AMENDED IN ASSEMBLY APRIL 6, 1995

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL No. 1663

Introduced by Assembly Member Friedman

February 24, 1995

An act to add Section ~~1348~~ *1363.6* to the Health and Safety Code, ~~relating to health care service plan coverage.~~ *and to add Section 10145.5 to the Insurance Code, relating to health insurance.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1663, as amended, Friedman. Health ~~care service plans: health benefits panel~~ *insurance*.

Existing law requires every health care service plan and disability insurer that denies coverage for an experimental medical procedure or plan of treatment for a claimant with a terminal illness to provide written notice of the medical and scientific reason for denial, references to pertinent policy provisions, a description of alternative medical treatments, and a description of an appeal process.

This bill would require every health care service plan and disability insurer to establish procedures in accordance with regulations, that govern actions when a subscriber or enrollee requests coverage or a particular service that may be considered experimental or investigational. The bill would provide for review of decisions by medical experts selected by an independent review entity certified by the Department of Corporations. The bill would require any coverage decision

that excludes a health care intervention because it has been determined to be experimental or investigational to be consistent with other determinations of the plan or insurer, as specified.

Since a violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program by expanding the scope of a crime.

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.

~~Existing law provides for the licensure and regulation of health care service plans by the Commissioner of Corporations. Existing law requires that health care service plan contracts meet certain requirements including the provision of coverage for prescribed services and treatments.~~

~~This bill would require the Department of Corporations to establish a health benefits panel to consider whether particular procedures, services, drugs, or devices may be excluded from coverage by health care service plan contracts because they are considered experimental or investigational.~~

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

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

~~SECTION 1. Section 1348 is added to the Health and~~

SECTION 1. Section 1363.6 is added to the Health and Safety Code, to read:

1363.6. (a) Every health care service plan shall establish procedures, in accordance with regulations adopted by the commissioner, that govern the actions of plans when a subscriber or enrollee requests coverage or a particular service that may be considered experimental or investigational. If the plan denies the subscriber's or enrollee's request, the plan shall offer the subscriber or enrollee the opportunity to have the requested service expeditiously reviewed by at least two independent

medical experts, notwithstanding Section 1368.1. These experts shall be physicians or other providers who are specialists in the treatment of the subscriber's or enrollee's condition. The plan shall not choose or control the choice of the experts, but shall contract with an impartial independent entity to select the experts and arrange for them to give their opinions. Neither the experts nor the entity arranging for the experts' opinions shall have any professional, familial, or financial affiliation with the plan, except that the plan may pay for the expert opinions. The experts shall have no patient-physician relationship or other affiliation with the specific patient whose case is under review.

(b) The review shall be required to be completed within 30 days of the request, except that if the enrollee's physician states that the requested treatment would be significantly less effective if not promptly initiated, the review shall be completed within five days of the request.

(c) If at least one medical expert finds that the service sought by the member is medically appropriate, the plan shall authorize and pay for the service. If neither expert finds that the requested service is medically appropriate, the plan may continue to decline authorization and payment for that service.

(d) For the purposes of this section, an "independent review entity" means an organization certified by the Department of Corporations as having the capacity to select and arrange for the provision of expert opinion specific to various classes of conditions for which an expert opinion is sought. The Department of Corporations may periodically review the disposition of cases submitted for review the performance of the independent entity to determine whether certification shall be continued.

(e) Any coverage decision that excludes a health care intervention because it has been determined to be experimental or investigational shall be consistent with other determinations of the plan involving enrollees with the same or similar medical conditions and stages of illness.

SEC. 2. Section 10145.5 is added to the Insurance Code, to read:

10145.5. (a) Every disability insurer shall establish procedures, in accordance with regulations adopted by the commissioner, that govern the actions of insurers when a subscriber or enrollee requests coverage or a particular service that may be considered experimental or investigational. If the insurer denies the subscriber's or enrollee's request, the insurer shall offer the subscriber or enrollee the opportunity to have the requested service expeditiously reviewed by at least two independent medical experts, notwithstanding Section 10123.19. These experts shall be physicians or other providers who are specialists in the treatment of the subscriber's or enrollee's condition. The insurer shall not choose or control the choice of the experts, but shall contract with an impartial independent entity to select the experts and arrange for them to give their opinions. Neither the experts nor the entity arranging for the experts' opinions shall have any professional, familial, or financial affiliation with the insurer, except that the insurer may pay for the expert opinions. The experts shall have no patient-physician relationship or other affiliation with the specific patient whose case is under review.

(b) The review shall be required to be completed within 30 days of the request, except that if the enrollee's physician states that the requested treatment would be significantly less effective if not promptly initiated, the review shall be completed within five days of the request.

(c) If at least one medical expert finds that the service sought by the member is medically appropriate, the insurer shall authorize and pay for the service. If neither expert finds that the requested service is medically appropriate, the insurer may continue to decline authorization and payment for that service.

(d) For the purposes of this section, an "independent review entity" means an organization certified by the Department of Corporations as having the capacity to select and arrange for the provision of expert opinion specific to various classes of conditions for which an

expert opinion is sought. The Department of Corporations may periodically review the disposition of cases submitted for review the performance of the independent entity to determine whether certification shall be continued.

(e) Any coverage decision that excludes a health care intervention because it has been determined to be experimental or investigational shall be consistent with other determinations of the insurer involving enrollees with the same or similar medical conditions and stages of illness.

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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

~~Safety Code, to read:~~

~~1348. There shall be established by the Department of Corporations a health benefits panel that shall consider whether particular procedures, service, drugs, or devices may be excluded from coverage by health care service plan contracts because they are considered experimental or investigational.~~

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