Assembly Bill No. 2012

CHAPTER 756

An act to amend Section 1367.18 of the Health and Safety Code, and to amend Section 10123.7 of the Insurance Code, relating to health care coverage.

[Approved by Governor September 29, 2006. Filed with Secretary of State September 29, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2012, Emmerson. Orthotic and prosthetic devices.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the 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 provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide coverage for orthotic and prosthetic devices under terms and conditions that may be agreed upon between the subscriber and plan or policyholder and insurer, and requires that the device be prescribed by a physician or ordered by a licensed health care provider acting within the scope of his or her license.

This bill would specify that a doctor of podiatric medicine, acting within the scope of his or her license, may prescribe the orthotic or prosthetic devices covered by the plan or insurer. The bill would, on and after July 1, 2007, require the amount of the benefit for orthotic and prosthetic devices and services to be, for health care service plans, no less than the annual and lifetime benefit maximums applicable to basic health care services and, for insurance policies, no less than the annual lifetime benefit maximums applicable to all benefits in the policy. The bill would also limit out-of-pocket amounts for covered orthotic and prosthetic devices and services.

Because a willful violation of this bill's provisions relating to health care service plans would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 1367.18 of the Health and Safety Code is amended to read:

1367.18. (a) Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contractholders and to all prospective group contractholders with whom they are negotiating. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Any coverage for orthotic devices shall provide for coverage when the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. Every plan shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367. If the contract does not include any annual or lifetime benefit maximums applicable to basic health care services, the amount of the benefit for orthotic and prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under Section 1367.

SEC. 2. Section 10123.7 of the Insurance Code is amended to read:

10123.7. (a) On or after January 1, 1986, every insurer issuing group health insurance shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Any coverage for orthotic devices shall provide for coverage when the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the

scope of his or her license. Every insurer shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to all benefits in the policy. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts contained in the policy.

(c) This section shall not apply to Medicare supplement, short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 3. 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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