date of receipt of the notification. The plan shall send
36 this notification to the subscriber at least 90 days prior to the date
37 the child attains the limiting age. Upon receipt of a request by the
38 subscriber for continued coverage of the child and proof of the
39 criteria described in subparagraphs (A) and (B) of paragraph (1),
40 the plan shall determine whether the child meets that criteria before

1 the child attains the limiting age. If the plan fails to make the
2 determination by that date, it shall continue coverage of the child
3 pending its determination.

4 (3) The plan may subsequently request information about a
5 dependent child whose coverage is continued beyond the limiting
6 age under this subdivision but not more frequently than annually
7 after the two-year period following the child's attainment of the
8 limiting age.

9 (4) If the subscriber changes carriers to another plan or to a
10 health insurer, the new plan or insurer shall continue to provide
11 coverage for the dependent child. The new plan or insurer may
12 request information about the dependent child initially and not
13 more frequently than annually thereafter to determine if the child
14 continues to satisfy the criteria in subparagraphs (A) and (B) of
15 paragraph (1). The subscriber shall submit the information
16 requested by the new plan or insurer within 60 days of receiving
17 the request.

18 (5) *Except as specified in this section, under no circumstances*
19 *shall the limiting age be less than 27 years of age. Nothing in this*
20 *section shall require employers participating in the Public*
21 *Employees' Medical and Hospital Care Act to pay the cost of*
22 *coverage for dependents who are at least 23 years of age, but less*
23 *than 27 years of age. Employees or annuitants receiving benefits*
24 *pursuant to the Public Employees' Medical and Hospital Care Act*
25 *may elect to provide coverage to their dependents who are at least*
26 *23 years of age, but are less than 27 years of age, provided they*
27 *contribute the premium for that coverage. Nothing in this section*
28 *shall require the University of California to pay the cost of*
29 *coverage for dependents who are at least 23 years of age, but less*
30 *than 27 years of age. Employees or annuitants of the University*
31 *of California may elect to provide coverage to their dependents*
32 *who are at least 23 years of age, but less than 27 years of age,*
33 *provided they contribute the premium for that coverage. Nothing*
34 *in this section shall require a city to pay the cost of coverage for*
35 *dependents who are at least 23 years of age, but less than 27 years*
36 *of age. Employees or annuitants of a city may elect to provide*
37 *coverage to their dependents who are at least 23 years of age, but*
38 *less than 27 years of age, provided they contribute the premium*
39 *for that coverage. The provision requiring the limiting age to be*
40 *a minimum of 27 years of age shall not be effective for employment*

1 *contracts subject to collective bargaining that are effective prior*
2 *to January 1, 2010. Any employment contract subject to collective*
3 *bargaining that is issued, amended, or renewed on or after January*
4 *1, 2010, shall be subject to this section.*

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

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

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

26 (h) (1) A health care service plan or specialized health care
27 service plan may provide for coverage of, or for payment for,
28 professional mental health services, or vision care services, or for
29 the exclusion of these services. If the terms and conditions include
30 coverage for services provided in a general acute care hospital or
31 an acute psychiatric hospital as defined in Section 1250 and do
32 not restrict or modify the choice of providers, the coverage shall
33 extend to care provided by a psychiatric health facility as defined
34 in Section 1250.2 operating pursuant to licensure by the State
35 Department of Mental Health. A health care service plan that offers
36 outpatient mental health services but does not cover these services
37 in all of its group contracts shall communicate to prospective group
38 contractholders as to the availability of outpatient coverage for the
39 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), (A) any marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, (B) any licensed clinical social worker who is the holder of a license under Section 4996 of the Business and Professions Code, (C) 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 (D) 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 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 licenseholder who is not directly

1 affiliated with or under contract to the health care service plan or
2 specialized health care service plan to which the member belongs.
3 All health care service plans and individual practice associations
4 that offer mental health benefits shall make reasonable efforts to
5 make available to their members the services of licensed
6 psychologists. However, a failure of a plan or association to comply
7 with the requirements of the preceding sentence shall not constitute
8 a misdemeanor.

