

Introduced by Senator Lowenthal

February 18, 2010

An act to amend Sections 1367.01, 1371, 1371.35, and 1374.72 of, and to add Section 1370.8 to, the Health and Safety Code, and to amend Sections 10123.13, 10123.135, 10123.147, and 10144.5 of, and to add Section 10123.125 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1169, as introduced, Lowenthal. Health care coverage: claims: prior authorization: mental health.

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 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 have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law requires health care service plans and health insurers to reimburse uncontested claims within 30 or 45 working days and specifies that a claim is contested if the plan or insurer has not received a completed claim and all information necessary to determine payer liability.

This bill would require plans and insurers to assign a tracking number to a claim or provider request for authorization, upon receipt thereof, and to provide acknowledgment of receipt thereof, including

identification of the tracking number, to both the provider and the enrollee or insured, as specified. With respect to claims that are contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the bill would require the plan or insurer to provide acknowledgment of receipt of any of that information within 3 working days, as specified.

Existing law requires a health care service plan contract or health insurance policy to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions that apply to other medical conditions. Existing law specifies that these terms and conditions include maximum lifetime benefits, copayments, and individual family deductibles.

This bill would instead require that any form of treatment limitation, or other action by a plan or insurer that may limit the receipt of the covered benefits described above, be applied under the same terms and conditions that apply to other benefits under the contract or policy.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill 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.

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

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

1 SECTION 1. Section 1367.01 of the Health and Safety Code
2 is amended to read:
3 1367.01. (a) A health care service plan and any entity with
4 which it contracts for services that include utilization review or
5 utilization management functions, that prospectively,
6 retrospectively, or concurrently reviews and approves, modifies,
7 delays, or denies, based in whole or in part on medical necessity,
8 requests by providers prior to, retrospectively, or concurrent with
9 the provision of health care services to enrollees, or that delegates
10 these functions to medical groups or independent practice

associations or to other contracting providers, shall comply with this section.

(b) (1) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(2) *Upon receipt of a request by a provider prior to, retrospectively, or concurrent with, the provision of health care services to an enrollee, a health care service plan subject to this section shall assign a tracking number to the request and shall provide acknowledgment of receipt of the request to both the provider and the enrollee. The acknowledgment of receipt shall identify the assigned tracking number and shall be provided via electronic mail, unless the provider or enrollee has opted out of the electronic method of transmittal and requested that all acknowledgments of receipt be transmitted in writing. In the case of an orally submitted request, the acknowledgment of receipt shall also be provided orally to the submitting provider. All communications regarding the request, including, but not limited to, the communications or responses identified in subdivision (h), shall reference the tracking number assigned pursuant to this paragraph.*

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the

1 Osteopathic Act, or, if the plan is a specialized health care service
2 plan, a clinical director with California licensure in a clinical area
3 appropriate to the type of care provided by the specialized health
4 care service plan. The medical director or clinical director shall
5 ensure that the process by which the plan reviews and approves,
6 modifies, or denies, based in whole or in part on medical necessity,
7 requests by providers prior to, retrospectively, or concurrent with
8 the provision of health care services to enrollees, complies with
9 the requirements of this section.

10 (d) If health plan personnel, or individuals under contract to the
11 plan to review requests by providers, approve the provider's
12 request, pursuant to subdivision (b), the decision shall be
13 communicated to the provider pursuant to subdivision (h).

14 (e) No individual, other than a licensed physician or a licensed
15 health care professional who is competent to evaluate the specific
16 clinical issues involved in the health care services requested by
17 the provider, may deny or modify requests for authorization of
18 health care services for an enrollee for reasons of medical necessity.
19 The decision of the physician or other health care professional
20 shall be communicated to the provider and the enrollee pursuant
21 to subdivision (h).

22 (f) The criteria or guidelines used by the health care service
23 plan to determine whether to approve, modify, or deny requests
24 by providers prior to, retrospectively, or concurrent with, the
25 provision of health care services to enrollees shall be consistent
26 with clinical principles and processes. These criteria and guidelines
27 shall be developed pursuant to the requirements of Section 1363.5.

28 (g) If the health care service plan requests medical information
29 from providers in order to determine whether to approve, modify,
30 or deny requests for authorization, the plan shall request only the
31 information reasonably necessary to make the determination.

32 (h) In determining whether to approve, modify, or deny requests
33 by providers prior to, retrospectively, or concurrent with the
34 provision of health care services to enrollees, based in whole or
35 in part on medical necessity, a health care service plan subject to
36 this section shall meet the following requirements:

37 (1) Decisions to approve, modify, or deny, based on medical
38 necessity, requests by providers prior to, or concurrent with the
39 provision of health care services to enrollees that do not meet the
40 requirements for the 72-hour review required by paragraph (2),

1 shall be made in a timely fashion appropriate for the nature of the
2 enrollee's condition, not to exceed five business days from the
3 plan's receipt of the information reasonably necessary and
4 requested by the plan to make the determination. In cases where
5 the review is retrospective, the decision shall be communicated to
6 the individual who received services, or to the individual's
7 designee, within 30 days of the receipt of information that is
8 reasonably necessary to make this determination, and shall be
9 communicated to the provider in a manner that is consistent with
10 current law. For purposes of this section, retrospective reviews
11 shall be for care rendered on or after January 1, 2000.

12 (2) When the enrollee's condition is such that the enrollee faces
13 an imminent and serious threat to his or her health, including, but
14 not limited to, the potential loss of life, limb, or other major bodily
15 function, or the normal timeframe for the decisionmaking process,
16 as described in paragraph (1), would be detrimental to the enrollee's
17 life or health or could jeopardize the enrollee's ability to regain
18 maximum function, decisions to approve, modify, or deny requests
19 by providers prior to, or concurrent with, the provision of health
20 care services to enrollees, shall be made in a timely fashion
21 appropriate for the nature of the enrollee's condition, not to exceed
22 72 hours after the plan's receipt of the information reasonably
23 necessary and requested by the plan to make the determination.
24 Nothing in this section shall be construed to alter the requirements
25 of subdivision (b) of Section 1371.4. Notwithstanding Section
26 1371.4, the requirements of this division shall be applicable to all
27 health plans and other entities conducting utilization review or
28 utilization management.

