

AMENDED IN SENATE MAY 28, 2010
AMENDED IN SENATE APRIL 26, 2010

SENATE BILL

No. 1169

Introduced by Senator Lowenthal

February 18, 2010

An act to amend Sections 1367.01, 1371, 1371.35, and 1374.72 of, and to add Section 1370.8 to, the Health and Safety Code, and to amend Sections 10123.13, 10123.135, 10123.147, and 10144.5 of, and to add Section 10123.125 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1169, as amended, Lowenthal. Health care coverage: claims: prior authorization: mental health.

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 willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law requires health care service plans and health insurers to reimburse uncontested claims within 30 or 45 working days and specifies that a claim is contested if the plan or insurer has not received a completed claim and all information necessary to determine payer liability.

This bill would require plans and insurers to assign a tracking number to a claim or provider request for authorization, upon receipt thereof, and to provide acknowledgment of receipt thereof, including identification of the tracking number, to ~~both the provider and the enrollee or insured~~, as specified. With respect to claims that are contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the bill would require the plan or insurer to provide acknowledgment of receipt of any of that information within 3 working days, as specified.

Existing law requires a health care service plan contract or health insurance policy to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions that apply to other medical conditions. Existing law specifies that these terms and conditions include maximum lifetime benefits, copayments, and individual family deductibles.

This bill would specify that these terms and conditions include, but are not limited to, any form of treatment limitation, or other action by a plan or insurer that may limit the receipt of the covered benefits described above.

Because a willful violation of the bill's provisions with respect to health care service plans 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:

1 SECTION 1. Section 1367.01 of the Health and Safety Code
2 is amended to read:
3 1367.01. (a) A health care service plan and any entity with
4 which it contracts for services that include utilization review or
5 utilization management functions, that prospectively,
6 retrospectively, or concurrently reviews and approves, modifies,
7 delays, or denies, based in whole or in part on medical necessity,

1 requests by providers prior to, retrospectively, or concurrent with
2 the provision of health care services to enrollees, or that delegates
3 these functions to medical groups or independent practice
4 associations or to other contracting providers, shall comply with
5 this section.

6 (b) (1) A health care service plan that is subject to this section
7 shall have written policies and procedures establishing the process
8 by which the plan prospectively, retrospectively, or concurrently
9 reviews and approves, modifies, delays, or denies, based in whole
10 or in part on medical necessity, requests by providers of health
11 care services for plan enrollees. These policies and procedures
12 shall ensure that decisions based on the medical necessity of
13 proposed health care services are consistent with criteria or
14 guidelines that are supported by clinical principles and processes.
15 These criteria and guidelines shall be developed pursuant to Section
16 1363.5. These policies and procedures, and a description of the
17 process by which the plan reviews and approves, modifies, delays,
18 or denies requests by providers prior to, retrospectively, or
19 concurrent with the provision of health care services to enrollees,
20 shall be filed with the director for review and approval, and shall
21 be disclosed by the plan to providers and enrollees upon request,
22 and by the plan to the public upon request.

23 (2) Upon receipt of a request by a provider prior to,
24 retrospectively, or concurrent with, the provision of health care
25 services to an enrollee, a health care service plan subject to this
26 section shall assign a tracking number to the request and shall
27 provide acknowledgment of receipt of the request to ~~both~~ the
28 provider ~~and the enrollee~~. The acknowledgment of receipt shall
29 identify the assigned tracking number and shall be provided via
30 electronic mail, unless the provider ~~or enrollee~~ has opted out of
31 the electronic method of transmittal and requested that all
32 acknowledgments of receipt be transmitted in writing. In the case
33 of an orally submitted request, the acknowledgment of receipt shall
34 also be provided orally to the submitting provider. All
35 communications regarding the request, including, but not limited
36 to, the communications or responses identified in subdivision (h),
37 shall reference the tracking number assigned pursuant to this
38 paragraph.

39 (c) A health care service plan subject to this section, except a
40 plan that meets the requirements of Section 1351.2, shall employ

1 or designate a medical director who holds an unrestricted license
2 to practice medicine in this state issued pursuant to Section 2050
3 of the Business and Professions Code or pursuant to the
4 Osteopathic Act, or, if the plan is a specialized health care service
5 plan, a clinical director with California licensure in a clinical area
6 appropriate to the type of care provided by the specialized health
7 care service plan. The medical director or clinical director shall
8 ensure that the process by which the plan reviews and approves,
9 modifies, or denies, based in whole or in part on medical necessity,
10 requests by providers prior to, retrospectively, or concurrent with
11 the provision of health care services to enrollees, complies with
12 the requirements of this section.

13 (d) If health plan personnel, or individuals under contract to the
14 plan to review requests by providers, approve the provider's
15 request, pursuant to subdivision (b), the decision shall be
16 communicated to the provider pursuant to subdivision (h).

