SENATE BILL No. 122

Introduced by Senator Price

January 24, 2011

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 coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 122, as introduced, Price. Health care coverage: dependents.

Existing law, the federal Patient Protection and Affordable Care Act, requires a health insurance issuer issuing group or individual coverage that provides dependent coverage of children to continue to make that coverage available for an adult child until the child attains 26 years of age with respect to plan years beginning on or after September 23, 2010. Regulations promulgated under that provision require issuers to provide certain dependents who have lost or been denied coverage an opportunity to enroll, as specified. Issuers of retiree-only plans or of excepted benefits are not required to comply with those dependent coverage requirements.

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. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the limiting age for dependent children covered by health care service plan contracts and health insurance policies from being less than 26 years of age with respect to plan or policy years beginning on or after September 23, 2010, except for certain group contracts and policies for plan or policy years beginning before January 1, 2014, as specified. Existing law requires plans and insurers to provide

certain dependents who have lost or been denied coverage an opportunity to enroll, as specified.

This bill would exempt from those dependent coverage requirements health care service plans or health insurance policies that provide only excepted benefits and retiree-only plans or policies.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. 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) (A) Except as set forth in subparagraph (B), under no circumstances shall the limiting age be less than 26 years of age with respect to plan years beginning on or after September 23, 2010.

(B) For plan years beginning before January 1, 2014, a group health care service plan contract that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained the age of 26 years only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

(C) (i) With respect to a child (I) whose coverage under a group or individual plan contract ended, or who was denied or not eligible for coverage under a group or individual plan contract, because under the terms of the contract the availability of dependent coverage of children ended before the attainment of 26 years of age, and (II) who becomes eligible for that coverage by reason of the application of this paragraph, the health care service plan shall give the child an opportunity to enroll that shall continue for at least 30 days. This opportunity and the notice described in clause

(ii) shall be provided not later than the first day of the first plan year beginning on or after September 23, 2010, consistent with 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 additional federal guidance or regulations issued by the United States Secretary of Health and Human Services.

(ii) The health care service plan shall provide written notice stating that a dependent described in clause (i) who has not attained the age of 26 years is eligible to enroll in the plan for coverage. This notice may be provided to the dependent's parent on behalf of the dependent. If the notice is included with other enrollment materials for a group plan, the notice shall be prominent.

(iii) In the case of an individual who enrolls under this subparagraph, coverage shall take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

(iv) A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall be treated as a special enrollee as provided under the rules of Section 146.117(d) of Title 45 of the Code of Federal Regulations. The health care service plan shall offer the recipient of the notice all of the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Any difference in benefits or cost-sharing requirements shall constitute a different benefit package. A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(D) Nothing in this section shall require a health care service plan to make coverage available for a child of a child receiving dependent coverage. Nothing in this section shall be construed to modify the definition of "dependent" as used in the Revenue and Taxation Code with respect to the tax treatment of the cost of coverage.

(E) This paragraph shall not apply to retiree-only plans or plans that provide only excepted benefits, as defined in subsection (c) of Section 300gg-91 of Title 42 of the United States Code.

(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 holder 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 26 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. 2. 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) If a group health insurance policy provides coverage for a dependent child who is over 26 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.

(f) (1) Except as set forth in paragraph (2), under no circumstances shall the limiting age under a group or individual health insurance policy that provides coverage of a dependent child be less than 26 years of age with respect to policy years beginning on or after September 23, 2010.

(2) For policy years beginning before January 1, 2014, a group health insurance policy that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained the age of 26 years only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan or policy of a parent.

(3) (A) With respect to a child (i) whose coverage under a group or individual health insurance policy ended, or who was denied or not eligible for coverage under a group or individual health insurance policy, because under the terms of the policy the availability of dependent coverage of children ended before the attainment of 26 years of age, and (ii) who becomes eligible for that coverage by reason of the application of this subdivision, the health insurer shall give the child an opportunity to enroll that shall continue for at least 30 days. This opportunity and the notice described in subparagraph (B) shall be provided not later than the first day of the first policy year beginning on or after September 23, 2010, consistent with 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 additional federal guidance or regulations issued by the United States Secretary of Health and Human Services.

(B) The health insurer shall provide written notice stating that a dependent described in subparagraph (A) who has not attained the age of 26 years is eligible to apply for coverage. This notice may be provided to the dependent's parent on behalf of the dependent. If the notice is included with enrollment materials for a group policy, the notice shall be prominent.

(C) In the case of an individual who enrolls under this paragraph, coverage shall take effect no later than the first day of the first policy year beginning on or after September 23, 2010.

(D) A dependent enrolling in coverage under a group policy pursuant to this paragraph shall be treated as a special enrollee as provided under the rules of Section 146.117(d) of Title 45 of the Code of Federal Regulations. The health insurer shall offer the recipient of the notice all of the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Any difference in benefit or cost-sharing requirements shall constitute a different benefit package. A dependent enrolling in coverage under a group policy pursuant to this paragraph shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(4) Nothing in this section shall require a health insurer to make coverage available for a child of a child receiving dependent coverage. Nothing in this section shall be construed to modify the definition of "dependent" as used in the Revenue and Taxation Code with respect to the tax treatment of the cost of coverage.

(5) This subdivision shall not apply to retiree-only policies or policies that provide only excepted benefits, as defined in subsection (c) of Section 300gg-91 of Title 42 of the United States Code.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to provide clarification in the law with regard to exemptions that apply to certain health care service plans and health insurance policies at the earliest possible time, it is necessary that this act take effect immediately.

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