29 (3) Decisions to approve, modify, or deny requests by providers
30 for authorization prior to, or concurrent with, the provision of
31 health care services to enrollees shall be communicated to the
32 requesting provider within 24 hours of the decision. Except for
33 concurrent review decisions pertaining to care that is underway,
34 which shall be communicated to the enrollee's treating provider
35 within 24 hours, decisions resulting in denial, delay, or
36 modification of all or part of the requested health care service shall
37 be communicated to the enrollee in writing within two business
38 days of the decision. In the case of concurrent review, care shall
39 not be discontinued until the enrollee's treating provider has been
40 notified of the plan's decision and a care plan has been agreed

1 upon by the treating provider that is appropriate for the medical
2 needs of that patient.

3 (4) Communications regarding decisions to approve requests
4 by providers prior to, retrospectively, or concurrent with the
5 provision of health care services to enrollees shall specify the
6 specific health care service approved. Responses regarding
7 decisions to deny, delay, or modify health care services requested
8 by providers prior to, retrospectively, or concurrent with the
9 provision of health care services to enrollees shall be
10 communicated to the enrollee in writing, and to providers initially
11 by telephone or facsimile, except with regard to decisions rendered
12 retrospectively, and then in writing, and shall include a clear and
13 concise explanation of the reasons for the plan's decision, a
14 description of the criteria or guidelines used, and the clinical
15 reasons for the decisions regarding medical necessity. Any written
16 communication to a physician or other health care provider of a
17 denial, delay, or modification of a request shall include the name
18 and telephone number of the health care professional responsible
19 for the denial, delay, or modification. The telephone number
20 provided shall be a direct number or an extension, to allow the
21 physician or health care provider easily to contact the professional
22 responsible for the denial, delay, or modification. Responses shall
23 also include information as to how the enrollee may file a grievance
24 with the plan pursuant to Section 1368, and in the case of Medi-Cal
25 enrollees, shall explain how to request an administrative hearing
26 and aid paid pending under Sections 51014.1 and 51014.2 of Title
27 22 of the California Code of Regulations.

28 (5) If the health care service plan cannot make a decision to
29 approve, modify, or deny the request for authorization within the
30 timeframes specified in paragraph (1) or (2) because the plan is
31 not in receipt of all of the information reasonably necessary and
32 requested, or because the plan requires consultation by an expert
33 reviewer, or because the plan has asked that an additional
34 examination or test be performed upon the enrollee, provided the
35 examination or test is reasonable and consistent with good medical
36 practice, the plan shall, immediately upon the expiration of the
37 timeframe specified in paragraph (1) or (2) or as soon as the plan
38 becomes aware that it will not meet the timeframe, whichever
39 occurs first, notify the provider and the enrollee, in writing, that
40 the plan cannot make a decision to approve, modify, or deny the

1 request for authorization within the required timeframe, and specify
2 the information requested but not received, or the expert reviewer
3 to be consulted, or the additional examinations or tests required.
4 The plan shall also notify the provider and enrollee of the
5 anticipated date on which a decision may be rendered. Upon receipt
6 of all information reasonably necessary and requested by the plan,
7 the plan shall approve, modify, or deny the request for authorization
8 within the timeframes specified in paragraph (1) or (2), whichever
9 applies.

10 (6) If the director determines that a health care service plan has
11 failed to meet any of the timeframes in this section, or has failed
12 to meet any other requirement of this section, the director may
13 assess, by order, administrative penalties for each failure. A
14 proceeding for the issuance of an order assessing administrative
15 penalties shall be subject to appropriate notice to, and an
16 opportunity for a hearing with regard to, the person affected, in
17 accordance with subdivision (a) of Section 1397. The
18 administrative penalties shall not be deemed an exclusive remedy
19 for the director. These penalties shall be paid to the Managed Care
20 Administrative Fines and Penalties Fund and shall be used for the
21 purposes specified in Section 1341.45.

22 (i) A health care service plan subject to this section shall
23 maintain telephone access for providers to request authorization
24 for health care services.

25 (j) A health care service plan subject to this section that reviews
26 requests by providers prior to, retrospectively, or concurrent with,
27 the provision of health care services to enrollees shall establish,
28 as part of the quality assurance program required by Section 1370,
29 a process by which the plan's compliance with this section is
30 assessed and evaluated. The process shall include provisions for
31 evaluation of complaints, assessment of trends, implementation
32 of actions to correct identified problems, mechanisms to
33 communicate actions and results to the appropriate health plan
34 employees and contracting providers, and provisions for evaluation
35 of any corrective action plan and measurements of performance.

36 (k) The director shall review a health care service plan's
37 compliance with this section as part of its periodic onsite medical
38 survey of each plan undertaken pursuant to Section 1380, and shall
39 include a discussion of compliance with this section as part of its
40 report issued pursuant to that section.

1 (l) This section shall not apply to decisions made for the care
2 or treatment of the sick who depend upon prayer or spiritual means
3 for healing in the practice of religion as set forth in subdivision
4 (a) of Section 1270.

5 (m) Nothing in this section shall cause a health care service plan
6 to be defined as a health care provider for purposes of any provision
7 of law, including, but not limited to, Section 6146 of the Business
8 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
9 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
10 Code of Civil Procedure.

