AMENDED IN SENATE JUNE 24, 2010

AMENDED IN ASSEMBLY APRIL 15, 2010

AMENDED IN ASSEMBLY APRIL 8, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1602

Introduced by Assembly Member John A. Pérez
(Principal coauthors: Assembly Members Bass and Monning)

January 5, 2010

An act to amend ~~Section~~ *Sections 1357.06, 1357.51, and* 1373 of, and to add Section 1367.001 to, the Health and Safety Code, and to amend ~~Section 10277~~ *Sections 10198.7, 10277, and 10708* 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, John A. Pérez. 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.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and meets certain other requirements.

This bill would enact the California Patient Protection and Affordable Care Act. The bill would create the California Health Benefit Exchange (the Exchange) in state government to be governed by an executive board ~~appointed, in an unspecified manner,~~ *with 5 members, including*

the Secretary of California Health and Human Services and 4 other members appointed by the Governor and the Legislature. The bill would specify the powers and duties of the board relative to determining eligibility for enrollment in the Exchange and arranging for coverage with qualified health plans, and would require the Exchange to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014. The bill would create the California Health Trust Fund as a continuously appropriated fund and would enact other related provisions. The bill would also state the intent of the Legislature to enact the necessary statutory changes relative to ~~those~~ *specified* 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 would prohibit the limiting age *in group or individual contracts or policies* from being less than 26 years of age for dependent children covered by 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 authorize certain public employees and annuitants to elect to provide coverage to those dependents 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 would authorize annual limits on the dollar value of benefits only in specified circumstances. 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: 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 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~~ *to California law in order to be 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), hereafter the federal act.* In doing so, it ~~in~~ *is* the intent of the Legislature to do all of the following:

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

(a) Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act.

(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.~~

(c) Strengthen the health care delivery system.

(d) Guarantee the availability and renewability of health *care* coverage through the private health insurance market to ~~individuals~~ *qualified individuals and qualified small employers*.

(e) Require that health care service plans and health insurers issuing coverage in the individual ~~market~~ *and small employer markets* 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.~~

(f) Meet the requirements of the federal act.

SEC. 3. (a) There is in state government the California Health Benefit Exchange, *an independent public entity,* which shall be known as the Exchange. The Exchange shall be governed by an executive board consisting of ____ *five* members. Of the members of the board, ____ *two* shall be appointed by the Governor, ____ *one* shall be appointed by the Senate Committee on Rules, and ____ *one* shall be appointed by the Speaker ~~of the Assembly.~~

~~(b) The board shall be responsible for~~ *of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the board.*

(b) Members of the board shall be appointed for a term of four years. Vacancies shall be filled by appointment for the unexpired term.

(c) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least two of the following areas:

(1) The health care coverage market.

(2) The small group health care coverage market.

(3) Health benefits plan administration.

(4) Health care finance.

(5) Administering a public or private health care delivery system.

(6) Health plan purchasing.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this act and the federal act, to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

(e) A member of the board or of the staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with an agent of, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic. A board member shall not receive compensation for his or her service on the board but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(f) The board shall hire an executive director to organize, administer, and manage the operations of the Exchange and to serve as secretary to the board. The executive director shall serve as an ex officio, nonvoting member of the board.

(g) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(h) The board shall apply for planning and establishment grants made available to the Exchange pursuant to Section 1311 of the federal act. If an executive director has not been hired under subdivision (f) when the United States Secretary of Health and Human Services makes the initial planning and establishment grants available, the California Health and Human Services Agency shall, upon request of the board, submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services. The board shall be responsible for using the funds awarded by the United States Secretary of Health and Human Services for the planning and establishment of the Exchange, *consistent with subdivision (b) of Section 1311 of the federal act*.

~~(e)~~

(i) The board shall, at a minimum, do all of the following to implement Section 1311 of the federal ~~Patient Protection and Affordable Care Act~~ *act*:

(1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the United States Secretary of Health and Human Services, of health plans as qualified health plans. *The board shall require health plans seeking certification as qualified health plans to do all of the following:*

(A) Submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their Internet Web sites. The board shall take this information, and the information and the recommendations provided to the board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(B) (i) Make available to the public and submit to the board, the United States Secretary of Health and Human Services, and the Insurance Commissioner or the Department of Managed Health Care, as applicable, accurate and timely disclosure of the following information:

(I) Claims payment policies and practices.

(II) Periodic financial disclosures.

(III) Data on enrollment.

(IV) Data on disenrollment.

(V) Data on the number of claims that are denied.

(VI) Data on rating practices.

(VII) Information on cost sharing and payments with respect to any out-of-network coverage.

