

AMENDED IN SENATE AUGUST 24, 1999

AMENDED IN SENATE AUGUST 16, 1999

AMENDED IN SENATE JULY 1, 1999

AMENDED IN ASSEMBLY MAY 25, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL

No. 12

Introduced by Assembly Member Davis
(Coauthor: Assembly Member Correa)

December 7, 1998

An act to add Section 1383.15 to the Health and Safety Code, and to add Section 10123.68 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 12, as amended, Davis. Health care coverage: second opinions.

Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Commissioner of Corporations. Existing law provides that disability insurers are regulated by the Insurance Commissioner. Willful violation of the law regulating health care service plans is a crime.

Existing law requires health care service plans and certain disability insurers to file a written policy describing the manner in which the plans or insurers determine if a ~~second~~ 2nd medical opinion is medically necessary and appropriate.

This bill would require a health care service plan and certain disability insurers to provide or authorize a medically necessary or appropriate 2nd opinion by an appropriately qualified health care professional if requested by an enrollee or an insured, or a participating or contracting health professional who is treating an enrollee or insured. The bill would also specify reasons for a 2nd opinion to be provided or authorized if, among other things, any one of 5 specified conditions occurs. The bill would also specify the mechanism for obtaining a 2nd opinion and the eligible providers for rendering a 2nd opinion.

This bill would also require an authorization or denial to be provided in an expeditious manner, would require that the plan or insurer file timelines for responding to requests for 2nd opinions, as described, by July 1, 2000, with the appropriate state agency, and would require that the timelines be made available to the public upon request. This bill would not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements and that do not limit 2nd medical opinions, to disability insurers that do not limit 2nd medical opinions, or to certain other specialized types of health insurance.

By changing the definition of a crime regarding 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.

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 1383.15 is added to the Health
2 and Safety Code, immediately following Section 1383.1, to
3 read:



1 1383.15. (a) When requested by an enrollee or
2 participating health professional who is treating an
3 enrollee, a health care service plan shall provide or
4 authorize a medically necessary or appropriate second
5 opinion by an appropriately qualified health care
6 professional. Reasons for a second opinion to be provided
7 or authorized shall include, but are not limited to, the
8 following:

9 (1) If the enrollee questions the reasonableness or
10 necessity of recommended surgical procedures.

11 (2) If the enrollee questions a diagnosis or plan of care
12 for a condition that threatens loss of life, loss of limb, loss
13 of bodily function, or substantial impairment, including,
14 but not limited to, a serious chronic condition.

15 (3) If the clinical indications are not clear or are
16 complex and confusing, a diagnosis is in doubt due to
17 conflicting test results, or the treating health professional
18 is unable to diagnose the condition, and the enrollee
19 requests an additional diagnosis.

20 (4) If the treatment plan in progress is not improving
21 the medical condition of the enrollee within an
22 appropriate period of time given the diagnosis and plan
23 of care, and the enrollee requests a second opinion
24 regarding the diagnosis or continuance of the treatment.

25 (5) If the enrollee has attempted to follow the plan of
26 care or consulted with the initial provider concerning
27 serious concerns about the diagnosis or plan of care.

28 (b) For purposes of this section, an appropriately
29 qualified health care professional is a specialist who is
30 acting within his or her scope of practice and who
31 possesses a clinical background, including training and
32 expertise, related to the particular illness, disease,
33 condition or conditions associated with the request for a
34 second opinion.

35 (c) If an enrollee or participating health professional
36 who is treating an enrollee requests a second opinion
37 pursuant to this section, an authorization or denial shall
38 be provided in an expeditious manner. Each plan shall file
39 with the Department of Corporations timelines for
40 responding to requests for second opinions for cases



1 involving emergency needs, urgent care, and other
2 requests by July 1, 2000, and within 30 days of any
3 amendment to the timelines. The timelines shall be made
4 available to the public upon request.

5 (d) If a health care service plan approves a request by
6 an enrollee for a second opinion, the enrollee shall be
7 responsible only for the costs of applicable copayments
8 that the plan requires for similar referrals.

9 (e) If the enrollee is requesting a second opinion about
10 care from his or her primary care physician, the second
11 opinion shall be provided by an appropriately qualified
12 health care professional within the same ~~physical~~
13 *physician* organization.

14 (f) If the enrollee is requesting a second opinion about
15 care from a specialist, the second opinion shall be
16 provided by any contracted plan provider of the same
17 specialty. If the specialist is not within the same physician
18 organization, the plan shall incur the cost *or negotiate the*
19 *fee arrangements* of that second opinion, beyond the
20 applicable copayments which shall be paid by the
21 enrollee. Additional second opinions not within the
22 original physician organization shall be the responsibility
23 of the enrollee.

24 (g) The enrollee shall obtain services only from a
25 provider who is participating in, or under contract with,
26 the plan pursuant to the specific contract between the
27 plan and the subscriber. The plan may limit referrals to
28 its network of providers if there is a participating plan
29 provider who meets the standard specified in subdivision
30 (b). ~~If there is no participating plan provider who meets~~
31 ~~this standard.~~ If there is no participating plan provider
32 who meets this standard, then the plan shall authorize a
33 second opinion by an appropriately qualified health
34 professional outside of the plan's provider network. In
35 approving a referral for a second opinion either inside or
36 outside of the plan's provider network, the plan shall take
37 into account the ability of the enrollee to travel to the
38 provider.