11 SEC. 2. Section 1370.8 is added to the Health and Safety Code,
12 to read:

13 1370.8. Upon receipt of a claim, a health care service plan shall
14 assign a tracking number to the claim and shall provide
15 acknowledgment of receipt of the claim to both the provider and
16 the enrollee. The acknowledgment of receipt shall identify the
17 assigned tracking number and shall be provided via electronic
18 mail, unless the provider or enrollee has opted out of the electronic
19 method of transmittal and requested that all acknowledgments of
20 receipt be transmitted in writing. In the case of an orally submitted
21 claim, the acknowledgment of receipt shall also be provided orally
22 to the submitting provider or enrollee. All communications
23 regarding the claim shall reference the tracking number assigned
24 pursuant to this section.

25 SEC. 3. Section 1371 of the Health and Safety Code is amended
26 to read:

27 1371. (a) A health care service plan, including a specialized
28 health care service plan, shall reimburse claims or any portion of
29 any claim, whether in state or out of state, as soon as ~~practicable~~
30 *practical*, but no later than 30 working days after receipt of the
31 claim by the health care service plan, or if the health care service
32 plan is a health maintenance organization, 45 working days after
33 receipt of the claim by the health care service plan, unless the claim
34 or portion thereof is contested by the plan in which case the
35 claimant shall be notified, in writing, that the claim is contested
36 or denied, within 30 working days after receipt of the claim by the
37 health care service plan, or if the health care service plan is a health
38 maintenance organization, 45 working days after receipt of the
39 claim by the health care service plan. The notice that a claim is

being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. ~~ff~~

(b) *If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar (\$10) fee.* ~~For~~

(c) *For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.* ~~ff~~

(d) *If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the both of the following shall apply:*

(1) *Within three working days of receipt of any of this additional information, the plan shall provide acknowledgment of receipt of that information to the claimant. The acknowledgment of receipt shall be provided via electronic mail unless the claimant has opted out of the electronic method of transmittal and requested that all acknowledgments of receipt be transmitted in writing. The acknowledgment of receipt shall include the tracking number assigned to the claim pursuant to Section 1370.8.*

(2) *The plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional all of the information necessary to determine payer liability to complete reconsideration of the claim.*

1 If a plan has received all of the information necessary to determine
2 payer liability for a contested claim and has not reimbursed a claim
3 it has determined to be payable within 30 working days of the
4 receipt of that information, or if the plan is a health maintenance
5 organization, within 45 working days of receipt of that information,
6 interest shall accrue and be payable at a rate of 15 percent per
7 annum beginning with the first calendar day after the 30- or
8 ~~45-working-day~~ 45-working day period.

9 The

10 (e) The obligation of the plan to comply with this section shall
11 not be deemed to be waived when the plan requires its medical
12 groups, independent practice associations, or other contracting
13 entities to pay claims for covered services.

14 SEC. 4. Section 1371.35 of the Health and Safety Code is
15 amended to read:

16 1371.35. (a) A health care service plan, including a specialized
17 health care service plan, shall reimburse each complete claim, or
18 portion thereof, whether in state or out of state, as soon as practical,
19 but no later than 30 working days after receipt of the complete
20 claim by the health care service plan, or if the health care service
21 plan is a health maintenance organization, 45 working days after
22 receipt of the complete claim by the health care service plan.
23 However, a plan may contest or deny a claim, or portion thereof,
24 by notifying the claimant, in writing, that the claim is contested
25 or denied, within 30 working days after receipt of the claim by the
26 health care service plan, or if the health care service plan is a health
27 maintenance organization, 45 working days after receipt of the
28 claim by the health care service plan. The notice that a claim, or
29 portion thereof, is contested shall identify the portion of the claim
30 that is contested, by revenue code, and the specific information
31 needed from the provider to reconsider the claim. The notice that
32 a claim, or portion thereof, is denied shall identify the portion of
33 the claim that is denied, by revenue code, and the specific reasons
34 for the denial. A plan may delay payment of an uncontested portion
35 of a complete claim for reconsideration of a contested portion of
36 that claim so long as the plan pays those charges specified in
37 subdivision (b).

38 (b) If a complete claim, or portion thereof, that is neither
39 contested nor denied, is not reimbursed by delivery to the
40 claimant's address of record within the respective 30 or 45 working

1 days after receipt, the plan shall pay the greater of fifteen dollars
2 (\$15) per year or interest at the rate of 15 percent per annum
3 beginning with the first calendar day after the 30- or
4 ~~45-working-day~~ 45-working day period. A health care service plan
5 shall automatically include the fifteen dollars (\$15) per year or
6 interest due in the payment made to the claimant, without requiring
7 a request therefor.

8 (c) For the purposes of this section, a claim, or portion thereof,
9 is reasonably contested if the plan has not received the completed
10 claim. A paper claim from an institutional provider shall be deemed
11 complete upon submission of a legible emergency department
12 report and a completed UB 92 or other format adopted by the
13 National Uniform Billing Committee, and reasonable relevant
14 information requested by the plan within 30 working days of receipt
15 of the claim. An electronic claim from an institutional provider
16 shall be deemed complete upon submission of an electronic
17 equivalent to the UB 92 or other format adopted by the National
18 Uniform Billing Committee, and reasonable relevant information
19 requested by the plan within 30 working days of receipt of the
20 claim. However, if the plan requests a copy of the emergency
21 department report within the 30 working days after receipt of the
22 electronic claim from the institutional provider, the plan may also
23 request additional reasonable relevant information within 30
24 working days of receipt of the emergency department report, at
25 which time the claim shall be deemed complete. A claim from a
26 professional provider shall be deemed complete upon submission
27 of a completed HCFA 1500 or its electronic equivalent or other
28 format adopted by the National Uniform Billing Committee, and
29 reasonable relevant information requested by the plan within 30
30 working days of receipt of the claim. The provider shall provide
31 the plan reasonable relevant information within 10 working days
32 of receipt of a written request that is clear and specific regarding
33 the information sought. If, as a result of reviewing the reasonable
34 relevant information, the plan requires further information, the
35 plan shall have an additional 15 working days after receipt of the
36 reasonable relevant information to request the further information,
37 notwithstanding any time limit to the contrary in this section, at
38 which time the claim shall be deemed complete.

