
Existing law provides for regulation of health care service plans by the Department of Managed Health Care. Existing law provides for regulation of health insurers by the Insurance Commissioner. A willful violation of the provisions governing health care service plans is a crime. Existing law requires health care service plans and health insurers to offer coverage for acupuncture under a group plan or policy, with certain exceptions.

This bill would require health care service plans and health insurers to provide, rather than to offer, coverage for acupuncture under a group plan or policy, and would delete the exceptions from that requirement. Because the bill would impose new requirements on health care service plans, the willful violation of which would be a crime, it 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.

Existing workers’ compensation law generally requires employers to secure the payment of workers’ compensation, including acupuncture treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law requires the administrative director to adopt a medical treatment utilization schedule, as specified, that is required to address the frequency, duration, intensity, and appropriateness of all treatment procedures— and modalities—commonly performed in workers’ compensation cases.

This bill would define acupuncture treatment to mean treatment based upon these guidelines or, prior to the adoption of these guidelines, the specified guidelines published by the Council of Acupuncture and Oriental Medicine Association and the Foundation for Acupuncture Research, including specified information.


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

SECTION 1. Section 1373.10 of the Health and Safety Code is amended to read:

1373.10. (a) On and after January 1, 1985, every health care service plan, that is not a health maintenance organization or is not a plan that enters exclusively into specialized health care service plan contracts, as defined by subdivision (n) of Section 1345, which provides coverage for hospital, medical, or surgical expenses, shall offer coverage to group contract holders for expenses incurred as a result of treatment by holders of certificates under Section 4938 of the Business and Professions Code, under such terms and conditions as may be agreed upon between the health care service plan and the group-contract holder.

A health care service plan is not required to offer the coverage provided by this section as part of any contract covering employees of a public entity.
(b) For the purposes of this section, “health maintenance organization” or “HMO” means a public or private organization, organized under the laws of this state, which does all of the following:

(1) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage.

(2) Is compensated, except for copayments, for the provision of basic health care services listed in paragraph (1) to enrolled participants on a predetermined periodic rate basis.

(3) Provides physician services primarily directly through physicians who are either employees or partners of the organization, or through arrangements with individual physicians or one or more groups of physicians, organized on a group practice or individual practice basis.

SEC. 2
Section 10127.3 of the Insurance Code is amended to read:

10127.3. On and after January 1, 1985, every insurer issuing group disability health insurance which covers hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of treatment by holders of certificates licenses under Section 4938 of the Business and Professions Code, under such terms and conditions as may be agreed upon between the group policyholder and the insurer.

An insurer is not required to offer the coverage provided by this section as part of any policy covering employees of a public entity.

SEC. 3
Section 10176 of the Insurance Code is amended to read:

10176. In disability health insurance, the policy may provide for payment of medical, surgical, chiropractic, physical therapy, speech pathology, audiology, acupuncture, professional mental health, dental, hospital, or optometric expenses upon a reimbursement basis, or for the exclusion of any of those services, and provision may be made therein for payment of all or a portion of the amount of charge for those services without requiring that the insured first pay the expenses. The policy shall not prohibit the insured from selecting any psychologist or other person who is the holder of a certificate or license under Section 1000, 1634,
If the insured selects any person who is a holder of a certificate under Section 4938 of the Business and Professions Code, a disability insurer or nonprofit hospital service plan shall pay the bona fide claim of an acupuncturist holding a certificate pursuant to Section 4938 of the Business and Professions Code for the treatment of an insured person only if the insured’s policy or contract expressly includes acupuncture as a benefit and includes coverage for the injury or illness treated. Unless the policy or contract expressly includes acupuncture as a benefit, no person who is the holder of any license or certificate set forth in this section shall be paid or reimbursed under the policy for acupuncture.

Nor shall the policy prohibit the insured, upon referral by a physician and surgeon licensed under Section 2050 of the Business and Professions Code, from selecting any licensed clinical social worker who is the holder of a license issued under Section 4996 of the Business and Professions Code or any occupational therapist as specified in Section 2570.2 of the Business and Professions Code, or any marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, to perform the particular services covered under the terms of the policy, or from selecting any speech-language pathologist or audiologist licensed under Section 2532 of the Business and Professions Code or any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master’s degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing or any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, or any respiratory care practitioner certified pursuant to Chapter 8.3 (commencing with Section 3700) of Division 2 of the Business and Professions Code to perform services deemed necessary by the referring physician,
that certificate holder, licensee or otherwise regulated person, being expressly authorized by law to perform the services.

Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional mental health services beyond his or her field or fields of competence as established by his or her education, training, and experience. For the purposes of this section, “marriage and family therapist” means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions that is equivalent to the instruction required for licensure on January 1, 1981.

An individual disability health insurance policy, which is issued, renewed, or amended on or after January 1, 1988, which includes mental health services coverage may not include a lifetime waiver for that coverage with respect to any applicant. The lifetime waiver of coverage provision shall be deemed unenforceable.

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.

SECTION 1. The Legislature hereby finds and declares all of the following:
(a) In order to encourage the more effective utilization of acupuncture and oriental medicine services, to provide California citizens a holistic approach, and to promote the health, safety, and welfare of the public, the Legislature created the Acupuncture Licensure Act as a framework to establish a profession that would provide these services.
(b) There are reports of shortages of qualified health care professionals who can address the needs of citizens who suffer from pain, work related injuries, and other nonlife-threatening illnesses.
(c) The National Institutes of Health has adopted a Consensus Statement on Acupuncture, recognizing a need for utilizing acupuncture in the American system of health care.

(d) For these reasons and others, acupuncture has been a common and effective treatment for work-related injuries and should continue to be a medical treatment choice for injured workers.

SEC. 2. Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines.

(c) As used in this division and notwithstanding any other provision of law, acupuncture treatment that is reasonable required to relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, as set forth in the “Acupuncture and Electroacupuncture: Evidence-Based Treatment Guidelines—August 2004” published by the Council of Acupuncture and Oriental Medicine Associations and the Foundation for Acupuncture Research, and which shall include any subsequent updates of those guidelines or other guidelines. Nothing in this section shall prohibit the administrative director from adopting treatment guidelines for acupuncture if those guidelines are at least as comprehensive as the “Acupuncture and Electroacupuncture: Evidence-Based Treatment Guidelines—August 2004.”
(d) Unless the employer or the employer’s insurer has established a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

(e) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if either of the following conditions exist:

(A) The employer provides nonoccupational group health coverage in a health care service plan, licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) The employer provides nonoccupational health coverage in a group health plan or a group health insurance policy as described in Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) The physician is the employee’s regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) The physician is the employee’s primary care physician and has previously directed the medical treatment of the employee, and who retains the employee’s medical records, including his or her medical history. “Personal physician” includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employer provides nonoccupational health care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and
Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employer provides nonoccupational health care, as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(7) The division shall conduct an evaluation of this program and present its findings to the Governor and the Legislature on or before December 31, 2008.

(8) This subdivision shall remain in effect only until December 31, 2009, and as of that date is repealed, unless a later enacted statute that is enacted before December 31, 2009, deletes or extends that date.

(f) (1) When at the request of the employer, the employer’s insurer, the administrative director, the appeals board, or a workers’ compensation administrative law judge, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, “reasonable expenses of transportation” includes mileage fees from the employee’s home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director
of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

(g) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.