

AMENDED IN SENATE APRIL 29, 1999

AMENDED IN SENATE APRIL 15, 1999

AMENDED IN SENATE APRIL 6, 1999

SENATE BILL

No. 18

Introduced by Senator Figueroa

(Coauthors: Senators Escutia and Speier)

(Coauthors: Assembly Members Alquist, Aroner, Corbett, Jackson, Kuehl, Longville, Romero, Thomson, and Washington)

December 7, 1998

An act to add Section 733 to the Business and Professions Code, to amend Section 1363.5 of, and to add Section 1368.07 to, the Health and Safety Code, and to add ~~Sections 791.28 and~~ Section 10123.91 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 18, as amended, Figueroa. Health care.

Existing law provides for the regulation and licensure, certification, or registration of various healing arts professionals.

This bill would provide that any decision or recommendation regarding the necessity or appropriateness of treatment or care that results in the denial or revision of the treatment or care originally ordered for a particular patient constitutes the practice of a healing arts profession to the same extent as the performance of the treatment or care itself, and such a decision or recommendation shall be performed only

by a healing arts licentiate acting within his or her scope of practice who possesses a valid license under law that authorizes the licentiate to make or perform the treatment or care. The bill would specify various exceptions to these provisions. The bill would provide that a violation of these provisions by a healing arts licentiate constitutes unprofessional conduct and grounds for suspension or revocation of the license, certification, or registration of the licentiate. The bill would also provide that a violation of these provisions is a misdemeanor punishable by imprisonment in a county jail not exceeding 6 months, or by a fine not exceeding \$2,500, or both. By creating a new crime, the bill would impose a state-mandated local program.

Existing law provides for the licensure and regulation of health care service plans by the Department of Corporations, and of disability insurers by the Department of Insurance.

Existing law requires a health care service plan to disclose to the commissioner, providers under contract with the plan, and enrollees or persons designated by enrollees, the ~~processes~~ *process* the plan uses to authorize or deny health care services by a provider pursuant to the benefits provided by the plan. Existing law also requires the criteria used by health care service plans to determine whether to authorize or deny health care services to, among other things, be developed with involvement from actively practicing health care providers.

This bill would require that disclosure to also be made to any person or organization, upon request, and would require the criteria to instead be determined by physicians and surgeons, nurses, or other appropriately licensed or certified health care professionals, as specified, and to be available to the public, upon request.

~~The bill would also make those disclosure requirements applicable to certain disability insurers.~~

~~This bill would prohibit a health care service plan from refusing to authorize health care services determined to be medically appropriate and necessary by the patient's physician or other appropriately licensed health care provider who contracts with the plan, unless certain conditions are satisfied. It would also prohibit a disability insurer from~~



~~refusing to reimburse for health care services within the scope of the contract, or if the insurer requires preapproval of health care services, from refusing to preapprove health care services determined to be medically necessary by the patient's physician or other appropriately licensed health care provider who contracts with the insurer, unless certain conditions are satisfied. It would prescribe certain administrative penalties against disability insurers for violations of those provisions.~~

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This bill would require a health care service plan to disclose the specific rationale used in rejecting a patient's health care claim, as specified.

This bill would also require certain disability insurers to have written policies and procedures establishing the process by which the insurer prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers of health care services for insureds, as specified.

Because a willful violation of the above requirements and prohibitions by a health care service plan would be subject to criminal sanction, this bill would impose a state-mandated local program by changing the definition 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.

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 733 is added to the Business and
- 2 Professions Code, to read:
- 3 733. (a) Any decision or recommendation regarding
- 4 the necessity or appropriateness of treatment or care that
- 5 results in the denial or revision of the treatment or care
- 6 originally ordered for a particular patient constitutes the



1 practice of a healing arts profession to the same extent as
2 the performance of the treatment or care itself, and shall
3 be performed only by a healing arts licentiate acting
4 within his or her scope of practice who possesses a valid
5 license issued pursuant to the Chiropractic Initiative Act
6 of California, the Osteopathic Initiative Act of California,
7 or this division that authorizes the licentiate to make or
8 perform the treatment or care.

9 (b) This section does not apply to any decision or
10 recommendation regarding the necessity or
11 appropriateness of treatment or care made by a person
12 licensed pursuant to Chapter 5 (commencing with
13 Section 2000).

14 (c) Nothing in this section shall apply to claims
15 decisions made pursuant to Division 4 (commencing with
16 Section 3200) of the Labor Code.

17 (d) Nothing in this section shall preclude actions taken
18 pursuant to Section 1370.4 of the Health and Safety Code
19 or Section 10145.3 of the Insurance Code.

20 (e) Nothing in this section shall apply to claim
21 decisions made under automobile or homeowners
22 insurance policies.