39 (d) This section shall not apply to claims about which there is
40 evidence of fraud and misrepresentation, to eligibility

1 determinations, or in instances where the plan has not been granted
2 reasonable access to information under the provider's control. A
3 plan shall specify, in a written notice sent to the provider within
4 the respective 30- or 45-working days of receipt of the claim,
5 which, if any, of these exceptions applies to a claim.

6 (e) If a claim or portion thereof is contested on the basis that
7 the plan has not received information reasonably necessary to
8 determine payer liability for the claim or portion thereof, ~~then the~~
9 *both of the following shall apply:*

10 (1) *Within three working days of receipt of any of this additional*
11 *information, a plan shall provide acknowledgment of receipt of*
12 *that information to the claimant. The acknowledgment of receipt*
13 *shall be provided via electronic mail unless the claimant has opted*
14 *out of the electronic method of transmittal and requested that all*
15 *acknowledgments of receipt be transmitted in writing. The*
16 *acknowledgment of receipt shall include the tracking number*
17 *assigned to the claim pursuant to Section 1370.8.*

18 (2) *The plan shall have 30 working days or, if the health care*
19 *service plan is a health maintenance organization, 45 working days*
20 *after receipt of ~~this additional~~ all of the information necessary to*
21 *determine payer liability to complete reconsideration of the claim.*
22 *If a claim, or portion thereof, undergoing reconsideration is not*
23 *reimbursed by delivery to the claimant's address of record within*
24 *the respective 30 or 45 working days after receipt of ~~the additional~~*
25 *all of the information necessary to determine payer liability, the*
26 *plan shall pay the greater of fifteen dollars (\$15) per year or interest*
27 *at the rate of 15 percent per annum beginning with the first calendar*
28 *day after the 30- or 45-working-day period. A health care service*
29 *plan shall automatically include the fifteen dollars (\$15) per year*
30 *or interest due in the payment made to the claimant, without*
31 *requiring a request therefor.*

32 (f) The obligation of the plan to comply with this section shall
33 not be deemed to be waived when the plan requires its medical
34 groups, independent practice associations, or other contracting
35 entities to pay claims for covered services. This section shall not
36 be construed to prevent a plan from assigning, by a written contract,
37 the responsibility to pay interest and late charges pursuant to this
38 section to medical groups, independent practice associations, or
39 other entities.

1 (g) A plan shall not delay payment on a claim from a physician
2 or other provider to await the submission of a claim from a hospital
3 or other provider, without citing specific rationale as to why the
4 delay was necessary and providing a monthly update regarding
5 the status of the claim and the plan's actions to resolve the claim,
6 to the provider that submitted the claim.

7 (h) A health care service plan shall not request or require that
8 a provider waive its rights pursuant to this section.

9 (i) This section shall not apply to capitated payments.

10 (j) This section shall apply only to claims for services rendered
11 to a patient who was provided emergency services and care as
12 defined in Section 1317.1 in the United States on or after
13 September 1, 1999.

14 (k) This section shall not be construed to affect the rights or
15 obligations of any person pursuant to Section 1371.

16 (l) This section shall not be construed to affect a written
17 agreement, if any, of a provider to submit bills within a specified
18 time period.

19 SEC. 5. Section 1374.72 of the Health and Safety Code is
20 amended to read:

21 1374.72. (a) Every health care service plan contract issued,
22 amended, or renewed on or after July 1, 2000, that provides
23 hospital, medical, or surgical coverage shall provide coverage for
24 the diagnosis and medically necessary treatment of severe mental
25 illnesses of a person of any age, and of serious emotional
26 disturbances of a child, as specified in subdivisions (d) and (e),
27 under the same terms and conditions applied to other medical
28 conditions as specified in subdivision (c).

29 (b) These benefits shall include the following:

30 (1) Outpatient services.

31 (2) Inpatient hospital services.

32 (3) Partial hospital services.

33 (4) Prescription drugs, if the plan contract includes coverage
34 for prescription drugs.

35 ~~(c) The terms and conditions applied to the benefits required~~
36 ~~by this section, that shall be applied equally to all benefits under~~
37 ~~the plan contract, shall~~ *Any form of treatment limitation or other*
38 *action by a plan that may limit the receipt of benefits required by*
39 *this section shall be applied under the same terms and conditions*
40 *that apply to other benefits under the plan contract. These*

1 *treatment limitations or actions* include, but ~~are not~~ be limited to,
2 *the use of any of the* following:

3 (1) Maximum lifetime benefits.

4 (2) Copayments.

5 (3) Individual and family deductibles.

6 (d) For the purposes of this section, “severe mental illnesses”
7 shall include:

8 (1) Schizophrenia.

9 (2) Schizoaffective disorder.

10 (3) Bipolar disorder (manic-depressive illness).

11 (4) Major depressive disorders.

12 (5) Panic disorder.

13 (6) Obsessive-compulsive disorder.

14 (7) Pervasive developmental disorder or autism.

15 (8) Anorexia nervosa.

16 (9) Bulimia nervosa.

17 (e) For the purposes of this section, a child suffering from,
18 “serious emotional disturbances of a child” shall be defined as a
19 child who (1) has one or more mental disorders as identified in the
20 most recent edition of the Diagnostic and Statistical Manual of
21 Mental Disorders, other than a primary substance use disorder or
22 developmental disorder, that result in behavior inappropriate to
23 the child’s age according to expected developmental norms, and
24 (2) who meets the criteria in paragraph (2) of subdivision (a) of
25 Section 5600.3 of the Welfare and Institutions Code.