(VIII) Information on enrollee and participant rights under Title I of the federal act.

(IX) Other information as determined appropriate by the United States Secretary of Health and Human Services.

(ii) The information required under clause (i) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal act.

(C) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(3) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans. *In developing the Internet Web site, the board shall ensure that information is presented in a plainly worded and easily understandable format to assist enrollees and potential enrollees in making an informed coverage choice.*

(4) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the United States Secretary of Health and Human Services.

(5) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the *federal* Public Health Service Act.

(6) Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.

(7) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any ~~cost sharing~~ *cost-sharing* reduction under Section 1402 of the federal ~~Patient Protection and Affordable Care Act~~ *act*.

(8) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that section because of any of the following:

(A) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(B) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(9) Transfer to the Secretary of the Treasury all of the following:

(A) A list of the individuals who are issued a certification under paragraph (8), including the name and taxpayer identification number of each individual.

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because of either of the following:

(i) The employer did not provide minimum essential coverage.

(ii) The employer provided the minimum essential coverage but it was determined under subparagraph (C) of paragraph (2) of subsection (c) of Section 36B of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(C) The name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subsection (b) of Section 1411 of the federal ~~Patient Protection and Affordable Care Act~~ *act* that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(10) Provide to each employer the name of each employee of the employer described in subparagraph (B) of paragraph (9) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

~~(d) 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:~~

(11) Perform duties required of, or delegated to, the Exchange by the United States Secretary of Health and Human Services or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(12) Establish the navigator program in accordance with subdivision (i) of Section 1311 of the federal act. Any entity chosen by the Exchange as a navigator shall do all of the following:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans.

(B) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal act.

(C) Facilitate enrollment in qualified health plans.

(D) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or health plan, coverage, or a determination under that plan or coverage.

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(13) Establish the Small Business Health Options Program, separate from the activities of the board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

(j) In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(1) Determine eligibility, enrollment, and disenrollment criteria and processes for enrollees and potential enrollees in the Exchange.

~~(2) Determine the participation requirements and the standards and selection criteria for qualified health plans, including reasonable limits on a plan's administrative costs.~~

(2) Determine the minimum requirements a health plan must meet to be considered for participation in the Exchange as a

qualified health plan, and the standards and criteria for selecting qualified health plans to be offered through the Exchange. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers to provide health insurance choices that offer the optimal choice, value, quality, and service.

(3) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act.

(4) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act.

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(5) Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

~~(3)~~

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

~~(4) Determine premium schedules, collect the premiums, and administer subsidies to eligible enrollees.~~

~~(5) Determine rates paid to qualified health plans.~~

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

(7) Determine and approve cost-sharing provisions for qualified health plans.

(7) Develop and maintain an electronic clearinghouse of information regarding all health benefits products offered by carriers in the individual and small employer markets to facilitate fair and affirmative marketing of all individual and small employer plans inside and outside the Exchange. In performing this function, the board shall routinely monitor individual and small employer benefits filings with the Department of Managed Health Care and

the Department of Insurance and complaints submitted by individuals and small employers with those regulatory agencies, and shall use any other available means to maintain the clearinghouse.

(8) Undertake activities necessary to market and publicize the availability of health care coverage through the Exchange.

(9) Select and set performance standards and compensation for navigators selected under paragraph (12) of subdivision (i).

(10) Employ necessary staff.

(11) Assess a charge as a part of the premium, at the lowest possible rate, on carriers participating in the Exchange, to support the development, operations, and prudent cash management of the Exchange.

(12) Authorize expenditures, as necessary, from the California Health Trust Fund to pay program expenses to administer the Exchange.

(13) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting.

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

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

(16) Consult with stakeholders relevant to carrying out the activities under this section, including, but not limited to, all of the following:

(A) Health care consumers who are enrolled in health plans.

(B) Individuals and entities with experience in facilitating enrollment in health plans.

(C) Representatives of small businesses and self-employed individuals.

(D) The Director of Health Care Services.

(E) Advocates for enrolling hard-to-reach populations.

(18) Facilitate the purchase of qualified health plans by qualified individuals and qualified small employers no later than January 1, 2014.

(k) The board may do the following:

(1) Collect premiums and assist in the administration of subsidies.

(2) Report, or contract with an independent entity to report, to the Legislature on whether to adopt the option in subdivision (b) of Section 1311 of the federal act to provide a single exchange for providing services to both qualified individuals and qualified small employers in the Exchange. In its report, the board shall provide data on the potential impact on rates paid by individuals and by small employers in a merged individual and small group market, as compared to the rates paid by individuals and small employers if a separate individual and small group market is maintained. A report made pursuant to this paragraph shall be submitted pursuant to Section 9795 of the Government Code.