17 (e) No individual, other than a licensed physician or a licensed
18 health care professional who is competent to evaluate the specific
19 clinical issues involved in the health care services requested by
20 the provider, may deny or modify requests for authorization of
21 health care services for an enrollee for reasons of medical necessity.
22 The decision of the physician or other health care professional
23 shall be communicated to the provider and the enrollee pursuant
24 to subdivision (h).

25 (f) The criteria or guidelines used by the health care service
26 plan to determine whether to approve, modify, or deny requests
27 by providers prior to, retrospectively, or concurrent with, the
28 provision of health care services to enrollees shall be consistent
29 with clinical principles and processes. These criteria and guidelines
30 shall be developed pursuant to the requirements of Section 1363.5.

31 (g) If the health care service plan requests medical information
32 from providers in order to determine whether to approve, modify,
33 or deny requests for authorization, the plan shall request only the
34 information reasonably necessary to make the determination.

35 (h) In determining whether to approve, modify, or deny requests
36 by providers prior to, retrospectively, or concurrent with the
37 provision of health care services to enrollees, based in whole or
38 in part on medical necessity, a health care service plan subject to
39 this section shall meet the following requirements:

1 (1) Decisions to approve, modify, or deny, based on medical
2 necessity, requests by providers prior to, or concurrent with the
3 provision of health care services to enrollees that do not meet the
4 requirements for the 72-hour review required by paragraph (2),
5 shall be made in a timely fashion appropriate for the nature of the
6 enrollee's condition, not to exceed five business days from the
7 plan's receipt of the information reasonably necessary and
8 requested by the plan to make the determination. In cases where
9 the review is retrospective, the decision shall be communicated to
10 the individual who received services, or to the individual's
11 designee, within 30 days of the receipt of information that is
12 reasonably necessary to make this determination, and shall be
13 communicated to the provider in a manner that is consistent with
14 current law. For purposes of this section, retrospective reviews
15 shall be for care rendered on or after January 1, 2000.

16 (2) When the enrollee's condition is such that the enrollee faces
17 an imminent and serious threat to his or her health, including, but
18 not limited to, the potential loss of life, limb, or other major bodily
19 function, or the normal timeframe for the decisionmaking process,
20 as described in paragraph (1), would be detrimental to the enrollee's
21 life or health or could jeopardize the enrollee's ability to regain
22 maximum function, decisions to approve, modify, or deny requests
23 by providers prior to, or concurrent with, the provision of health
24 care services to enrollees, shall be made in a timely fashion
25 appropriate for the nature of the enrollee's condition, not to exceed
26 72 hours after the plan's receipt of the information reasonably
27 necessary and requested by the plan to make the determination.
28 Nothing in this section shall be construed to alter the requirements
29 of subdivision (b) of Section 1371.4. Notwithstanding Section
30 1371.4, the requirements of this division shall be applicable to all
31 health plans and other entities conducting utilization review or
32 utilization management.

33 (3) Decisions to approve, modify, or deny requests by providers
34 for authorization prior to, or concurrent with, the provision of
35 health care services to enrollees shall be communicated to the
36 requesting provider within 24 hours of the decision. Except for
37 concurrent review decisions pertaining to care that is underway,
38 which shall be communicated to the enrollee's treating provider
39 within 24 hours, decisions resulting in denial, delay, or
40 modification of all or part of the requested health care service shall

1 be communicated to the enrollee in writing within two business
2 days of the decision. In the case of concurrent review, care shall
3 not be discontinued until the enrollee's treating provider has been
4 notified of the plan's decision and a care plan has been agreed
5 upon by the treating provider that is appropriate for the medical
6 needs of that patient.

7 (4) Communications regarding decisions to approve requests
8 by providers prior to, retrospectively, or concurrent with the
9 provision of health care services to enrollees shall specify the
10 specific health care service approved. Responses regarding
11 decisions to deny, delay, or modify health care services requested
12 by providers prior to, retrospectively, or concurrent with the
13 provision of health care services to enrollees shall be
14 communicated to the enrollee in writing, and to providers initially
15 by telephone or facsimile, except with regard to decisions rendered
16 retrospectively, and then in writing, and shall include a clear and
17 concise explanation of the reasons for the plan's decision, a
18 description of the criteria or guidelines used, and the clinical
19 reasons for the decisions regarding medical necessity. Any written
20 communication to a physician or other health care provider of a
21 denial, delay, or modification of a request shall include the name
22 and telephone number of the health care professional responsible
23 for the denial, delay, or modification. The telephone number
24 provided shall be a direct number or an extension, to allow the
25 physician or health care provider easily to contact the professional
26 responsible for the denial, delay, or modification. Responses shall
27 also include information as to how the enrollee may file a grievance
28 with the plan pursuant to Section 1368, and in the case of Medi-Cal
29 enrollees, shall explain how to request an administrative hearing
30 and aid paid pending under Sections 51014.1 and 51014.2 of Title
31 22 of the California Code of Regulations.

