An act to amend Section 1373 of, and to add Sections 1373.35 and 1373.45 to, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL’S DIGEST

AB 1927, as amended, Cohn. 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, and makes a violation of the act a crime. Under existing law, a plan may provide for coverage of, or exclusion of, vision care services, and prohibits a plan from prohibiting a member from selecting an optometrist for vision care services.

This bill would instead require a plan that offers vision care benefits to contract with both optometrists and physicians and surgeons. The bill would prohibit a plan that provides for coverage of vision care services from discriminating against or refusing to contract with a clinic that provides vision care services, and would make a plan that violates that provision ineligible for any contract or to receive any funds under the Healthy Families or Medi-Cal programs.

Because a willful violation of the bill’s requirements with respect to health care service plans would be a crime, it would impose a state-mandated local program by creating new crimes.

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 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 for the exclusion of these services. 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) 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 services from a certificate or licenseholder 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) Except for specialized health care service plans, every health care service plan entered into, amended, or renewed on or after January 1, 2005, that provides vision or medical eye care services or procedures, shall contract with both optometrists licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code and physicians and surgeons licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(b) A health care service plan shall allow contracting optometrists to provide vision and medical eye care services and procedures and to participate to the full extent of their license. Vision and medical care services and procedures include, but are not limited to, comprehensive primary eye care services, treatment of medical eye conditions, and emergency care.

(c) A plan may require an optometrist to do the following:

(1) Abide by the terms and conditions of the health care service plan contract.

(2) Comply with the plan’s credentialing standards for optometrists.

(3) Provide evidence of current licensure in good standing.

SEC. 3. Section 1373.45 is added to the Health and Safety Code, to read:

1373.45. (a) A health care service plan or specialized health care service plan that provides for coverage of, or for payment for, vision care services shall not discriminate against or refuse to contract with a clinic that provides vision care services consisting of vision examination and the prescribing and dispensing of ophthalmic materials, the provision of any good or services, the delivery of which is within the scope of practice of an optometrist, provided that all other reasonable plan requirements are satisfied.
A plan that violates this section shall be ineligible for any contract under the Healthy Families and Medi-Cal programs.

(b) For purposes of this section, “clinic” the following terms have the following meanings:

(1) “Clinic” means a clinic that is operated under subdivision (a) of Section 1204, or is exempt from licensure under subdivision (b), (c), or (h) of Section 1206.

(2) “Discriminate” means either of the following:

(A) A repeated failure to comply with subdivision (a), (b), or (d) of Section 14087.325 of the Welfare and Institutions Code, subdivision (a) or (b) of Section 12693.515 of the Insurance Code, or subsection (m) of Section 233 of Title 42 of the United States Code.

(B) The adoption or utilization of a policy under which the plan will not contract with a clinic for optometry services, or assign patients to a clinic having a contract with the plan or a subcontractor of the plan to provide optometry services, unless one of the following conditions apply:

(i) The optometrist owns the equipment, facilities, dispensary, books, records, trade name, or inventory relating to the provision of optometry services.

(ii) The optometrist is either a majority owner of the clinic or an employee of another optometrist.

(iii) The optometrist provides proof of professional liability insurance coverage with respect to the provision of services that are covered by the Federal Tort Claims Act (28 U.S.C. Sec. 2671).

(c) A plan that is found by the director, after notice and an opportunity to be heard, to have violated this section shall be ineligible to receive funds, either directly or under a subcontract with another plan, under the Healthy Families and Medi-Cal programs.

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.