~~(8)~~

(3) Enter into contracts.

~~(9)~~

(4) Sue and be sued.

~~(10) Employ necessary staff.~~

~~(11)~~

(5) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, any municipality, county, or other political subdivision of the state.

~~(12)~~

(6) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, or corporations, subject to the adoption by the board at a public meeting of conflict of interest provisions.

~~(13) Authorize expenditures, as necessary, from the fund to pay program expenses to administer the Exchange.~~

~~(14) Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting.~~

~~(15)~~

(7) Adopt rules and regulations, as necessary. *Until January 1, 2014, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed to be an emergency*

and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

~~(16) 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) Share information with the Employment Development Department for the purpose of the administration and enforcement of this section.~~

~~(18) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this section.~~

~~(e) The board shall consult with stakeholders relevant to carrying out the activities under this section, including, but not limited to, all of the following:~~

~~(1) Health care consumers who are enrollees in qualified health plans.~~

~~(2) Individuals and entities with experience in facilitating enrollment in qualified health plans.~~

~~(3) Representatives of small businesses and self-employed individuals.~~

~~(4) The Director of Health Care Services.~~

~~(5) Advocates for enrolling hard-to-reach populations.~~

~~(f) No later than January 1, 2014, the Exchange shall facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.~~

(l) As used in this section, "federal act" means 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).

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) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

~~(b)~~

(c) The board of the California Health Benefit Exchange shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

~~(c)~~

(e) 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.

SEC. 5. Section 1357.06 of the Health and Safety Code is amended to read:

1357.06. (a) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any

affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services ~~Act(42~~ *Act (42* U.S.C. Sec. 300gg(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to any of the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(g) Notwithstanding any other provision of this chapter, a group 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 contract of any enrollee under 19 years of age.

SEC. 6. Section 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(d) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of

prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(e) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(f) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(g) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon the following:

(1) A newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan.

(2) A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) A condition relating to benefits for pregnancy or maternity care.

(h) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

(i) Notwithstanding any other provision of this chapter, a health benefit plan, as defined in Section 1357.50, 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.

~~SEC. 5.~~

SEC. 7. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) (1) 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 participant or beneficiary.

(2) With respect to plan years beginning prior to January 1, 2014, a group or individual health care service plan contract that is issued, amended, renewed, or delivered on or after September 23, 2010, may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under subsection (b) of Section 1302 of the federal Patient Protection and Affordable Care Act, as determined by the United States Secretary of Health and Human Services.

(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.~~

(c) This section shall not apply to Medicare supplement plans or to specialized health care service plans.

~~(e)~~

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

~~SEC. 6.~~

SEC. 8. 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~~ *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. 7.~~

SEC. 9. Section 10112.1 is added to the Insurance Code, to read:

10112.1. (a) (1) A group or individual health 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 participant or beneficiary.

(2) With respect to plan years beginning prior to January 1, 2014, a group or individual health insurance policy that is issued, amended, renewed, or delivered on or after September 23, 2010, may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under subsection (b) of Section 1302 of the federal Patient Protection and Affordable Care Act, as determined by the United States Secretary of Health and Human Services.

(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.~~

(c) This section shall not apply to specialized health insurance policies, Medicare supplement policies, CHAMPUS-supplement insurance policies, TRICARE-supplement insurance policies, accident-only insurance policies, or insurance policies excluded from the definition of "health insurance" under subdivision (b) of Section 106.

~~(e)~~

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

SEC. 10. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer,

nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(d) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to

conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(e) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(f) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(g) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services ~~Act, 42 U.S.C. Sec. 300gg(e)~~ *Act. (42 U.S.C. Sec. 300gg(e)*.

(h) A group health benefit plan may not impose a preexisting condition exclusion to any of the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(i) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

(j) Notwithstanding any other provision of this code, a health benefit plan 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 insured under 19 years of age.

~~SEC. 8.~~

SEC. 11. 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 *under a group or individual health insurance policy that provides coverage of a dependent child*. ~~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~~ *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.

SEC. 12. Section 10708 of the Insurance Code is amended to read:

10708. (a) Preexisting condition provisions of health benefit plans shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan,

including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) Group health benefit plans may not impose a preexisting conditions exclusion to the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(e) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting or affiliation periods.

(f) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

(g) Notwithstanding any other provision of this code, a group health benefit plan 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 insured under 19 years of age.

~~SEC. 9.~~

SEC. 13. 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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