26 (f) This section shall not apply to contracts entered into pursuant
27 to Chapter 7 (commencing with Section 14000) or Chapter 8
28 (commencing with Section 14200) of Division 9 of Part 3 of the
29 Welfare and Institutions Code, between the State Department of
30 Health Services and a health care service plan for enrolled
31 Medi-Cal beneficiaries.

32 (g) (1) For the purpose of compliance with this section, a plan
33 may provide coverage for all or part of the mental health services
34 required by this section through a separate specialized health care
35 service plan or mental health plan, and shall not be required to
36 obtain an additional or specialized license for this purpose.

37 (2) A plan shall provide the mental health coverage required by
38 this section in its entire service area and in emergency situations
39 as may be required by applicable laws and regulations. For
40 purposes of this section, health care service plan contracts that

1 provide benefits to enrollees through preferred provider contracting
2 arrangements are not precluded from requiring enrollees who reside
3 or work in geographic areas served by specialized health care
4 service plans or mental health plans to secure all or part of their
5 mental health services within those geographic areas served by
6 specialized health care service plans or mental health plans.

7 (3) Notwithstanding any other provision of law, in the provision
8 of benefits required by this section, a health care service plan may
9 utilize case management, network providers, utilization review
10 techniques, prior authorization, copayments, or other cost sharing,
11 *subject to the limitation imposed under subdivision (c).*

12 (h) Nothing in this section shall be construed to deny or restrict
13 in any way the department's authority to ensure plan compliance
14 with this chapter when a plan provides coverage for prescription
15 drugs.

16 SEC. 6. Section 10123.125 is added to the Insurance Code, to
17 read:

18 10123.125. Upon receipt of a claim, a health insurer shall assign
19 a tracking number to the claim and shall provide acknowledgment
20 of receipt of the claim to both the provider and the insured. The
21 acknowledgment of receipt shall identify the assigned tracking
22 number and shall be provided via electronic mail, unless the
23 provider or insured has opted out of the electronic method of
24 transmittal and requested that all acknowledgments of receipt be
25 transmitted in writing. In the case of an orally submitted claim,
26 the acknowledgment of receipt shall also be provided orally to the
27 submitting provider or insured. All communications regarding the
28 claim shall reference the tracking number assigned pursuant to
29 this section.

30 SEC. 7. Section 10123.13 of the Insurance Code is amended
31 to read:

32 10123.13. (a) Every insurer issuing group or individual policies
33 of health insurance that covers hospital, medical, or surgical
34 expenses, including those telemedicine services covered by the
35 insurer as defined in subdivision (a) of Section 2290.5 of the
36 Business and Professions Code, shall reimburse claims or any
37 portion of any claim, whether in state or out of state, for those
38 expenses as soon as practical, but no later than 30 working days
39 after receipt of the claim by the insurer unless the claim or portion
40 thereof is contested by the insurer, in which case the claimant shall

1 be notified, in writing, that the claim is contested or denied, within
2 30 working days after receipt of the claim by the insurer. The
3 notice that a claim is being contested or denied shall identify the
4 portion of the claim that is contested or denied and the specific
5 reasons including for each reason the factual and legal basis known
6 at that time by the insurer for contesting or denying the claim. If
7 the reason is based solely on facts or solely on law, the insurer is
8 required to provide only the factual or the legal basis for its reason
9 for contesting or denying the claim. The insurer shall provide a
10 copy of the notice to each insured who received services pursuant
11 to the claim that was contested or denied and to the insured's health
12 care provider that provided the services at issue. The notice shall
13 advise the provider who submitted the claim on behalf of the
14 insured or pursuant to a contract for alternative rates of payment
15 and the insured that either may seek review by the department of
16 a claim that the insurer contested or denied, and the notice shall
17 include the address, Internet Web site address, and telephone
18 number of the unit within the department that performs this review
19 function. The notice to the provider may be included on either the
20 explanation of benefits or remittance advice and shall also contain
21 a statement advising the provider of its right to enter into the
22 dispute resolution process described in Section 10123.137. The
23 notice to the insured may also be included on the explanation of
24 benefits.

25 (b) If an uncontested claim is not reimbursed by delivery to the
26 claimant's address of record within 30 working days after receipt,
27 interest shall accrue and shall be payable at the rate of 10 percent
28 per annum beginning with the first calendar day after the
29 30-working day period.

30 (c) For purposes of this section, a claim, or portion thereof, is
31 reasonably contested when the insurer has not received a completed
32 claim and all information necessary to determine payer liability
33 for the claim, or has not been granted reasonable access to
34 information concerning provider services. Information necessary
35 to determine liability for the claims includes, but is not limited to,
36 reports of investigations concerning fraud and misrepresentation,
37 and necessary consents, releases, and assignments, a claim on
38 appeal, or other information necessary for the insurer to determine
39 the medical necessity for the health care services provided to the
40 claimant. If an

(d) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, both of the following shall apply:

(1) Within three working days of receipt of any of this additional information, the insurer shall provide acknowledgment of receipt of that information to the claimant. The acknowledgment of receipt shall be provided via electronic mail unless the claimant has opted out of the electronic method of transmittal and requested that all acknowledgments of receipt be transmitted in writing. The acknowledgment of receipt shall include the tracking number assigned to the claim pursuant to Section 10123.125.

