AMENDED IN SENATE MAY 20, 2009

SENATE BILL No. 630

Introduced by Senator Steinberg
(Coauthor: Senator Alquist)

February 27, 2009

An act to amend Section 1367.63 of the Health and Safety Code, and to amend Section 10123.88 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 630, as amended, Steinberg. Health care coverage: reconstructive surgery: dental and orthodontic services.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. A willful violation of the provisions governing health care service plans is a crime. Existing law requires health care service plan contracts and health insurance policies to cover reconstructive surgery, as defined.

This bill would provide that the requirement to cover reconstructive surgery includes dental or orthodontic services that are medically necessary ~~and related~~ to *provide or complete* the reconstructive surgery, *except as specified*. Because a willful violation of the provision by a health care service plan ~~is~~ *would be* a crime, 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:

SECTION 1. Section 1367.63 of the Health and Safety Code is amended 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 paragraph (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) (1) "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:

(A) To improve function.

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

(2) No plan contract shall exclude coverage for dental or orthodontic services that are ~~related to, and~~ medically necessary to provide or complete~~,~~ the reconstructive surgery required by this section.

(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 Care Services.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14590) of, Part 3 of Division 9 of the Welfare and Institutions Code, where such contracts do not provide coverage for California Children's Services (CCS) or dental services.

SEC. 2. Section 10123.88 of the Insurance Code is amended to read:

10123.88. (a) Every policy of health 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 paragraph (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) (1) "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:

(A) To improve function.

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

(2) No policy shall exclude coverage for dental or orthodontic services that are ~~related to, and~~ medically necessary to provide or complete~~,~~ the reconstructive surgery required by this section.

(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. 3. It is the intent of the Legislature to clarify and confirm that any dental or orthodontic services, when ~~related to and~~ medically necessary to provide or complete reconstructive surgery,

are services that are already required by the statutory provisions amended by this act.

SEC. 4. 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.

O