23 (f) Nothing in this section shall be construed as
24 limiting the exercise of any treatment by prayer, or as
25 interfering in any way with the practice of religion as set
26 forth in Section 2063 or 2731.

27 (g) Any violation of this section is a misdemeanor,
28 punishable by imprisonment in a county jail not
29 exceeding six months, or by a fine not exceeding two
30 thousand five hundred dollars (\$2,500), or by both the
31 fine and imprisonment. A violation by a healing arts
32 licentiate also constitutes unprofessional conduct and
33 grounds for suspension or revocation of his or her license,
34 certification, or registration. Disciplinary proceedings to
35 suspend or revoke a license shall be conducted by the
36 relevant licensing, certifying, or registering body in
37 accordance with Chapter 5 (commencing with Section
38 11500) of Part 1 of Division 3 of Title 2 of the Government
39 Code and all other applicable laws and regulations.



1 (h) Nothing in this section shall cause a health care
2 service plan or managed care entity, *as described in*
3 *subdivision (f) of Section 1345 of the Health and Safety*
4 *Code*, to be defined as a health care provider under any
5 provision of law. Nothing in this section shall restrict,
6 diminish, repeal, abrogate, or limit any other theory of
7 liability otherwise available at law, including, but not
8 limited to, under Section 2400 or under Section 1342 or
9 1367 of the Health and Safety Code.

10 SEC. 2. Section 1363.5 of the Health and Safety Code
11 is amended to read:

12 1363.5. (a) A plan shall disclose or provide for the
13 disclosure to the commissioner and providers under
14 contract with the plan the process the plan uses to
15 authorize or deny health care services under the benefits
16 provided by the plan, including coverage for subacute
17 care, transitional inpatient care, or care provided in
18 skilled nursing facilities. A plan shall also disclose those
19 processes to enrollees or persons designated by an
20 enrollee, or to any other person or organization, upon
21 request. The criteria used by plans to determine whether
22 to authorize or deny health care services shall:

23 (1) Be determined by physicians and surgeons, nurses,
24 or other appropriately licensed or certified health care
25 professionals who are acting within their existing scope of
26 practice ~~and are actively providing direct care to patients~~
27 *or other health care professionals or researchers with*
28 *expertise in the particular field.*

29 (2) Be developed using sound clinical principles and
30 processes.

31 (3) Be evaluated, and updated if necessary, at least
32 annually.

33 (4) If used as the basis of a decision to deny services in
34 a specified case under review, be disclosed to the
35 provider or the enrollee, or both, in that specified case,
36 upon request.

37 (5) Be available to the public upon request.

38 (b) Subdivision (a) shall not apply to plans that, prior
39 to January 1, 1995, have entered into a contract with an
40 entity that performs determinations for the authorization



1 of health care services to plan enrollees where the
2 contract prohibits disclosure of utilization guidelines and
3 other procedures used to make those determinations.
4 Plans that have existing contracts of this type prior to
5 January 1, 1995, shall not be subject to subdivision (a)
6 until January 1, 1996.

7 *(c) For purposes of this section, the processes for*
8 *approval or denial shall not violate Section 2063 or 2731*
9 *of the Business and Professions Code with respect to*
10 *treatment by prayer.*

11 SEC. 3. Section 1368.07 is added to the Health and
12 Safety Code, to read:

13 ~~1368.07. (a) Except as otherwise provided in~~
14 ~~subdivision (b), in arranging for medical care and in~~
15 ~~providing direct care to a patient, no health care service~~
16 ~~plan shall refuse to authorize health care services if both~~
17 ~~of the following conditions exist:~~

18 ~~(1) The patient's physician or other appropriately~~
19 ~~licensed health care provider determines the services to~~
20 ~~be medically necessary or appropriate.~~

21 ~~(2) The patient's physician or other appropriately~~
22 ~~licensed health care provider has a contractual~~
23 ~~relationship with the health care service plan.~~

24 ~~(b) Subdivision (a) shall not apply if the employee or~~
25 ~~contractor who authorizes the denial on behalf of the~~
26 ~~health care service plan, or designee of the employee or~~
27 ~~contractor, meets both of the following requirements:~~

28 ~~(1) He or she has examined the patient's medical~~
29 ~~records or, if the original treating physician or other~~
30 ~~appropriately licensed health care provider finds that any~~
31 ~~of the following circumstances exist, he or she has~~
32 ~~physically examined the patient in a timely manner:~~

33 ~~(A) There is or reasonably appears to be a danger of~~
34 ~~significant impairment to the patient's bodily functions.~~

35 ~~(B) There is or reasonably appears to be a significant~~
36 ~~dysfunction of any bodily organ or part.~~

37 ~~(C) The patient's health is otherwise in significant~~
38 ~~jeopardy.~~

39 ~~(2) He or she is an appropriately licensed health care~~
40 ~~professional with the education, training, and relevant~~



