AMENDED IN ASSEMBLY APRIL 8, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1602

Introduced by Assembly Member ~~Bass~~ *John A. Perez*
(Principal coauthor: Assembly Member Bass)

January 5, 2010

An act to amend Section 1373 of, *and to add Section 1367.001 to,* the Health and Safety Code, and to amend Section 10277 of, *and to add Section 10112.1 to,* the Insurance Code, relating to health care coverage, *and making an appropriation therefor*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1602, as amended, ~~Bass~~ *John A. Perez*. Health care coverage.

(1) Existing law provides various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the Healthy Families Program.

This bill would enact the California Patient Protection and Affordable ~~Health Choices~~ *Care* Act. It would create the California ~~Cooperative Insurance Purchasing~~ *Health Benefit* Exchange ~~(Cal-CHIPE)~~ *(the Exchange)* in state government to be governed by an executive board appointed, in an unspecified manner, by the Governor and the Legislature. The bill would specify the powers and duties of the board relative to determining eligibility for enrollment in ~~Cal-CHIPE~~ *the Exchange* and arranging for coverage with participating health, dental, and vision ~~coverage~~ *plans*. The bill would create the California Health Trust Fund *as a continuously appropriated fund* and *would* enact other related provisions. All of these provisions would become operative ~~at~~ *on* an unspecified date. The bill would also state the intent of the

Legislature to enact the necessary statutory changes relative to federal health care reforms.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care~~,~~ and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires every health care service plan contract that provides for termination of coverage of a dependent child upon the attainment of the limiting age for dependent children to also provide that attainment of the limiting age shall not terminate the coverage of a child under certain conditions. Existing law establishes similar requirements for group health insurance policies that provide coverage of dependent children.

This bill~~, at an unspecified date,~~ would prohibit~~, with specified exceptions,~~ the limiting age from being less than 26 years of age for dependent children covered by~~ these health insurance~~ *those* plan contracts and insurance policies. The *bill would provide that it does not require certain public employers to pay the cost of coverage for those dependents who are between 23 and 26 years of age; instead the* bill would~~ also~~ authorize certain public employees and annuitants to elect to provide coverage to~~ their~~ *those* dependents~~ who would otherwise be ineligible for coverage~~ by contributing the premium for that coverage. *The bill would provide that this limiting age requirement shall apply with respect to employment contracts subject to collective bargaining that are issued, amended, or renewed on or after September 23, 2010.*

The bill would modify certain of the requirements applicable to group or individual health care service plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, consistent with requirements of the federal Patient Protection and Affordable Care Act. The bill would prohibit lifetime limits on the dollar value of benefits and unreasonable annual limits on the dollar value of benefits. The bill would require coverage, and prohibit cost-sharing requirements applicable to enrollees or insureds, for certain health care benefits. The bill would prohibit preexisting condition exclusions for enrollees or insureds under 19 years of age. These provisions would apply only to health care service plan contracts and health insurance policies that are required to provide essential health benefits, as defined.

Because a willful violation of these requirements with respect to a health care service plan would be a crime, the bill would impose a state-mandated local program.

(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~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the California Patient Protection and Affordable ~~Health Choices~~ *Care* Act.

SEC. 2. It is the intent of the Legislature to enact the necessary statutory changes provided for in and consistent with federal health reform. In doing so, it in the intent of the Legislature to do all of the following:

(a) Ensure that all Californians have access to affordable, comprehensive, quality health care.

(b) Leverage available federal funds to the greatest extent possible.

(c) Strengthen the health care delivery system through (1) enhanced access to effective primary and preventive services, including management of chronic illnesses; (2) investment in training the health care workforce; (3) promotion of cost-effective health technologies; and (4) implementation of meaningful, systemwide cost containment strategies.

(d) Guarantee the availability and renewability of health coverage through the private health insurance market to individuals.

(e) Require that health care service plans and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service, and not on risk selection.

(f) Engage in early and systematic evaluation at each step of the implementation process to identify the impacts on state costs, the costs of coverage, employment and insurance markets, health delivery systems, quality of care, and overall progress in moving toward universal coverage.

SEC. 3. (a) There is in state government the California ~~Cooperative Health Insurance Purchasing~~ *Health Benefit* Exchange, which shall be known as ~~Cal-CHIPE. The exchange~~ *the Exchange. The Exchange* shall be governed by an executive board consisting of ____ members. Of the members of the board, ____ shall be appointed by the Governor, ____ shall be appointed by the Senate Committee on Rules, and ____ shall be appointed by the Speaker of the Assembly.

(b) The board shall be responsible for establishing ~~Cal-CHIPE~~ *the Exchange* and administering this section.

(c) The board may do all of the following consistent with the standards, regulations, and rules promulgated by the United States Secretary of Health and Human Services:

(1) Determine eligibility, enrollment, and disenrollment criteria and processes for ~~Cal-CHIPE~~ *the Exchange*.