32 (5) If the health care service plan cannot make a decision to
33 approve, modify, or deny the request for authorization within the
34 timeframes specified in paragraph (1) or (2) because the plan is
35 not in receipt of all of the information reasonably necessary and
36 requested, or because the plan requires consultation by an expert
37 reviewer, or because the plan has asked that an additional
38 examination or test be performed upon the enrollee, provided the
39 examination or test is reasonable and consistent with good medical
40 practice, the plan shall, immediately upon the expiration of the

1 timeframe specified in paragraph (1) or (2) or as soon as the plan
2 becomes aware that it will not meet the timeframe, whichever
3 occurs first, notify the provider and the enrollee, in writing, that
4 the plan cannot make a decision to approve, modify, or deny the
5 request for authorization within the required timeframe, and specify
6 the information requested but not received, or the expert reviewer
7 to be consulted, or the additional examinations or tests required.
8 The plan shall also notify the provider and enrollee of the
9 anticipated date on which a decision may be rendered. Upon receipt
10 of all information reasonably necessary and requested by the plan,
11 the plan shall approve, modify, or deny the request for authorization
12 within the timeframes specified in paragraph (1) or (2), whichever
13 applies.

14 (6) If the director determines that a health care service plan has
15 failed to meet any of the timeframes in this section, or has failed
16 to meet any other requirement of this section, the director may
17 assess, by order, administrative penalties for each failure. A
18 proceeding for the issuance of an order assessing administrative
19 penalties shall be subject to appropriate notice to, and an
20 opportunity for a hearing with regard to, the person affected, in
21 accordance with subdivision (a) of Section 1397. The
22 administrative penalties shall not be deemed an exclusive remedy
23 for the director. These penalties shall be paid to the Managed Care
24 Administrative Fines and Penalties Fund and shall be used for the
25 purposes specified in Section 1341.45.

26 (i) A health care service plan subject to this section shall
27 maintain telephone access for providers to request authorization
28 for health care services.

29 (j) A health care service plan subject to this section that reviews
30 requests by providers prior to, retrospectively, or concurrent with,
31 the provision of health care services to enrollees shall establish,
32 as part of the quality assurance program required by Section 1370,
33 a process by which the plan's compliance with this section is
34 assessed and evaluated. The process shall include provisions for
35 evaluation of complaints, assessment of trends, implementation
36 of actions to correct identified problems, mechanisms to
37 communicate actions and results to the appropriate health plan
38 employees and contracting providers, and provisions for evaluation
39 of any corrective action plan and measurements of performance.

1 (k) The director shall review a health care service plan's
2 compliance with this section as part of its periodic onsite medical
3 survey of each plan undertaken pursuant to Section 1380, and shall
4 include a discussion of compliance with this section as part of its
5 report issued pursuant to that section.

6 (l) This section shall not apply to decisions made for the care
7 or treatment of the sick who depend upon prayer or spiritual means
8 for healing in the practice of religion as set forth in subdivision
9 (a) of Section 1270.

10 (m) Nothing in this section shall cause a health care service plan
11 to be defined as a health care provider for purposes of any provision
12 of law, including, but not limited to, Section 6146 of the Business
13 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
14 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
15 Code of Civil Procedure.

16 SEC. 2. Section 1370.8 is added to the Health and Safety Code,
17 to read:

18 1370.8. Upon receipt of a claim, a health care service plan shall
19 assign a tracking number to the claim and shall provide
20 acknowledgment of receipt of the claim to ~~both the provider and~~
21 ~~the enrollee~~. The acknowledgment of receipt shall identify the
22 assigned tracking number and shall be provided via electronic
23 mail, unless the provider ~~or enrollee~~ has opted out of the electronic
24 method of transmittal and requested that all acknowledgments of
25 receipt be transmitted in writing. In the case of an orally submitted
26 claim, the acknowledgment of receipt shall also be provided orally
27 to the submitting provider ~~or enrollee~~. All communications
28 regarding the claim shall reference the tracking number assigned
29 pursuant to this section.

30 SEC. 3. Section 1371 of the Health and Safety Code is amended
31 to read:

32 1371. (a) A health care service plan, including a specialized
33 health care service plan, shall reimburse claims or any portion of
34 any claim, whether in state or out of state, as soon as practical, but
35 no later than 30 working days after receipt of the claim by the
36 health care service plan, or if the health care service plan is a health
37 maintenance organization, 45 working days after receipt of the
38 claim by the health care service plan, unless the claim or portion
39 thereof is contested by the plan in which case the claimant shall
40 be notified, in writing, that the claim is contested or denied, within

1 30 working days after receipt of the claim by the health care service
2 plan, or if the health care service plan is a health maintenance
3 organization, 45 working days after receipt of the claim by the
4 health care service plan. The notice that a claim is being contested
5 shall identify the portion of the claim that is contested and the
6 specific reasons for contesting the claim.