1 ~~experience that is appropriate for evaluating the specific~~
2 ~~clinical issues involved in the denial.~~

3 ~~(e) A health care service plan shall, upon rejecting a~~
4 ~~claim regarding a patient's health care, and upon the~~
5 ~~patient's demand, disclose within five working days of the~~
6 ~~demand the specific rationale used in rejecting that~~
7 ~~claim. Nothing in this section shall expand or restrict the~~
8 ~~ability of a patient to obtain approval of health care~~
9 ~~coverage in advance of the performance of services.~~

10 ~~(d) Nothing in this section shall restrict, diminish, or~~
11 ~~repeal any civil remedy to which a patient is otherwise~~
12 ~~entitled, or abrogate any rights a patient may have under~~
13 ~~Section 2400 of the Business and Professions Code or~~
14 ~~under Section 1342 or 1367. Nothing in this section shall~~
15 ~~preclude the use of utilization review or utilization~~
16 ~~management that is consistent with this section.~~

17 ~~SEC. 4. Section 791.28 is added to the Insurance Code,~~
18 ~~to read:~~

19 ~~791.28. A disability insurer that provides coverage for~~
20 ~~hospital, medical, or surgical expenses shall disclose or~~
21 ~~provide for the disclosure to the commissioner and~~
22 ~~providers under contract with the insurer the process the~~
23 ~~insurer uses to authorize or deny health care services or~~
24 ~~payment for health care services under the benefits~~
25 ~~provided by the insurer, including coverage for subacute~~
26 ~~care, transitional inpatient care, or care provided in~~
27 ~~skilled nursing facilities. An insurer shall also disclose~~
28 ~~those processes to policyholders or persons designated by~~
29 ~~a policyholder, or to any other person or organization,~~
30 ~~upon request. The criteria used by insurers to determine~~
31 ~~whether to authorize or deny health care services or~~
32 ~~payment for health care services shall:~~

33 ~~(a) Be determined by physicians and surgeons, nurses,~~
34 ~~or other appropriately licensed or certified health care~~
35 ~~professionals who are acting within their existing scope of~~
36 ~~practice and actively providing direct care to patients.~~

37 ~~(b) Be developed using sound clinical principles and~~
38 ~~processes.~~

39 ~~(c) Be evaluated, and updated if necessary, at least~~
40 ~~annually.~~



1 ~~(d) If used as the basis of a decision to deny services in~~
2 ~~a specified case under review, be disclosed to the~~
3 ~~provider or the policyholder, or both, in that specified~~
4 ~~case, upon request.~~

5 ~~(e) Be available to the public upon request.~~

6 ~~SEC. 5. Section 10123.91 is added to the Insurance~~
7 ~~Code, to read:~~

8 ~~10123.91. (a) Except as otherwise provided in~~
9 ~~subdivision (b), in arranging for medical care and in~~
10 ~~providing direct care to a patient, no disability insurer~~
11 ~~shall refuse to reimburse for health care services within~~
12 ~~the scope of the contract or, if the disability insurer~~
13 ~~requires preapproval of health care services, shall refuse~~
14 ~~to preapprove health care services if both of the following~~
15 ~~conditions exist:~~

16 ~~(1) The patient's physician or other appropriately~~
17 ~~licensed health care provider determines the services to~~
18 ~~be medically appropriate and necessary.~~

19 ~~(2) The patient's physician or other appropriately~~
20 ~~licensed health care provider has a contractual~~
21 ~~relationship with the disability insurer.~~

22 ~~(b) Subdivision (a) shall not apply if the employee or~~
23 ~~contractor who authorizes the denial on behalf of the~~
24 ~~disability insurer, or a designee of the employee or~~
25 ~~contractor, meets both of the following requirements:~~

26 ~~(1) He or she has examined the patient's medical~~
27 ~~records or, if the disability insurer requires preapproval~~
28 ~~of health care services and the original treating physician~~
29 ~~or other appropriately licensed health care provider finds~~
30 ~~that any of the following circumstances exist, he or she has~~
31 ~~physically examined the patient in a timely manner:~~

32 ~~(A) There is or reasonably appears to be a danger of~~
33 ~~significant impairment to the patient's bodily functions.~~

34 ~~(B) There is or reasonably appears to be a significant~~
35 ~~dysfunction of any bodily organ or part.~~

36 ~~(C) The patient's health is otherwise in significant~~
37 ~~jeopardy.~~

38 ~~(2) He or she is an appropriately licensed health care~~
39 ~~professional with the education, training, and relevant~~



1 ~~experience that is appropriate for evaluating the specific~~
2 ~~clinical issues involved in the denial.~~

