

Senate Bill No. 255

CHAPTER 449

An act to amend Sections 1367.6 and 1367.635 of the Health and Safety Code, and to amend Sections 10123.8 and 10123.86 of the Insurance Code, relating to health care coverage.

[Approved by Governor September 22, 2012. Filed with
Secretary of State September 22, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

SB 255, Pavley. Health care coverage: breast cancer.

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 its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires every health care service plan contract and health insurance policy to provide coverage for screening for, diagnosis of, and treatment for, breast cancer, including coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Existing law requires every health care service plan contract and health insurance policy that provides coverage for mastectomies and lymph node dissections to allow the length of any hospital stay to be determined by the attending physician and surgeon in consultation with the patient, to cover prosthetic devices or reconstructive surgery, and to cover all complications from a mastectomy. Existing law defines mastectomy for those purposes as the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

This bill would revise and recast the definition of mastectomy and would specify that the partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins. The bill would require the consultation regarding the length of any hospital stay to be conducted postsurgery.

Because a willful violation of these provisions by a health care service plan is 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.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) The National Cancer Institute estimates that a woman born today in the United States has a one in eight chance of developing breast cancer during her lifetime.

(b) According to the American Cancer Society, excluding cancers of the skin, breast cancer is the most frequently diagnosed cancer in women.

(c) According to the American Cancer Society, an estimated 40,480 women and 450 men died from breast cancer in 2008.

(d) Nationwide, in 2008, an estimated 182,460 new cases of invasive breast cancer were diagnosed in women, and an estimated 1,990 invasive breast cancer cases were diagnosed in men. In addition, an estimated 67,770 new cases of in situ breast cancer occurred in women in 2008, and, of these, approximately 85 percent were ductal carcinoma in situ.

(e) According to the American Cancer Society, most breast cancer patients undergo some type of surgical treatment, which may involve breast-conserving surgeries, such as lumpectomy (surgical removal of the tumor with clear margins) or mastectomy (surgical removal of the breast) with removal of some of the axillary (underarm) lymph nodes.

(f) Currently, 20 states mandate minimum inpatient coverage after a patient undergoes a mastectomy, including California.

(g) Breast cancer patients have reported adverse outcomes, including infection, and inadequately controlled pain resulting from premature hospital discharge following breast cancer surgery.

SEC. 2. Section 1367.6 of the Health and Safety Code is amended to read:

1367.6. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No health care service plan contract shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every health care service plan contract shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the enrollee's participating physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the copayment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a

licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(f) As used in this section, “prosthetic devices” means the provision of initial and subsequent devices pursuant to an order of the patient’s physician and surgeon.

SEC. 3. Section 1367.635 of the Health and Safety Code is amended to read:

1367.635. (a) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, postsurgery, consistent with sound clinical principles and processes. No health care service plan shall require a treating physician and surgeon to receive prior approval from the plan in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) “Coverage for prosthetic devices or reconstructive surgery” means any initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) “Prosthetic devices” means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient’s physician and surgeon.

(3) “Mastectomy” means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(4) “To restore and achieve symmetry” means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section.

(d) No health care service plan shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee or subscriber in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee or subscriber in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an individual enrollee or subscriber to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every health care service plan shall include notice of the coverage required by this section in the plan's evidence of coverage.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the plan.

SEC. 4. Section 10123.8 of the Insurance Code is amended to read:

10123.8. (a) Every policy of disability insurance that provides coverage for hospital, medical, or surgical expenses, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No policy of disability insurance that provides coverage for hospital, medical, or surgical expenses shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every policy of disability insurance shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participating physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(f) As used in this section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

(g) For purposes of this section, disability insurance does not include accident only, credit, disability income, specified disease and hospital confinement indemnity, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care

insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

SEC. 5. Section 10123.86 of the Insurance Code is amended to read:

10123.86. (a) Every policy of disability insurance covering hospital, surgical, or medical expenses that is issued, amended, renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, postsurgery, consistent with sound clinical principles and processes. No disability insurer shall require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) "Coverage for prosthetic devices or reconstructive surgery" means any initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) "Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

(3) "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(4) "To restore and achieve symmetry" means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section.

(d) No insurer shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an insured in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an insured to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every insurer shall include notice of the coverage required by this section in the insurer's evidence of coverage or certificate of insurance.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the insurer.

(g) This section shall only apply to health benefit plans, as defined in subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

SEC. 6. Nothing in this act shall be construed to establish a new mandated benefit. The purpose of this act is to clarify that the existing definition of the term "mastectomy" also includes lumpectomy.

SEC. 7. 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.