

Assembly Bill No. 2168

CHAPTER 426

An act to amend, add, and repeal Section 1374.16 of the Health and Safety Code, relating to health care.

[Approved by Governor September 12, 2000. Filed
with Secretary of State September 13, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2168, Gallegos. Health care coverage.

Existing law provides for regulation and licensing of health care service plans by the Department of Managed Care, effective no later than July 1, 2000, or earlier pursuant to an Executive Order of the Governor. A willful violation of the provisions governing health care service plans is a crime. Existing law requires every health care service plan, except a specialized health care service plan, to establish and implement procedures by which an enrollee could receive a standing referral, as defined, to a specialist and by which an enrollee with a condition or disease that requires specialized care over a prolonged period of time and is life-threatening, degenerative, or disabling could receive a referral to a specialist who, or a specialty care center, as defined, that, has expertise in treating the condition or disease for the purpose of having the specialist, or the specialty care center, coordinate the enrollee's health care.

This bill would require, until January 1, 2004, or an earlier determined date, that human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) be interpreted broadly as a "condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling" so as to maximize the access of an enrollee with HIV or AIDS to a provider with demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring of the patient's adherence to the regimen.

Because a violation of this bill's requirements with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program by expanding the definition of an existing 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.

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

SECTION 1. Section 1374.16 of the Health and Safety Code is amended to read:

1374.16. (a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the



determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

(g) As used in this section, with regard to an enrollee with human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), "a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling" shall be interpreted broadly so as to maximize the enrollee's access to provider with demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring of the patient's adherence to the regimen.

(h) This section shall become inoperative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier, and, as of January 1, 2004, or of the January 1 following the inoperative date whichever date is earlier, is repealed, unless a later enacted statute that is enacted before those dates deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1374.16 is added to the Health and Safety Code, to read:

1374.16. (a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure



by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.



(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, “specialty care center” means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a “standing referral” means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

(g) This section shall become operative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier.

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.