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

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

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

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

25 (k) If a plan provides coverage for a dependent child who is
26 over 18 years of age and enrolled as a full-time student at a
27 secondary or postsecondary educational institution, the following
28 shall apply:

29 (1) Any break in the school calendar shall not disqualify the
30 dependent child from coverage.

31 (2) If the dependent child takes a medical leave of absence, and
32 the nature of the dependent child’s injury, illness, or condition
33 would render the dependent child incapable of self-sustaining
34 employment, the provisions of subdivision (d) shall apply if the
35 dependent child is chiefly dependent on the subscriber for support
36 and maintenance.

37 (3) (A) If the dependent child takes a medical leave of absence
38 from school, but the nature of the dependent child’s injury, illness,
39 or condition does not meet the requirements of paragraph (2), the
40 dependent child’s coverage shall not terminate for a period not to

1 exceed 12 months or until the date on which the coverage is
2 scheduled to terminate pursuant to the terms and conditions of the
3 plan, whichever comes first. The period of coverage under this
4 paragraph shall commence on the first day of the medical leave of
5 absence from the school or on the date the physician determines
6 the illness prevented the dependent child from attending school,
7 whichever comes first. Any break in the school calendar shall not
8 disqualify the dependent child from coverage under this paragraph.

9 (B) Documentation or certification of the medical necessity for
10 a leave of absence from school shall be submitted to the plan at
11 least 30 days prior to the medical leave of absence from the school,
12 if the medical reason for the absence and the absence are
13 foreseeable, or 30 days after the start date of the medical leave of
14 absence from school and shall be considered prima facie evidence
15 of entitlement to coverage under this paragraph.

16 (4) This subdivision shall not apply to a specialized health care
17 service plan or to a Medicare supplement plan.

18 SEC. 2. Section 10277 of the Insurance Code is amended to
19 read:

20 10277. (a) A group health insurance policy that provides that
21 coverage of a dependent child of an employee or other member of
22 the covered group shall terminate upon attainment of the limiting
23 age for dependent children specified in the policy, shall also
24 provide that attainment of the limiting age shall not operate to
25 terminate the coverage of the child while the child is and continues
26 to meet both of the following criteria:

27 (1) Incapable of self-sustaining employment by reason of a
28 physically or mentally disabling injury, illness, or condition.

29 (2) Chiefly dependent upon the employee or member for support
30 and maintenance.

31 (b) The insurer shall notify the employee or member that the
32 dependent child's coverage will terminate upon attainment of the
33 limiting age unless the employee or member submits proof of the
34 criteria described in paragraphs (1) and (2) of subdivision (a) to
35 the insurer within 60 days of the date of receipt of the notification.
36 The insurer shall send this notification to the employee or member
37 at least 90 days prior to the date the child attains the limiting age.
38 Upon receipt of a request by the employee or member for continued
39 coverage of the child and proof of the criteria described in
40 paragraphs (1) and (2) of subdivision (a), the insurer shall

1 determine whether the dependent child meets that criteria before
2 the child attains the limiting age. If the insurer fails to make the
3 determination by that date, it shall continue coverage of the child
4 pending its determination.

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

10 (d) If the employee or member changes carriers to another
11 insurer or to a health care service plan, the new insurer or plan
12 shall continue to provide coverage for the dependent child. The
13 new plan or insurer may request information about the dependent
14 child initially and not more frequently than annually thereafter to
15 determine if the child continues to satisfy the criteria in paragraphs
16 (1) and (2) of subdivision (a). The employee or member shall
17 submit the information requested by the new plan or insurer within
18 60 days of receiving the request.

19 (e) If a group health insurance policy provides coverage for a
20 dependent child who is over 18 years of age and enrolled as a
21 full-time student at a secondary or postsecondary educational
22 institution, the following shall apply:

23 (1) Any break in the school calendar shall not disqualify the
24 dependent child from coverage.