39 (h) The health care service plan shall require the
40 second opinion health professional to provide the



1 enrollee and the initial health professional with a
2 consultation report, including any recommended
3 procedures or tests that the second opinion health
4 professional believes appropriate. Nothing in this section
5 shall be construed to prevent the plan from authorizing,
6 based on its independent determination, additional
7 medical opinions concerning the medical condition of an
8 enrollee.

9 (i) If the health care service plan denies a request by
10 an enrollee for a second opinion, it shall notify the
11 enrollee in writing of the reasons for the denial and shall
12 inform the enrollee of the right to file a grievance with
13 the plan. The notice shall comply with subdivision (b) of
14 Section 1368.02.

15 (j) This section shall not apply to health care service
16 plan contracts that provide benefits to enrollees through
17 preferred provider contracting arrangements if, subject
18 to all other terms and conditions of the contract that apply
19 generally to all other benefits, access to and coverage for
20 second opinions are not limited.

21 SEC. 2. Section 10123.68 is added to the Insurance
22 Code, immediately following Section 10123.67, to read:

23 10123.68. (a) When requested by an insured or
24 contracting health professional who is treating an
25 insured, a disability insurer that covers hospital, medical,
26 or surgical expenses shall authorize a medically necessary
27 or appropriate second opinion by an appropriately
28 qualified health care professional. Reasons for a second
29 opinion to be provided or authorized shall include, but
30 are not limited to, the following:

31 (1) If the insured questions the reasonableness or
32 necessity of recommended surgical procedures.

33 (2) If the insured questions a diagnosis or plan of care
34 for a condition that threatens loss of life, loss of limb, loss
35 of bodily function, or substantial impairment, including,
36 but not limited to, a serious chronic condition.

37 (3) If clinical indications are not clear or are complex
38 and confusing, a diagnosis is in doubt due to conflicting
39 test results, or the treating health professional is unable



1 to diagnose the condition and the insured requests an
2 additional diagnosis.

3 (4) If the treatment plan in progress is not improving
4 the medical condition of the insured within an
5 appropriate period of time given the diagnosis and plan
6 of care, and the insured requests a second opinion
7 regarding the diagnosis or continuance of the treatment.

8 (5) If the insured has attempted to follow the plan of
9 care or consulted with the initial provider concerning
10 serious concerns about the diagnosis or plan of care.

11 (b) For purposes of this section, an appropriately
12 qualified health care professional is a specialist who is
13 acting within his or her scope of practice and who
14 possesses a clinical background, including training and
15 expertise, related to the particular illness, disease,
16 condition or conditions associated with the request for a
17 second opinion.

18 (c) If an insured or participating health professional
19 who is treating an insured requests a second opinion
20 pursuant to this section, an authorization or denial shall
21 be provided in an expeditious manner. Each insurer shall
22 file with the Department of Insurance timelines for
23 responding to requests for second opinions for cases
24 involving emergency needs, urgent care, and other
25 requests by July 1, 2000, and within 30 days of any
26 amendment to the timelines. The timelines shall be made
27 available to the public upon request.

28 (d) If an insurer approves a request by an insured for
29 a second opinion, the insured shall be responsible only for
30 the costs of applicable coinsurances that the insurer
31 requires for similar referrals.

32 (e) If the insured is requesting a second opinion about
33 care from his or her primary care physician, the second
34 opinion shall be provided by an appropriately qualified
35 health care professional who is contracted with the
36 insurer.

37 (f) If the insured is requesting a second opinion about
38 care from a specialist, the second opinion shall be
39 provided by any contracted provider of the same
40 specialty.



1 (g) The insured shall obtain services only from a
2 provider who is participating in, or under contract with,
3 the insurer pursuant to the specific contract between the
4 insurer and the insured. The insurer may limit referrals
5 to its network of providers if there is a participating
6 provider who meets the standard specified in subdivision
7 (b). If there is no participating provider who meets this
8 standard, then the insurer shall authorize a second
9 opinion by an appropriately qualified health professional
10 outside of the insurer's provider network. In approving a
11 referral for a second opinion either inside or outside of the
12 insurer's provider network, the insurer shall take into
13 account the ability of the insured to travel to the provider.

14 (h) The insurer shall require the second opinion
15 health professional to provide the insured and the initial
16 health professional with a consultation report, including
17 any recommended procedures or tests that the second
18 opinion health professional believes appropriate.
19 Nothing in this section shall be construed to prevent the
20 insurer from authorizing, based on its independent
21 determination, additional medical opinions concerning
22 the medical condition of an insured.

23 (i) If the insurer denies a request by an insured for a
24 second opinion, it shall notify the insured in writing of the
25 reasons for the denial and shall inform the insured of the
26 right to dispute the claim.

27 (j) This section shall not apply to any policy or contract
28 of disability insurance that covers hospital, medical, or
29 surgical expenses and that does not limit second opinions,
30 subject to all other terms and conditions of the contract.

31 (k) This section shall not apply to accident-only,
32 specified disease, hospital indemnity, or long-term care
33 health insurance policies.

34 SEC. 3. No reimbursement is required by this act
35 pursuant to Section 6 of Article XIII B of the California
36 Constitution because the only costs that may be incurred
37 by a local agency or school district will be incurred
38 because this act creates a new crime or infraction,
39 eliminates a crime or infraction, or changes the penalty
40 for a crime or infraction, within the meaning of Section



1 17556 of the Government Code, or changes the definition
2 of a crime within the meaning of Section 6 of Article
3 XIII B of the California Constitution.

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