7 (b) If an uncontested claim is not reimbursed by delivery to the
8 claimants' address of record within the respective 30 or 45 working
9 days after receipt, interest shall accrue at the rate of 15 percent per
10 annum beginning with the first calendar day after the 30- or
11 45-working-day period. A health care service plan shall
12 automatically include in its payment of the claim all interest that
13 has accrued pursuant to this section without requiring the claimant
14 to submit a request for the interest amount. Any plan failing to
15 comply with this requirement shall pay the claimant a ten-dollar
16 (\$10) fee.

17 (c) For the purposes of this section, a claim, or portion thereof,
18 is reasonably contested if the plan has not received the completed
19 claim and all information necessary to determine payer liability
20 for the claim, or has not been granted reasonable access to
21 information concerning provider services. Information necessary
22 to determine payer liability for the claim includes, but is not limited
23 to, reports of investigations concerning fraud and
24 misrepresentation, and necessary consents, releases, and
25 assignments, a claim on appeal, or other information necessary for
26 the plan to determine the medical necessity for the health care
27 services provided.

28 (d) If a claim or portion thereof is contested on the basis that
29 the plan has not received all information necessary to determine
30 payer liability for the claim or portion thereof and notice has been
31 provided pursuant to this section both of the following shall apply:

32 (1) Within three working days of receipt of any of this additional
33 information, the plan shall provide acknowledgment of receipt of
34 that information to the claimant. The acknowledgment of receipt
35 shall be provided via electronic mail unless the claimant has opted
36 out of the electronic method of transmittal and requested that all
37 acknowledgments of receipt be transmitted in writing. The
38 acknowledgment of receipt shall include the tracking number
39 assigned to the claim pursuant to Section 1370.8.

1 (2) The plan shall have 30 working days or, if the health care
2 service plan is a health maintenance organization, 45 working days
3 after receipt of all of the information necessary to determine payer
4 liability to complete reconsideration of the claim. If a plan has
5 received all of the information necessary to determine payer
6 liability for a contested claim and has not reimbursed a claim it
7 has determined to be payable within 30 working days of the receipt
8 of that information, or if the plan is a health maintenance
9 organization, within 45 working days of receipt of that information,
10 interest shall accrue and be payable at a rate of 15 percent per
11 annum beginning with the first calendar day after the 30- or
12 45-working-day period.

13 (e) The obligation of the plan to comply with this section shall
14 not be deemed to be waived when the plan requires its medical
15 groups, independent practice associations, or other contracting
16 entities to pay claims for covered services.

17 SEC. 4. Section 1371.35 of the Health and Safety Code is
18 amended to read:

19 1371.35. (a) A health care service plan, including a specialized
20 health care service plan, shall reimburse each complete claim, or
21 portion thereof, whether in state or out of state, as soon as practical,
22 but no later than 30 working days after receipt of the complete
23 claim by the health care service plan, or if the health care service
24 plan is a health maintenance organization, 45 working days after
25 receipt of the complete claim by the health care service plan.
26 However, a plan may contest or deny a claim, or portion thereof,
27 by notifying the claimant, in writing, that the claim is contested
28 or denied, within 30 working days after receipt of the claim by the
29 health care service plan, or if the health care service plan is a health
30 maintenance organization, 45 working days after receipt of the
31 claim by the health care service plan. The notice that a claim, or
32 portion thereof, is contested shall identify the portion of the claim
33 that is contested, by revenue code, and the specific information
34 needed from the provider to reconsider the claim. The notice that
35 a claim, or portion thereof, is denied shall identify the portion of
36 the claim that is denied, by revenue code, and the specific reasons
37 for the denial. A plan may delay payment of an uncontested portion
38 of a complete claim for reconsideration of a contested portion of
39 that claim so long as the plan pays those charges specified in
40 subdivision (b).

1 (b) If a complete claim, or portion thereof, that is neither
2 contested nor denied, is not reimbursed by delivery to the
3 claimant's address of record within the respective 30 or 45 working
4 days after receipt, the plan shall pay the greater of fifteen dollars
5 (\$15) per year or interest at the rate of 15 percent per annum
6 beginning with the first calendar day after the 30- or
7 45-working-day period. A health care service plan shall
8 automatically include the fifteen dollars (\$15) per year or interest
9 due in the payment made to the claimant, without requiring a
10 request therefor.

