ASSEMBLY BILL

No. 1084

Introduced by Assembly Member Maddox

February 20, 2003

An act to amend Section 1373 of, and to add Section 1373.35 to, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL’S DIGEST

AB 1084, as introduced, Maddox. Vision care benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under existing law, a plan may provide for coverage of, or exclusion of, vision care services.

This bill would instead require a plan that offers vision care benefits to contract with sufficient optometrists and physicians so that an enrollee has a choice between obtaining services from a physician or an optometrist. The bill would prohibit a plan from prohibiting an enrollee from selecting a provider from either profession to render vision care services. The bill would authorize a plan to require enrollees to select from a list of specified providers.

Because the bill would impose additional requirements on health care service plans, the willful violation of which is 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.
AB 1084


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

SECTION 1. Section 1373 of the Health and Safety Code is amended to read:

1373. (a) A plan contract may not provide an exception for other coverage if the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

Each plan contract shall be interpreted not to provide an exception for the Medi-Cal or medicaid benefits.

A plan contract shall not provide an exemption for enrollment because of an applicant’s entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to the Medi-Cal or medicaid benefits.

(b) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual’s reason for sterilization.

As used in this section, “sterilization operations or procedures” shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child’s birth parent or other appropriate
legal authority signs a written document, including, but not limited
to, a health facility minor release report, a medical authorization
form, or a relinquishment form, granting the subscriber or spouse
the right to control health care for the adoptive child or, absent this
written document, on the date there exists evidence of the
subscriber’s or spouse’s right to control the health care of the child
placed for adoption. No plan may be entered into or amended if it
contains any disclaimer, waiver, or other limitation of coverage
relative to the coverage or insurability of newborn infants of, or
children placed for adoption with, a subscriber or spouse covered
as required by this subdivision.

(d) Every plan contract that provides that coverage of a
dependent child of a subscriber shall terminate upon attainment of
the limiting age for dependent children specified in the plan, shall
also provide in substance that attainment of the limiting age shall
not operate to terminate the coverage of the child while the child
is and continues to be both (1) incapable of self-sustaining
employment by reason of mental retardation or physical handicap
and (2) chiefly dependent upon the subscriber for support and
maintenance, provided proof of the incapacity and dependency is
furnished to the plan by the member within 31 days of the request
for the information by the plan or group plan contractholder and
subsequently as may be required by the plan or group plan
contractholder, but not more frequently than annually after the
two-year period following the child’s attainment of the limiting
age.

(e) A plan contract that provides coverage, whether by specific
benefit or by the effect of general wording, for both an employee
and one or more covered persons dependent upon the employee
and provides for an extension of the coverage for any period
following a termination of employment of the employee shall also
provide that this extension of coverage shall apply to dependents
upon the same terms and conditions precedent as applied to the
covered employee, for the same period of time, subject to payment
of premiums, if any, as required by the terms of the policy and
subject to any applicable collective bargaining agreement.

(f) A group contract shall not discriminate against handicapped
persons or against groups containing handicapped persons.
Nothing in this subdivision shall preclude reasonable provisions
in a plan contract against liability for services or reimbursement
of the handicap condition or conditions relating thereto, as may be
allowed by rules of the director.

(g) Every group contract shall set forth the terms and
conditions under which subscribers and enrollees may remain in
the plan in the event the group ceases to exist, the group contract
is terminated or an individual subscriber leaves the group, or the
enrollees’ eligibility status changes.

(h) (1) A health care service plan or specialized health care
service plan may provide for coverage of, or for payment for,
professional mental health services, or vision care services, or for
the exclusion of these services—this service. If the terms and
conditions include coverage for services provided in a general
acute care hospital or an acute psychiatric hospital as defined in
Section 1250 and do not restrict or modify the choice of providers,
the coverage shall extend to care provided by a psychiatric health
facility as defined in Section 1250.2 operating pursuant to
licensure by the State Department of Mental Health. A health care
service plan that offers outpatient mental health services but does
not cover these services in all of its group contracts shall
communicate to prospective group contractholders as to the
availability of outpatient coverage for the treatment of mental or
nervous disorders.

(2) No plan shall prohibit the member from selecting any
psychologist who is licensed pursuant to the Psychology Licensing
Law (Chapter 6.6 (commencing with Section 2900) of Division 2
of the Business and Professions Code), any optometrist who is the
holder of a certificate issued pursuant to Chapter 7 (commencing
with Section 3000) of Division 2 of the Business and Professions
Code or, upon referral by a physician and surgeon licensed
pursuant to the Medical Practice Act (Chapter 5 (commencing
with Section 2000) of Division 2 of the Business and Professions
Code), (i) any marriage and family therapist who is the holder of
a license under Section 4980.50 of the Business and Professions
Code, (ii) any licensed clinical social worker who is the holder of
a license under Section 4996 of the Business and Professions
Code, (iii) 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 (iv) 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, to perform the
particular services covered under the terms of the plan, and the
certificate holder is expressly authorized by law to perform these
services.

(3) 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.

(4) 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 which is
equivalent to the instruction required for licensure on January 1,
1981.

(5) Nothing in this section shall be construed to allow a member
to select and obtain mental health or psychological or vision care
services from a certificate or license holder who is not directly
affiliated with or under contract to the health care service plan or
specialized health care service plan to which the member belongs.
All health care service plans and individual practice associations
that offer mental health benefits shall make reasonable efforts to
make available to their members the services of licensed
psychologists. However, a failure of a plan or association to
comply with the requirements of the preceding sentence shall not
constitute a misdemeanor.

(6) As used in this subdivision, “individual practice
association” means an entity as defined in subsection (5) of
Section 1307 of the federal Public Health Service Act (42 U.S.C.
Sec. 300e-1, subsec. (5)).

(7) Health care service plan coverage for professional mental
health services may include community residential treatment
services that are alternatives to inpatient care and that are directly
affiliated with the plan or to which enrollees are referred by
providers affiliated with the plan.
(i) If the plan utilizes arbitration to settle disputes, the plan contracts shall set forth the type of disputes subject to arbitration, the process to be utilized, and how it is to be initiated.

(j) A plan contract that provides benefits that accrue after a certain time of confinement in a health care facility shall specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requisite to the commencement of benefits.

SEC. 2. Section 1373.35 is added to the Health and Safety Code, to read:

1373.35. (a) For purposes of this section, ‘vision care’ includes, but is not limited to, comprehensive primary eye care services, medical eye conditions, and emergency care.

(b) A health care service plan that offers vision care benefits shall contract with sufficient providers to offer enrollees a meaningful, accessible, and adequate choice between an optometrist licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code and a physician and surgeon licensed pursuant to the Medical Practice Act in Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code for services within the scope of the provider’s license.

(c) A plan may not prohibit an enrollee who is entitled to vision care that may be rendered by either an optometrist or a physician and surgeon within the scope of the provider’s license from selecting a provider from either profession to render the service as long as the provider has not been removed or suspended from participation in the plan for cause.

(d) A plan may prepare a list of providers and require enrollees to select a provider on the list as a condition of payment by the plan for the services. If a particular service may be performed by either an optometrist or a physician and surgeon, the list shall contain a sufficient number of both types of providers to assure enrollees an adequate choice.

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.