**Assembly Bill No. 910**

CHAPTER 617

An act to amend Sections 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.

[Approved by Governor October 13, 2007. Filed with Secretary of State October 13, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

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

Actual Text

(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, provided that proof of those facts is furnished within 31 days of the request for the information or the child's attainment of the limiting age, as specified.

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, in addition to meeting the 2nd criterion, as specified, the child is and continues to be incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. The bill would require the plan and insurer to notify the subscriber or insured at least 90 days before the dependent child attains the limiting age and would require the subscriber or insured to submit proof, within 60 days of receiving that notice, that the child meets the criteria. The bill would require the plan or insurer upon request from the subscriber, group member, or policyholder and proof the child meets the criteria for continued coverage, to determine whether the child meets that criteria before the date the child attains the limiting age. The bill would also require, after a change in carriers, that the new plan or insurer continue coverage of the dependent child and would authorize that new plan or insurer to request information about the dependent child initially and not more frequently than annually thereafter in order to determine if the child continues to meet the criteria. The bill would require the subscriber, group member, or policyholder to submit the information requested by the new plan or insurer within 60 days of receiving the request.

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 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 a reasonable cost to the parents. Existing law also requires a child support order to include a provision requiring the child support obligor and obligee to inform each other of the availability of health insurance coverage, as specified, and requires the Judicial Council to modify the form of the order to include those provisions.

The bill would require a support order to direct the parent or parents who, at the time of the order or subsequently, provide health insurance coverage for a supported child to seek continuation of 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 a child support order to include a provision for the obligor and obligee to provide information about the availability of health insurance coverage for a child or an adult who meets that criteria and would not require the Judicial Council to modify the order's form for this purpose until January 1, 2010.

(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.

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

SECTION 1. 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 a 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 a 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 cost or at a 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 cost or at a reasonable cost. Upon health insurance coverage at no cost or at a 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 who, at the time of the order or subsequently, provides 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 a reasonable cost to the parent or parents, as applicable.

SEC. 2. 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 or an adult 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.

(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. Notwithstanding any other provision of law, the Judicial Council shall not be required to modify the form of the order for health insurance coverage (family law) to include the provisions described in subdivision (b) until January 1, 2010.

SEC. 3. 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.

(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 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.

SEC. 4. 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.

SEC. 5. Section 10278 of the Insurance Code is amended to read:

10278. (a) An individual health insurance policy 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 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 policyholder or subscriber for support and 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 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 policyholder or subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the policyholder or subscriber 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 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. 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 subscriber or policyholder shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

SEC. 6. 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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