11 (c) For the purposes of this section, a claim, or portion thereof,
12 is reasonably contested if the plan has not received the completed
13 claim. A paper claim from an institutional provider shall be deemed
14 complete upon submission of a legible emergency department
15 report and a completed UB 92 or other format adopted by the
16 National Uniform Billing Committee, and reasonable relevant
17 information requested by the plan within 30 working days of receipt
18 of the claim. An electronic claim from an institutional provider
19 shall be deemed complete upon submission of an electronic
20 equivalent to the UB 92 or other format adopted by the National
21 Uniform Billing Committee, and reasonable relevant information
22 requested by the plan within 30 working days of receipt of the
23 claim. However, if the plan requests a copy of the emergency
24 department report within the 30 working days after receipt of the
25 electronic claim from the institutional provider, the plan may also
26 request additional reasonable relevant information within 30
27 working days of receipt of the emergency department report, at
28 which time the claim shall be deemed complete. A claim from a
29 professional provider shall be deemed complete upon submission
30 of a completed HCFA 1500 or its electronic equivalent or other
31 format adopted by the National Uniform Billing Committee, and
32 reasonable relevant information requested by the plan within 30
33 working days of receipt of the claim. The provider shall provide
34 the plan reasonable relevant information within 10 working days
35 of receipt of a written request that is clear and specific regarding
36 the information sought. If, as a result of reviewing the reasonable
37 relevant information, the plan requires further information, the
38 plan shall have an additional 15 working days after receipt of the
39 reasonable relevant information to request the further information,

1 notwithstanding any time limit to the contrary in this section, at
2 which time the claim shall be deemed complete.

3 (d) This section shall not apply to claims about which there is
4 evidence of fraud and misrepresentation, to eligibility
5 determinations, or in instances where the plan has not been granted
6 reasonable access to information under the provider's control. A
7 plan shall specify, in a written notice sent to the provider within
8 the respective 30 or 45 working days of receipt of the claim, which,
9 if any, of these exceptions applies to a claim.

10 (e) If a claim or portion thereof is contested on the basis that
11 the plan has not received information reasonably necessary to
12 determine payer liability for the claim or portion thereof, both of
13 the following shall apply:

14 (1) Within three working days of receipt of any of this additional
15 information, a plan shall provide acknowledgment of receipt of
16 that information to the claimant. The acknowledgment of receipt
17 shall be provided via electronic mail unless the claimant has opted
18 out of the electronic method of transmittal and requested that all
19 acknowledgments of receipt be transmitted in writing. The
20 acknowledgment of receipt shall include the tracking number
21 assigned to the claim pursuant to Section 1370.8.

22 (2) The plan shall have 30 working days or, if the health care
23 service plan is a health maintenance organization, 45 working days
24 after receipt of all of the information necessary to determine payer
25 liability to complete reconsideration of the claim. If a claim, or
26 portion thereof, undergoing reconsideration is not reimbursed by
27 delivery to the claimant's address of record within the respective
28 30 or 45 working days after receipt of all of the information
29 necessary to determine payer liability, the plan shall pay the greater
30 of fifteen dollars (\$15) per year or interest at the rate of 15 percent
31 per annum beginning with the first calendar day after the 30- or
32 45-working-day period. A health care service plan shall
33 automatically include the fifteen dollars (\$15) per year or interest
34 due in the payment made to the claimant, without requiring a
35 request therefor.

36 (f) The obligation of the plan to comply with this section shall
37 not be deemed to be waived when the plan requires its medical
38 groups, independent practice associations, or other contracting
39 entities to pay claims for covered services. This section shall not
40 be construed to prevent a plan from assigning, by a written contract,

1 the responsibility to pay interest and late charges pursuant to this
2 section to medical groups, independent practice associations, or
3 other entities.

4 (g) A plan shall not delay payment on a claim from a physician
5 or other provider to await the submission of a claim from a hospital
6 or other provider, without citing specific rationale as to why the
7 delay was necessary and providing a monthly update regarding
8 the status of the claim and the plan's actions to resolve the claim,
9 to the provider that submitted the claim.

10 (h) A health care service plan shall not request or require that
11 a provider waive its rights pursuant to this section.

12 (i) This section shall not apply to capitated payments.

13 (j) This section shall apply only to claims for services rendered
14 to a patient who was provided emergency services and care as
15 defined in Section 1317.1 in the United States on or after
16 September 1, 1999.

17 (k) This section shall not be construed to affect the rights or
18 obligations of any person pursuant to Section 1371.

19 (l) This section shall not be construed to affect a written
20 agreement, if any, of a provider to submit bills within a specified
21 time period.

22 SEC. 5. Section 1374.72 of the Health and Safety Code is
23 amended to read:

24 1374.72. (a) Every health care service plan contract issued,
25 amended, or renewed on or after July 1, 2000, that provides
26 hospital, medical, or surgical coverage shall provide coverage for
27 the diagnosis and medically necessary treatment of severe mental
28 illnesses of a person of any age, and of serious emotional
29 disturbances of a child, as specified in subdivisions (d) and (e),
30 under the same terms and conditions applied to other medical
31 conditions as specified in subdivision (c).

32 (b) These benefits shall include the following:

33 (1) Outpatient services.

34 (2) Inpatient hospital services.

35 (3) Partial hospital services.

36 (4) Prescription drugs, if the plan contract includes coverage
37 for prescription drugs.