(2) Determine the participation requirements for enrollees.

(3) Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans, including reasonable limits on a plan's administrative costs.

(4) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(5) Determine premium schedules, collect the premiums, and administer subsidies to eligible enrollees.

(6) Determine rates paid to participating health, dental, and vision care plans.

(7) Provide, or make available, coverage through participating health plans in ~~Cal-CHIPE~~ *the Exchange*.

(8) Provide, or make available, coverage through participating dental and vision care plans in ~~Cal-CHIPE~~ *the Exchange*.

(9) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(10) Determine and approve the benefit designs and cost-sharing provisions for participating health, dental, and vision care plans.

(11) Enter into contracts.

(12) Sue and be sued.

(13) Employ necessary staff.

(14) Receive and accept gifts, grants, or donations of moneys for purposes of this section from any agency of the United States, any agency of the state, any municipality, county, or other political

subdivision of the state, or any individual, association, or corporation.

~~(14)~~

(15) Authorize expenditures, as necessary, from the fund to pay program expenses that exceed enrollee contributions and to administer ~~Cal-CHIPE~~ *the Exchange*.

~~(15)~~

(16) Adopt rules and regulations, as necessary.

~~(16)~~

(17) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenues in the fund, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency.

~~(17)~~

(18) Establish the criteria and procedures through which employers direct employees' premium dollars, withheld under the terms of a cafeteria plan pursuant to Section 4801 of the Unemployment Insurance Code, to ~~Cal-CHIPE~~ *the Exchange* to be credited against the employees' premium obligations.

~~(18)~~

(19) Share information obtained pursuant to this section with the Employment Development Department solely for the purpose of the administration and enforcement of this section.

~~(19)~~

(20) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this section.

(d) This section shall become operative on ____ ____, ____.

(e) The board shall provide health care coverage pursuant to this section on and after _____ ____, ____.

SEC. 4. (a) The California Health Trust Fund is hereby created in the State Treasury for the purpose of this section and Section 3 of this act. *Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this section and Section 3 of this act.* Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) The board of the California ~~Cooperative Health Insurance Purchasing~~ *Health Benefit* Exchange shall establish a prudent reserve in the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(d) The board~~, subject to federal approval and an appropriation therefor,~~ shall pay the nonfederal share of cost from the fund for ~~individuals eligible under that federal approval~~ *eligible individuals*. Revenues in the fund shall be used~~, upon appropriation,~~ to the extent allowable under federal law, as state matching funds for receipt of federal funds.

(e) This section shall become operative on ____ ____, ____.

SEC. 5. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) A group or individual health care service plan contract that is issued, amended, renewed, or delivered on or after September 23, 2010, may not establish lifetime limits on the dollar value of benefits for any enrollee or unreasonable annual limits on the dollar value of benefits for any enrollee within the meaning of Section 223 of the Internal Revenue Code of 1986.

(b) (1) Subject to the minimum interval established by the United States Secretary of Health and Human Services pursuant to subsection (b) of Section 2713 of Section 1001 of the federal Patient Protection and Affordable Care Act, a group or individual health care service plan contract that is issued, amended, renewed, or delivered on or after September 23, 2010, shall, at a minimum, provide coverage for, and shall not impose any cost sharing requirements for, all of the following:

(A) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(C) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for

in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(D) With respect to women, any additional preventive care and screenings not described in subparagraph (A) as provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration.

(2) For purposes of this subdivision, the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current, other than recommendations issued by the task force in November of 2009, or within 30 days of that month.

(3) Nothing in this subdivision shall be construed to prohibit a plan from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by the task force.

(c) A group or individual health care service plan contract that is issued, amended, renewed, or delivered on or after September 23, 2010, may not impose any preexisting condition exclusion with respect to coverage under the plan of any enrollee under 19 years of age.

(d) This section shall not apply to a group or individual health care service plan contract that is not required to provide essential health benefits. "Essential health benefits" shall have the meaning as determined by the United States Secretary of Health and Human Services pursuant to the federal Patient Protection and Affordable Care Act.

(e) This section shall apply notwithstanding any other provision of this chapter.

~~SEC. 5.~~

SEC. 6. 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 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 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 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 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 that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

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

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

(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 criteria described in subparagraphs (A) and (B) of paragraph (1) to the plan within 60 days of the date of receipt of the notification. The plan shall send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs (A) and (B) of paragraph (1), the plan shall determine whether the child meets that criteria 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. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in subparagraphs (A) and (B) of paragraph (1). The subscriber shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

(5) Except as specified in this section *and except as necessary to be consistent with the regulations promulgated by the United States Secretary of Health and Human Services that define "dependent" for purposes of the limiting age*, under no circumstances shall the limiting age be less than 26 years of age. Nothing in this section shall require employers participating in the