(2) If the insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d)

(e) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 8. Section 10123.135 of the Insurance Code is amended to read:

10123.135. (a) Every ~~disability~~ health insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, ~~that covers hospital, medical, or surgical expenses and~~ that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) (1) A ~~disability~~ health insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole

1 or in part on medical necessity, requests by providers of health
2 care services for insureds. These policies and procedures shall
3 ensure that decisions based on the medical necessity of proposed
4 health care services are consistent with criteria or guidelines that
5 are supported by clinical principles and processes. These criteria
6 and guidelines shall be developed pursuant to subdivision (f).
7 These policies and procedures, and a description of the process by
8 which an insurer, or an entity with which an insurer contracts for
9 services that include utilization review or utilization management
10 functions, reviews and approves, modifies, delays, or denies
11 requests by providers prior to, retrospectively, or concurrent with
12 the provision of health care services to insureds, shall be filed with
13 the commissioner, and shall be disclosed by the insurer to insureds
14 and providers upon request, and by the insurer to the public upon
15 request.

16 *(2) Upon receipt of a request by a provider prior to,*
17 *retrospectively, or concurrent with the provision of health care*
18 *services to an insured, a health insurer, or the entity with which*
19 *the insurer contracts for services that include utilization review*
20 *or utilization management functions, shall assign a tracking*
21 *number to the request and shall provide acknowledgment of receipt*
22 *of the request to both the provider and the insured. The*
23 *acknowledgment of receipt shall identify the assigned tracking*
24 *number and shall be provided via electronic mail, unless the*
25 *provider or insured has opted out of the electronic method of*
26 *transmittal and requested that all acknowledgments of receipt be*
27 *transmitted in writing. In the case of an orally submitted request,*
28 *the acknowledgment of receipt shall also be provided orally to the*
29 *submitting provider. All communications regarding the request,*
30 *including, but not limited to, the communications or responses*
31 *identified in subdivision (h), shall reference the tracking number*
32 *assigned pursuant to this paragraph.*

33 (c) If the number of insureds covered under health benefit plans
34 in this state that are issued by an insurer subject to this section
35 constitute at least 50 percent of the number of insureds covered
36 under health benefit plans issued nationwide by that insurer, the
37 insurer shall employ or designate a medical director who holds an
38 unrestricted license to practice medicine in this state issued
39 pursuant to Section 2050 of the Business and Professions Code or
40 the Osteopathic Initiative Act, or the insurer may employ a clinical

1 director licensed in California whose scope of practice under
2 California law includes the right to independently perform all those
3 services covered by the insurer. The medical director or clinical
4 director shall ensure that the process by which the insurer reviews
5 and approves, modifies, delays, or denies, based in whole or in
6 part on medical necessity, requests by providers prior to,
7 retrospectively, or concurrent with the provision of health care
8 services to insureds, complies with the requirements of this section.
9 Nothing in this subdivision shall be construed as restricting the
10 existing authority of the Medical Board of California.

11 (d) If an insurer subject to this section, or individuals under
12 contract to the insurer to review requests by providers, approve
13 the provider's request pursuant to subdivision (b), the decision
14 shall be communicated to the provider pursuant to subdivision (h).

15 (e) An individual, other than a licensed physician or a licensed
16 health care professional who is competent to evaluate the specific
17 clinical issues involved in the health care services requested by
18 the provider, may not deny or modify requests for authorization
19 of health care services for an insured for reasons of medical
20 necessity. The decision of the physician or other health care
21 provider shall be communicated to the provider and the insured
22 pursuant to subdivision (h).

23 (f) (1) An insurer shall disclose, or provide for the disclosure,
24 to the commissioner and to network providers, the process the
25 insurer, its contracting provider groups, or any entity with which
26 it contracts for services that include utilization review or utilization
27 management functions, uses to authorize, delay, modify, or deny
28 health care services under the benefits provided by the insurance
29 contract, including coverage for subacute care, transitional inpatient
30 care, or care provided in skilled nursing facilities. An insurer shall
31 also disclose those processes to policyholders or persons designated
32 by a policyholder, or to any other person or organization, upon
33 request.

34 (2) The criteria or guidelines used by an insurer, or an entity
35 with which an insurer contracts for utilization review or utilization
36 management functions, to determine whether to authorize, modify,
37 delay, or deny health care services, shall comply with all of the
38 following:

39 (A) Be developed with involvement from actively practicing
40 health care providers.

1 (B) Be consistent with sound clinical principles and processes.

2 (C) Be evaluated, and updated if necessary, at least annually.

3 (D) If used as the basis of a decision to modify, delay, or deny
4 services in a specified case under review, be disclosed to the
5 provider and the policyholder in that specified case.

6 (E) Be available to the public upon request. An insurer shall
7 only be required to disclose the criteria or guidelines for the
8 specific procedures or conditions requested. An insurer may charge
9 reasonable fees to cover administrative expenses related to
10 disclosing criteria or guidelines pursuant to this paragraph that are
11 limited to copying and postage costs. The insurer may also make
12 the criteria or guidelines available through electronic
13 communication means.

14 (3) The disclosure required by subparagraph (E) of paragraph
15 (2) shall be accompanied by the following notice: “The materials
16 provided to you are guidelines used by this insurer to authorize,
17 modify, or deny health care benefits for persons with similar
18 illnesses or conditions. Specific care and treatment may vary
19 depending on individual need and the benefits covered under your
20 insurance contract.”

21 (g) If an insurer subject to this section requests medical
22 information from providers in order to determine whether to
23 approve, modify, or deny requests for authorization, the insurer
24 shall request only the information reasonably necessary to make
25 the determination.