38 (c) The terms and conditions applied to the benefits required
39 by this section, that shall be applied equally to all benefits under
40 the plan contract, include, but are not limited to, any form of

1 treatment limitation or other action by a plan that may limit the
2 receipt of benefits required by this section. These treatment
3 limitations or actions include, but are not limited to, the use of any
4 of the following:

- 5 (1) Maximum lifetime benefits.
- 6 (2) Copayments.
- 7 (3) Individual and family deductibles.
- 8 (d) For the purposes of this section, “severe mental illnesses”
9 shall include:

- 10 (1) Schizophrenia.
- 11 (2) Schizoaffective disorder.
- 12 (3) Bipolar disorder (manic-depressive illness).
- 13 (4) Major depressive disorders.
- 14 (5) Panic disorder.
- 15 (6) Obsessive-compulsive disorder.
- 16 (7) Pervasive developmental disorder or autism.
- 17 (8) Anorexia nervosa.
- 18 (9) Bulimia nervosa.

19 (e) For the purposes of this section, a child suffering from,
20 “serious emotional disturbances of a child” shall be defined as a
21 child who (1) has one or more mental disorders as identified in the
22 most recent edition of the Diagnostic and Statistical Manual of
23 Mental Disorders, other than a primary substance use disorder or
24 developmental disorder, that result in behavior inappropriate to
25 the child’s age according to expected developmental norms, and
26 (2) who meets the criteria in paragraph (2) of subdivision (a) of
27 Section 5600.3 of the Welfare and Institutions Code.

28 (f) This section shall not apply to contracts entered into pursuant
29 to Chapter 7 (commencing with Section 14000) or Chapter 8
30 (commencing with Section 14200) of Division 9 of Part 3 of the
31 Welfare and Institutions Code, between the State Department of
32 Health Services and a health care service plan for enrolled
33 Medi-Cal beneficiaries.

34 (g) (1) For the purpose of compliance with this section, a plan
35 may provide coverage for all or part of the mental health services
36 required by this section through a separate specialized health care
37 service plan or mental health plan, and shall not be required to
38 obtain an additional or specialized license for this purpose.

39 (2) A plan shall provide the mental health coverage required by
40 this section in its entire service area and in emergency situations

1 as may be required by applicable laws and regulations. For
2 purposes of this section, health care service plan contracts that
3 provide benefits to enrollees through preferred provider contracting
4 arrangements are not precluded from requiring enrollees who reside
5 or work in geographic areas served by specialized health care
6 service plans or mental health plans to secure all or part of their
7 mental health services within those geographic areas served by
8 specialized health care service plans or mental health plans.

9 (3) Notwithstanding any other provision of law, in the provision
10 of benefits required by this section, a health care service plan may
11 utilize case management, network providers, utilization review
12 techniques, prior authorization, copayments, or other cost sharing,
13 subject to the limitation imposed under subdivision (c).

14 (h) Nothing in this section shall be construed to deny or restrict
15 in any way the department's authority to ensure plan compliance
16 with this chapter when a plan provides coverage for prescription
17 drugs.

18 SEC. 6. Section 10123.125 is added to the Insurance Code, to
19 read:

20 10123.125. Upon receipt of a claim, a health insurer shall assign
21 a tracking number to the claim and shall provide acknowledgment
22 of receipt of the claim to ~~both the provider and the insured~~. The
23 acknowledgment of receipt shall identify the assigned tracking
24 number and shall be provided via electronic mail, unless the
25 ~~provider or insured~~ has opted out of the electronic method of
26 transmittal and requested that all acknowledgments of receipt be
27 transmitted in writing. In the case of an orally submitted claim,
28 the acknowledgment of receipt shall also be provided orally to the
29 submitting provider ~~or insured~~. All communications regarding the
30 claim shall reference the tracking number assigned pursuant to
31 this section.

32 SEC. 7. Section 10123.13 of the Insurance Code is amended
33 to read:

34 10123.13. (a) Every insurer issuing group or individual policies
35 of health insurance that covers hospital, medical, or surgical
36 expenses, including those telemedicine services covered by the
37 insurer as defined in subdivision (a) of Section 2290.5 of the
38 Business and Professions Code, shall reimburse claims or any
39 portion of any claim, whether in state or out of state, for those
40 expenses as soon as practical, but no later than 30 working days