25 (2) If the dependent child takes a medical leave of absence, and
26 the nature of the dependent child's injury, illness, or condition
27 would render the dependent child incapable of self-sustaining
28 employment, the provisions of subdivision (a) shall apply if the
29 dependent child is chiefly dependent on the policyholder for
30 support and maintenance.

31 (3) (A) If the dependent child takes a medical leave of absence
32 from school, but the nature of the dependent child's injury, illness,
33 or condition does not meet the requirements of paragraph (2), the
34 dependent child's coverage shall not terminate for a period not to
35 exceed 12 months or until the date on which the coverage is
36 scheduled to terminate pursuant to the terms and conditions of the
37 policy, whichever comes first. The period of coverage under this
38 paragraph shall commence on the first day of the medical leave of
39 absence from the school or on the date the physician determines
40 the illness prevented the dependent child from attending school,

1 whichever comes first. Any break in the school calendar shall not
2 disqualify the dependent child from coverage under this paragraph.

3 (B) Documentation or certification of the medical necessity for
4 a leave of absence from school shall be submitted to the insurer
5 at least 30 days prior to the medical leave of absence from the
6 school, if the medical reason for the absence and the absence are
7 foreseeable, or 30 days after the start date of the medical leave of
8 absence from school and shall be considered prima facie evidence
9 of entitlement to coverage under this paragraph.

10 (4) This subdivision shall not apply to a policy of specialized
11 health insurance, Medicare supplement insurance,
12 CHAMPUS-supplement, or TRICARE-supplement insurance
13 policies, or to hospital-only, accident-only, or specified disease
14 insurance policies that reimburse for hospital, medical, or surgical
15 benefits.

16 *(f) Except as specified in this subdivision, under no*
17 *circumstances shall the limiting age under subdivision (a) be less*
18 *than 27 years of age. Nothing in this section shall require*
19 *employers participating in the Public Employees' Medical and*
20 *Hospital Care Act to pay the cost of coverage for dependents who*
21 *are at least 23 years of age, but less than 27 years of age.*
22 *Employees or annuitants receiving benefits pursuant to the Public*
23 *Employees' Medical and Hospital Care Act may elect to provide*
24 *coverage to their dependents who are at least 23 years of age, but*
25 *are less than 27 years of age, provided they contribute the premium*
26 *for that coverage. Nothing in this section shall require the*
27 *University of California to pay the cost of coverage for dependents*
28 *who are at least 23 years of age, but less than 27 years of age.*
29 *Employees or annuitants of the University of California may elect*
30 *to provide coverage to their dependents who are at least 23 years*
31 *of age, but less than 27 years of age, provided they contribute the*
32 *premium for that coverage. Nothing in this section shall require*
33 *a city to pay the cost of coverage for dependents who are at least*
34 *23 years of age, but less than 27 years of age. Employees or*
35 *annuitants of a city may elect to provide coverage to their*
36 *dependents who are at least 23 years of age, but less than 27 years*
37 *of age, provided they contribute the premium for that coverage.*
38 *The provision requiring the limiting age to be a minimum of 27*
39 *years of age shall not be effective for employment contracts subject*
40 *to collective bargaining that are effective prior to January 1, 2010.*

1 *Any employment contract subject to collective bargaining that is*
2 *issued, amended, or renewed on or after January 1, 2010, shall*
3 *be subject to the provisions of this section.*

4 SEC. 3. No reimbursement is required by this act pursuant to
5 Section 6 of Article XIII B of the California Constitution because
6 the only costs that may be incurred by a local agency or school
7 district will be incurred because this act creates a new crime or
8 infraction, eliminates a crime or infraction, or changes the penalty
9 for a crime or infraction, within the meaning of Section 17556 of
10 the Government Code, or changes the definition of a crime within
11 the meaning of Section 6 of Article XIII B of the California
12 Constitution.