26 (h) In determining whether to approve, modify, or deny requests
27 by providers prior to, retrospectively, or concurrent with the
28 provision of health care services to insureds, based in whole or in
29 part on medical necessity, every insurer subject to this section shall
30 meet the following requirements:

31 (1) Decisions to approve, modify, or deny, based on medical
32 necessity, requests by providers prior to, or concurrent with, the
33 provision of health care services to insureds that do not meet the
34 requirements for the 72-hour review required by paragraph (2),
35 shall be made in a timely fashion appropriate for the nature of the
36 insured’s condition, not to exceed five business days from the
37 insurer’s receipt of the information reasonably necessary and
38 requested by the insurer to make the determination. In cases where
39 the review is retrospective, the decision shall be communicated to
40 the individual who received services, or to the individual’s

1 designee, within 30 days of the receipt of information that is
2 reasonably necessary to make this determination, and shall be
3 communicated to the provider in a manner that is consistent with
4 current law. For purposes of this section, retrospective reviews
5 shall be for care rendered on or after January 1, 2000.

6 (2) When the insured's condition is such that the insured faces
7 an imminent and serious threat to his or her health, including, but
8 not limited to, the potential loss of life, limb, or other major bodily
9 function, or the normal timeframe for the decisionmaking process,
10 as described in paragraph (1), would be detrimental to the insured's
11 life or health or could jeopardize the insured's ability to regain
12 maximum function, decisions to approve, modify, or deny requests
13 by providers prior to, or concurrent with, the provision of health
14 care services to insureds shall be made in a timely fashion,
15 appropriate for the nature of the insured's condition, but not to
16 exceed 72 hours after the insurer's receipt of the information
17 reasonably necessary and requested by the insurer to make the
18 determination.

19 (3) Decisions to approve, modify, or deny requests by providers
20 for authorization prior to, or concurrent with, the provision of
21 health care services to insureds shall be communicated to the
22 requesting provider within 24 hours of the decision. Except for
23 concurrent review decisions pertaining to care that is underway,
24 which shall be communicated to the insured's treating provider
25 within 24 hours, decisions resulting in denial, delay, or
26 modification of all or part of the requested health care service shall
27 be communicated to the insured in writing within two business
28 days of the decision. In the case of concurrent review, care shall
29 not be discontinued until the insured's treating provider has been
30 notified of the insurer's decision and a care plan has been agreed
31 upon by the treating provider that is appropriate for the medical
32 needs of that patient.

33 (4) Communications regarding decisions to approve requests
34 by providers prior to, retrospectively, or concurrent with the
35 provision of health care services to insureds shall specify the
36 specific health care service approved. Responses regarding
37 decisions to deny, delay, or modify health care services requested
38 by providers prior to, retrospectively, or concurrent with the
39 provision of health care services to insureds shall be communicated
40 to insureds in writing, and to providers initially by telephone or

1 facsimile, except with regard to decisions rendered retrospectively,
2 and then in writing, and shall include a clear and concise
3 explanation of the reasons for the insurer's decision, a description
4 of the criteria or guidelines used, and the clinical reasons for the
5 decisions regarding medical necessity. Any written communication
6 to a physician or other health care provider of a denial, delay, or
7 modification or a request shall include the name and telephone
8 number of the health care professional responsible for the denial,
9 delay, or modification. The telephone number provided shall be a
10 direct number or an extension, to allow the physician or health
11 care provider easily to contact the professional responsible for the
12 denial, delay, or modification. Responses shall also include
13 information as to how the provider or the insured may file an appeal
14 with the insurer or seek department review under the unfair
15 practices provisions of Article 6.5 (commencing with Section 790)
16 of Chapter 1 of Part 2 of Division 1 and the regulations adopted
17 thereunder.

18 (5) If the insurer cannot make a decision to approve, modify,
19 or deny the request for authorization within the timeframes
20 specified in paragraph (1) or (2) because the insurer is not in receipt
21 of all of the information reasonably necessary and requested, or
22 because the insurer requires consultation by an expert reviewer,
23 or because the insurer has asked that an additional examination or
24 test be performed upon the insured, provided that the examination
25 or test is reasonable and consistent with good medical practice,
26 the insurer shall, immediately upon the expiration of the timeframe
27 specified in paragraph (1) or (2), or as soon as the insurer becomes
28 aware that it will not meet the timeframe, whichever occurs first,
29 notify the provider and the insured, in writing, that the insurer
30 cannot make a decision to approve, modify, or deny the request
31 for authorization within the required timeframe, and specify the
32 information requested but not received, or the expert reviewer to
33 be consulted, or the additional examinations or tests required. The
34 insurer shall also notify the provider and enrollee of the anticipated
35 date on which a decision may be rendered. Upon receipt of all
36 information reasonably necessary and requested by the insurer,
37 the insurer shall approve, modify, or deny the request for
38 authorization within the timeframes specified in paragraph (1) or
39 (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 9. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to

1 deny the claim. The insurer shall provide a copy of the notice
2 required by this subdivision to each insured who received services
3 pursuant to the claim that was contested or denied and to the
4 insured's health care provider that provided the services at issue.
5 The notice required by this subdivision shall include a statement
6 advising the provider who submitted the claim on behalf of the
7 insured or pursuant to a contract for alternative rates of payment
8 and the insured that either may seek review by the department of
9 a claim that was contested or denied by the insurer and the address,
10 Internet Web site address, and telephone number of the unit within
11 the department that performs this review function. The notice to
12 the provider may be included on either the explanation of benefits
13 or remittance advice and shall also contain a statement advising
14 the provider of its right to enter into the dispute resolution process
15 described in Section 10123.137. An insurer may delay payment
16 of an uncontested portion of a complete claim for reconsideration
17 of a contested portion of that claim so long as the insurer pays
18 those charges specified in subdivision (b).

19 (b) If a complete claim, or portion thereof, that is neither
20 contested nor denied, is not reimbursed by delivery to the
21 claimant's address of record within the 30 working days after
22 receipt, the insurer shall pay the greater of fifteen dollars (\$15)
23 per year or interest at the rate of 10 percent per annum beginning
24 with the first calendar day after the 30-working-day period. An
25 insurer shall automatically include the fifteen dollars (\$15) per
26 year or interest due in the payment made to the claimant, without
27 requiring a request therefor.