1 after receipt of the claim by the insurer unless the claim or portion
2 thereof is contested by the insurer, in which case the claimant shall
3 be notified, in writing, that the claim is contested or denied, within
4 30 working days after receipt of the claim by the insurer. The
5 notice that a claim is being contested or denied shall identify the
6 portion of the claim that is contested or denied and the specific
7 reasons, including for each reason the factual and legal basis known
8 at that time by the insurer, for contesting or denying the claim. If
9 the reason is based solely on facts or solely on law, the insurer is
10 required to provide only the factual or the legal basis for its reason
11 for contesting or denying the claim. The insurer shall provide a
12 copy of the notice to each insured who received services pursuant
13 to the claim that was contested or denied and to the insured's health
14 care provider that provided the services at issue. The notice shall
15 advise the provider who submitted the claim on behalf of the
16 insured or pursuant to a contract for alternative rates of payment
17 and the insured that either may seek review by the department of
18 a claim that the insurer contested or denied, and the notice shall
19 include the address, Internet Web site address, and telephone
20 number of the unit within the department that performs this review
21 function. The notice to the provider may be included on either the
22 explanation of benefits or remittance advice and shall also contain
23 a statement advising the provider of its right to enter into the
24 dispute resolution process described in Section 10123.137. The
25 notice to the insured may also be included on the explanation of
26 benefits.

27 (b) If an uncontested claim is not reimbursed by delivery to the
28 claimant's address of record within 30 working days after receipt,
29 interest shall accrue and shall be payable at the rate of 10 percent
30 per annum beginning with the first calendar day after the
31 30-working-day period.

32 (c) For purposes of this section, a claim, or portion thereof, is
33 reasonably contested when the insurer has not received a completed
34 claim and all information necessary to determine payer liability
35 for the claim, or has not been granted reasonable access to
36 information concerning provider services. Information necessary
37 to determine liability for the claims includes, but is not limited to,
38 reports of investigations concerning fraud and misrepresentation,
39 and necessary consents, releases, and assignments, a claim on
40 appeal, or other information necessary for the insurer to determine

1 the medical necessity for the health care services provided to the
2 claimant.

3 (d) If a claim or portion thereof is contested on the basis that
4 the insurer has not received information reasonably necessary to
5 determine payer liability for the claim or portion thereof, both of
6 the following shall apply:

7 (1) Within three working days of receipt of any of this additional
8 information, the insurer shall provide acknowledgment of receipt
9 of that information to the claimant. The acknowledgment of receipt
10 shall be provided via electronic mail unless the claimant has opted
11 out of the electronic method of transmittal and requested that all
12 acknowledgments of receipt be transmitted in writing. The
13 acknowledgment of receipt shall include the tracking number
14 assigned to the claim pursuant to Section 10123.125.

15 (2) If the insurer has received all of the information necessary
16 to determine payer liability for a contested claim and has not
17 reimbursed a claim determined to be payable within 30 working
18 days of receipt of that information, interest shall accrue and be
19 payable at a rate of 10 percent per annum beginning with the first
20 calendar day after the 30-working-day period.

21 (e) The obligation of the insurer to comply with this section
22 shall not be deemed to be waived when the insurer requires its
23 contracting entities to pay claims for covered services.

24 SEC. 8. Section 10123.135 of the Insurance Code is amended
25 to read:

26 10123.135. (a) Every health insurer, or an entity with which
27 it contracts for services that include utilization review or utilization
28 management functions, that prospectively, retrospectively, or
29 concurrently reviews and approves, modifies, delays, or denies,
30 based in whole or in part on medical necessity, requests by
31 providers prior to, retrospectively, or concurrent with the provision
32 of health care services to insureds, or that delegates these functions
33 to medical groups or independent practice associations or to other
34 contracting providers, shall comply with this section.

35 (b) (1) A health insurer that is subject to this section, or any
36 entity with which an insurer contracts for services that include
37 utilization review or utilization management functions, shall have
38 written policies and procedures establishing the process by which
39 the insurer prospectively, retrospectively, or concurrently reviews
40 and approves, modifies, delays, or denies, based in whole or in

1 part on medical necessity, requests by providers of health care
2 services for insureds. These policies and procedures shall ensure
3 that decisions based on the medical necessity of proposed health
4 care services are consistent with criteria or guidelines that are
5 supported by clinical principles and processes. These criteria and
6 guidelines shall be developed pursuant to subdivision (f). These
7 policies and procedures, and a description of the process by which
8 an insurer, or an entity with which an insurer contracts for services
9 that include utilization review or utilization management functions,
10 reviews and approves, modifies, delays, or denies requests by
11 providers prior to, retrospectively, or concurrent with the provision
12 of health care services to insureds, shall be filed with the
13 commissioner, and shall be disclosed by the insurer to insureds
14 and providers upon request, and by the insurer to the public upon
15 request.

16 (2) Upon receipt of a request by a provider prior to,
17 retrospectively, or concurrent with the provision of health care
18 services to an insured, a health insurer, or the entity with which
19 the insurer contracts for services that include utilization review or
20 utilization management functions, shall assign a tracking number
21 to the request and shall provide acknowledgment of receipt of the
22 request to ~~both the provider and the insured~~. The acknowledgment
23 of receipt shall identify the assigned tracking number and shall be
24 provided via electronic mail, unless the ~~provider or insured~~ has
25 opted out of the electronic method of transmittal and requested
26 that all acknowledgments of receipt be transmitted in writing. In
27 the case of an orally submitted request, the acknowledgment of
28 receipt shall also be provided orally to the submitting provider.
29 All communications regarding the request, including, but not
30 limited to, the communications or responses identified in
31 subdivision (h), shall reference the tracking number assigned
32 pursuant to this paragraph.