Public Employees' Medical and Hospital Care Act to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants receiving benefits pursuant to the Public Employees' Medical and Hospital Care Act may elect to provide coverage to their dependents who are at least 23 years of age, but are less than 26 years of age, provided they contribute the premium for that coverage. Nothing in this section shall require the University of California to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants of the University of California may elect to provide coverage to their dependents who are at least 23 years of age, but less than 26 years of age, provided they contribute the premium for that coverage. Nothing in this section shall require a city to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants of a city may elect to provide coverage to their dependents who are at least 23 years of age, but less than 26 years of age, provided they contribute the premium for that coverage. The provision requiring the limiting age to be up to 26 years of age shall not be effective for employment contracts subject to collective bargaining that are effective prior to ____ ____, ____ *September 23, 2010*. Any employment contract subject to collective bargaining that is issued, amended, or renewed after ____, ____ ____ *on and after September 23, 2010*, shall be subject to the provisions of this section.

(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), (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 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 (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.

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

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

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

(3) (A) If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not meet the requirements of paragraph (2), the dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the plan, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

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

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

SEC. 7. Section 10112.1 is added to the Insurance Code, to read:

10112.1. (a) A group or individual health care insurance policy that is issued, amended, renewed, or delivered on or after September 23, 2010, may not establish lifetime limits on the dollar value of benefits for any insured or unreasonable annual limits on the dollar value of benefits for any insured within the meaning of Section 223 of the Internal Revenue Code of 1986.

(b) (1) Subject to the minimum interval established by the United States Secretary of Health and Human Services pursuant to subsection (b) of Section 2713 of Section 1001 of the federal Patient Protection and Affordable Care Act, a group or individual health insurance policy that is issued, amended, renewed, or delivered on or after September 23, 2010, shall, at a minimum, provide coverage for, and shall not impose any cost sharing requirements for, all of the following:

(A) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(C) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(D) With respect to women, any additional preventive care and screenings not described in subparagraph (A) as provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration.

(2) For purposes of this subdivision, the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current, other than recommendations issued by the task force in November of 2009, or within 30 days of that month.

(3) Nothing in this subdivision shall be construed to prohibit a health insurer from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by the task force.

(c) A group or individual health insurance policy that is issued, amended, renewed, or delivered on or after September 23, 2010, may not impose any preexisting condition exclusion with respect to coverage under the policy of any insured under 19 years of age.

(d) This section shall not apply to a group or individual health insurance policy that is not required to provide essential health benefits. "Essential health benefits" shall have the meaning as determined by the United States Secretary of Health and Human Services pursuant to the federal Patient Protection and Affordable Care Act.

(e) This section shall apply notwithstanding any other provision of this part.

~~SEC. 6.~~

SEC. 8. Section 10277 of the Insurance Code is amended to read:

10277. (a) A group health insurance policy 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 that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

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

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

(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 the criteria described in paragraphs (1) and (2) of subdivision (a) to the insurer within 60 days of the date of receipt of the notification. The insurer shall send this notification to the employee or member at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the employee or member for continued coverage of the child and proof of the criteria described in paragraphs (1) and (2) of subdivision (a), the insurer shall determine whether the dependent child meets that criteria 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.

(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. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in paragraphs (1) and (2) of subdivision (a). The employee or member shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

(e) Except as specified in this subdivision *and except as necessary to be consistent with the regulations promulgated by the United States Secretary of Health and Human Services that define "dependent" for purposes of the limiting age*, under no circumstances shall the limiting age be less than 26 years of age. Nothing in this section shall require employers participating in the Public Employees' Medical and Hospital Care Act to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants receiving benefits pursuant to the Public Employees' Medical and Hospital Care Act may elect to provide coverage to their dependents who are at least 23 years of age, but are less than 26 years of age, provided they contribute the premium for that coverage. Nothing in this section shall require the University of California to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants of the University of California may elect to provide coverage to their dependents who are at least 23 years of age, but less than 26 years of age, provided they contribute the premium for that coverage. Nothing in this section shall require a city to pay the cost of coverage for dependents who are at least 23 years of age, but less than 26 years of age. Employees or annuitants of a city may elect to provide coverage to their dependents who are at least 23 years of age, but less than 26 years of age, provided they contribute the premium for that coverage. The provision requiring the limiting age to be up to 26 years of age shall not be effective for

employment contracts subject to collective bargaining that are effective prior to _____ _____, _____ *September 23, 2010*. Any employment contract subject to collective bargaining that is issued, amended, or renewed after _____, _____ *on and after September 23, 2010*, shall be subject to the provisions of this section.

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

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

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

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

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

(4) This subdivision shall not apply to a policy of specialized health insurance, Medicare supplement insurance, CHAMPUS-supplement, or TRICARE-supplement insurance policies, or to hospital-only, accident-only, or specified disease

insurance policies that reimburse for hospital, medical, or surgical benefits.

~~SEC. 7.~~

SEC. 9. 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.

O