28 (c) For the purposes of this section, a claim, or portion thereof,
29 is reasonably contested if the insurer has not received the completed
30 claim. A paper claim from an institutional provider shall be deemed
31 complete upon submission of a legible emergency department
32 report and a completed UB 92 or other format adopted by the
33 National Uniform Billing Committee, and reasonable relevant
34 information requested by the insurer within 30 working days of
35 receipt of the claim. An electronic claim from an institutional
36 provider shall be deemed complete upon submission of an
37 electronic equivalent to the UB 92 or other format adopted by the
38 National Uniform Billing Committee, and reasonable relevant
39 information requested by the insurer within 30 working days of
40 receipt of the claim. However, if the insurer requests a copy of the

emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, ~~then the~~ *both of the following shall apply:*

(1) Within three working days of receipt of any of this additional information, the insurer shall provide acknowledgment of receipt of that information to the claimant. The acknowledgment of receipt shall be provided via electronic mail unless the claimant has opted out of the electronic method of transmittal and requested that all acknowledgments of receipt be transmitted in writing. The acknowledgment of receipt shall include the tracking number assigned to the claim pursuant to Section 10123.125.

(2) The insurer shall have 30 working days after receipt of this additional all of the information necessary to determine payer

1 *liability* to complete reconsideration of the claim. If a claim, or
2 portion thereof, undergoing reconsideration is not reimbursed by
3 delivery to the claimant's address of record within the 30 working
4 days after receipt of ~~the additional~~ *all of the* information *necessary*
5 *to determine payer liability*, the insurer shall pay the greater of
6 fifteen dollars (\$15) per year or interest at the rate of 10 percent
7 per annum beginning with the first calendar day after the
8 30-working-day period. An insurer shall automatically include the
9 fifteen dollars (\$15) per year or interest due in the payment made
10 to the claimant, without requiring a request therefor.

11 (f) An insurer shall not delay payment on a claim from a
12 physician or other provider to await the submission of a claim from
13 a hospital or other provider, without citing specific rationale as to
14 why the delay was necessary and providing a monthly update
15 regarding the status of the claim and the insurer's actions to resolve
16 the claim, to the provider that submitted the claim.

17 (g) An insurer shall not request or require that a provider waive
18 its rights pursuant to this section.

19 (h) This section shall apply only to claims for services rendered
20 to a patient who was provided emergency services and care as
21 defined in Section 1317.1 of the Health and Safety Code in the
22 United States on or after September 1, 1999.

23 (i) This section shall not be construed to affect the rights or
24 obligations of any person pursuant to Section 10123.13.

25 (j) This section shall not be construed to affect a written
26 agreement, if any, of a provider to submit bills within a specified
27 time period.

28 SEC. 10. Section 10144.5 of the Insurance Code is amended
29 to read:

30 10144.5. (a) Every policy of ~~disability health~~ *health* insurance ~~that~~
31 ~~covers hospital, medical, or surgical expenses in this state~~ that is
32 issued, amended, or renewed on or after July 1, 2000, shall provide
33 coverage for the diagnosis and medically necessary treatment of
34 severe mental illnesses of a person of any age, and of serious
35 emotional disturbances of a child, as specified in subdivisions (d)
36 and (e), under the same terms and conditions applied to other
37 medical conditions, as specified in subdivision (c).

38 (b) These benefits shall include the following:

39 (1) Outpatient services.

40 (2) Inpatient hospital services.

1 (3) Partial hospital services.

2 (4) Prescription drugs, if the policy or contract includes coverage
3 for prescription drugs.

4 ~~(c) The terms and conditions applied to the benefits required~~
5 ~~by this section that shall be applied equally to all benefits under~~
6 ~~the disability insurance policy shall.~~ *Any form of treatment*
7 *limitation or other action by an insurer that may limit the receipt*
8 *of benefits required by this section shall be applied under the same*
9 *terms and conditions that apply to other benefits under the policy.*
10 *These treatment limitations or actions include, but are not be*
11 *limited to, the use of any of the following:*

12 (1) Maximum lifetime benefits.

13 (2) Copayments and coinsurance.

14 (3) Individual and family deductibles.

15 (d) For the purposes of this section, “severe mental illnesses”
16 shall include:

17 (1) Schizophrenia.

18 (2) Schizoaffective disorder.

19 (3) Bipolar disorder (manic-depressive illness).

20 (4) Major depressive disorders.

21 (5) Panic disorder.

22 (6) Obsessive-compulsive disorder.

23 (7) Pervasive developmental disorder or autism.

24 (8) Anorexia nervosa.

25 (9) Bulimia nervosa.

26 (e) For the purposes of this section, a child suffering from,
27 “serious emotional disturbances of a child” shall be defined as a
28 child who (1) has one or more mental disorders as identified in the
29 most recent edition of the Diagnostic and Statistical Manual of
30 Mental Disorders, other than a primary substance use disorder or
31 developmental disorder, that result in behavior inappropriate to
32 the child’s age according to expected developmental norms, and
33 (2) who meets the criteria in paragraph (2) of subdivision (a) of
34 Section 5600.3 of the Welfare and Institutions Code.

35 (f) (1) For the purpose of compliance with this section, a
36 ~~disability health~~ insurer may provide coverage for all or part of
37 the mental health services required by this section through a
38 separate specialized health care service plan or mental health plan,
39 and shall not be required to obtain an additional or specialized
40 license for this purpose.

(2) A ~~disability health~~ insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, ~~disability health~~ insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a ~~disability health~~ insurer may utilize case management, managed care, or utilization review, *subject to the limitation imposed under subdivision (c)*.

(4) Any action that a ~~disability health~~ insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

SEC. 11. 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.