3 ~~(c) A disability insurer shall, upon rejecting a claim~~
4 ~~regarding a patient's health care, and upon the patient's~~
5 ~~demand, disclose within five working days of the demand~~
6 ~~the specific rationale used in rejecting that claim.~~
7 ~~Nothing in this section shall expand or restrict the ability~~
8 ~~of a patient to obtain approval of health care coverage in~~
9 ~~advance of the performance of services.~~

10 ~~(d) Nothing in this section shall restrict, diminish, or~~
11 ~~repeal any civil remedy to which a patient is otherwise~~
12 ~~entitled, or abrogate any rights a patient may have under~~
13 ~~Section 2400 of the Business and Professions Code or~~
14 ~~under Section 1342 or 1367 of the Health and Safety Code.~~
15 ~~Nothing in this section shall preclude the use of utilization~~
16 ~~review or utilization management that is consistent with~~
17 ~~this section.~~

18 ~~(e) Nothing in this section shall be construed as~~
19 ~~limiting the exercise of any treatment by prayer, or as~~
20 ~~interfering with the practice of religion or the care of the~~
21 ~~sick in connection with the practice of religious tenets, as~~
22 ~~defined by Section 2063 or 2731 of the Business and~~
23 ~~Professions Code.~~

24 ~~(f) (1) In addition to any other penalty permitted by~~
25 ~~law, the commissioner shall have the administrative~~
26 ~~authority to assess penalties specified in this subdivision~~
27 ~~against disability insurers for violations of this section.~~

28 ~~(2) Any disability insurer that violates this section is~~
29 ~~liable for administrative penalties of not more than two~~
30 ~~thousand five hundred dollars (\$2,500) for the first~~
31 ~~violation and not more than five thousand dollars (\$5,000)~~
32 ~~for each subsequent violation.~~

33 ~~(3) Any disability insurer that violates this section with~~
34 ~~a frequency that indicates a general business practice or~~
35 ~~commits a knowing violation of this section is liable for~~
36 ~~administrative penalties of not less than fifteen thousand~~
37 ~~dollars (\$15,000) and not more than one hundred~~
38 ~~thousand dollars (\$100,000) for each violation.~~

39 ~~SEC. 6.~~



1 SEC. 4. Section 10123.91 is added to the Insurance
2 Code, to read:

3 10123.91. (a) Every disability insurer that covers
4 hospital, medical, or surgical expenses and that
5 prospectively or concurrently reviews and approves,
6 modifies, or denies, based in whole or in part on medical
7 necessity or appropriateness, requests by providers prior
8 to, or concurrent with, the provision of health care
9 services to insureds, or that delegates these functions to
10 contracting providers, shall comply with this section.

11 (b) A disability insurer that is subject to this section
12 shall have written policies and procedures establishing
13 the process by which the insurer prospectively or
14 concurrently reviews and approves, modifies, or denies,
15 based in whole or in part on medical necessity or
16 appropriateness, requests by providers of health care
17 services for insureds. These policies and procedures shall
18 ensure that decisions based on medical necessity or
19 appropriateness of a proposed health care service are
20 supported by criteria developed pursuant to subdivision
21 (c). These policies and procedures, and a description of
22 the process by which an insurer reviews and approves,
23 modifies, or denies requests by providers prior to, or
24 concurrent with, the provision of health care services to
25 insureds, shall be filed with the commissioner, and shall
26 be disclosed to insureds and providers upon request, and
27 by the commissioner to the public upon request.

28 (c) If an insurer subject to this section uses clinical
29 criteria to determine whether to approve, modify, or
30 deny requests by providers prior to, or concurrent with,
31 the provision of health care services to insureds, the
32 criteria shall:

33 (1) Be determined by physicians and surgeons, nurses,
34 or other appropriately licensed or certified health care
35 professionals who are acting within their existing scope of
36 practice, or other health care professionals or researchers
37 with expertise in the particular field.

38 (2) Be developed using sound clinical principles and
39 processes.



1 (3) *Be evaluated, and updated if necessary, at least*
2 *once annually.*

3 (d) *If an insurer subject to this section requests*
4 *medical information from providers in order to*
5 *determine whether to approve, modify, or deny requests*
6 *for authorization, the insurer shall request only the*
7 *information reasonably necessary to make the*
8 *determination.*

9 (e) *For purposes of this section, the processes for*
10 *approval, modification, or denial shall not violate Section*
11 *2063 or 2731 of the Business and Professions Code with*
12 *respect to treatment by prayer.*

13 SEC. 5. No reimbursement is required by this act
14 pursuant to Section 6 of Article XIII B of the California
15 Constitution because the only costs that may be incurred
16 by a local agency or school district will be incurred
17 because this act creates a new crime or infraction,
18 eliminates a crime or infraction, or changes the penalty
19 for a crime or infraction, within the meaning of Section
20 17556 of the Government Code, or changes the definition
21 of a crime within the meaning of Section 6 of Article
22 XIII B of the California Constitution.

