

Assembly Bill No. 1621

Passed the Assembly August 31, 1998

Chief Clerk of the Assembly

Passed the Senate August 28, 1998

Secretary of the Senate

This bill was received by the Governor this ____ day
of _____, 1998, at ____ o'clock __M.

Private Secretary of the Governor



CHAPTER ____

An act to add Section 1367.63 to the Health and Safety Code, to add Section 10123.88 to the Insurance Code, and to add Section 14132.62 to the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1621, Figueroa. Health care coverage: reconstructive surgery.

Under existing law, health care service plans are subject to licensure and regulation by the Commissioner of Corporations. Under existing law, disability insurers are subject to licensure and regulation by the Insurance Commissioner. Existing law establishes the Medi-Cal program to provide health care benefits to low-income individuals. Willful violation of the law regulating health care service plans is a crime.

This bill would require certain health care service plan contracts, and certain policies of disability insurance, issued, amended, renewed, or delivered on or after July 1, 1999, to cover reconstructive surgery, as defined, but would exclude coverage for cosmetic surgery, as defined. The bill would authorize health care service plans, certain disability insurers, and the Medi-Cal program to utilize prior authorization and utilization review that may include denial of proposed surgery under specified circumstances. It would also require reconstructive surgery to be covered under the Medi-Cal program on and after July 1, 1999.

By changing the definition of a crime relative to health care service plans, 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. In enacting this act, it is the intent of the Legislature that health care service plans and disability insurers shall cover surgical procedures for enrollees and insureds if it is determined that the surgical procedures meet the definition of reconstructive surgery set forth in this act. However, in enacting subdivision (e) of Section 1367.63 of the Health and Safety Code, Section 10123.88 of the Insurance Code, and Section 14132.62 of the Welfare and Institutions Code, it is the intent of the Legislature that health care service plans and disability insurers shall not be required to cover a surgical procedure that will only result in a minimal improvement in the appearance of the patient. The determination of whether a surgery will produce only a minimal improvement shall be based upon the standard of care as practiced by physicians specializing in reconstructive surgery, and for services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), as specified in Section 14132.62 of the Welfare and Institutions Code.

SEC. 2. Section 1367.63 is added to the Health and Safety Code, to read:

1367.63. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require a plan to provide coverage for cosmetic surgery, as defined in subdivision (d).

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the



request may be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

(c) “Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function.

(2) To create a normal appearance, to the extent possible.

(d) “Cosmetic surgery” means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

(4) For services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the enrollee, as may be defined in any regulations that may be promulgated by the State Department of Health Services.

SEC. 3. Section 10123.88 is added to the Insurance Code, to read:

10123.88. (a) Every policy of disability insurance covering hospital, medical, or surgical expenses that is



issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require a policy to provide coverage for cosmetic surgery, as defined in subdivision (d). 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.

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

(c) “Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function.

(2) To create a normal appearance, to the extent possible.

(d) Nothing in this section shall be construed to require an insurer to provide coverage for cosmetic surgery. “Cosmetic surgery” means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance.

(e) In interpreting the definition of reconstructive surgery, an insurer may utilize prior authorization and



utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

SEC. 4. Section 14132.62 is added to the Welfare and Institutions Code, to read:

14132.62. (a) Reconstructive surgery shall be covered under this chapter, as defined in subdivision (c), when necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require coverage for cosmetic surgery, as defined in subdivision (d).

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual competent to evaluate the specific clinical issues involved in the care requested.

(c) "Reconstructive surgery" means surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function.

(2) To create a normal appearance, to the extent possible.

(d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.



(e) In connection with the interpretation of the definition of reconstructive surgery, a proposed surgical procedure may be subject to prior authorization and utilization review that may include, but need not be limited to, denial under any of the following circumstances:

(1) There is another more appropriate surgical procedure that will be approved for the enrollee.

(2) The procedure or procedures offer only a minimal improvement in the appearance of the enrollee, as defined in regulations adopted by the department.

(3) Denial of payment for procedures performed without prior authorization.

(f) This section shall become operative July 1, 1999.

SEC. 5. 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.



Approved _____, 1998

Governor