33 (c) If the number of insureds covered under health benefit plans
34 in this state that are issued by an insurer subject to this section
35 constitute at least 50 percent of the number of insureds covered
36 under health benefit plans issued nationwide by that insurer, the
37 insurer shall employ or designate a medical director who holds an
38 unrestricted license to practice medicine in this state issued
39 pursuant to Section 2050 of the Business and Professions Code or
40 the Osteopathic Initiative Act, or the insurer may employ a clinical

1 director licensed in California whose scope of practice under
2 California law includes the right to independently perform all those
3 services covered by the insurer. The medical director or clinical
4 director shall ensure that the process by which the insurer reviews
5 and approves, modifies, delays, or denies, based in whole or in
6 part on medical necessity, requests by providers prior to,
7 retrospectively, or concurrent with the provision of health care
8 services to insureds, complies with the requirements of this section.
9 Nothing in this subdivision shall be construed as restricting the
10 existing authority of the Medical Board of California.

11 (d) If an insurer subject to this section, or individuals under
12 contract to the insurer to review requests by providers, approve
13 the provider's request pursuant to subdivision (b), the decision
14 shall be communicated to the provider pursuant to subdivision (h).

15 (e) An individual, other than a licensed physician or a licensed
16 health care professional who is competent to evaluate the specific
17 clinical issues involved in the health care services requested by
18 the provider, may not deny or modify requests for authorization
19 of health care services for an insured for reasons of medical
20 necessity. The decision of the physician or other health care
21 provider shall be communicated to the provider and the insured
22 pursuant to subdivision (h).

23 (f) (1) An insurer shall disclose, or provide for the disclosure,
24 to the commissioner and to network providers, the process the
25 insurer, its contracting provider groups, or any entity with which
26 it contracts for services that include utilization review or utilization
27 management functions, uses to authorize, delay, modify, or deny
28 health care services under the benefits provided by the insurance
29 contract, including coverage for subacute care, transitional inpatient
30 care, or care provided in skilled nursing facilities. An insurer shall
31 also disclose those processes to policyholders or persons designated
32 by a policyholder, or to any other person or organization, upon
33 request.

34 (2) The criteria or guidelines used by an insurer, or an entity
35 with which an insurer contracts for utilization review or utilization
36 management functions, to determine whether to authorize, modify,
37 delay, or deny health care services, shall comply with all of the
38 following:

39 (A) Be developed with involvement from actively practicing
40 health care providers.

1 (B) Be consistent with sound clinical principles and processes.

2 (C) Be evaluated, and updated if necessary, at least annually.

3 (D) If used as the basis of a decision to modify, delay, or deny
4 services in a specified case under review, be disclosed to the
5 provider and the policyholder in that specified case.

6 (E) Be available to the public upon request. An insurer shall
7 only be required to disclose the criteria or guidelines for the
8 specific procedures or conditions requested. An insurer may charge
9 reasonable fees to cover administrative expenses related to
10 disclosing criteria or guidelines pursuant to this paragraph that are
11 limited to copying and postage costs. The insurer may also make
12 the criteria or guidelines available through electronic
13 communication means.

14 (3) The disclosure required by subparagraph (E) of paragraph
15 (2) shall be accompanied by the following notice: “The materials
16 provided to you are guidelines used by this insurer to authorize,
17 modify, or deny health care benefits for persons with similar
18 illnesses or conditions. Specific care and treatment may vary
19 depending on individual need and the benefits covered under your
20 insurance contract.”

21 (g) If an insurer subject to this section requests medical
22 information from providers in order to determine whether to
23 approve, modify, or deny requests for authorization, the insurer
24 shall request only the information reasonably necessary to make
25 the determination.

26 (h) In determining whether to approve, modify, or deny requests
27 by providers prior to, retrospectively, or concurrent with the
28 provision of health care services to insureds, based in whole or in
29 part on medical necessity, every insurer subject to this section shall
30 meet the following requirements:

31 (1) Decisions to approve, modify, or deny, based on medical
32 necessity, requests by providers prior to, or concurrent with, the
33 provision of health care services to insureds that do not meet the
34 requirements for the 72-hour review required by paragraph (2),
35 shall be made in a timely fashion appropriate for the nature of the
36 insured’s condition, not to exceed five business days from the
37 insurer’s receipt of the information reasonably necessary and
38 requested by the insurer to make the determination. In cases where
39 the review is retrospective, the decision shall be communicated to
40 the individual who received services, or to the individual’s

1 designee, within 30 days of the receipt of information that is
2 reasonably necessary to make this determination, and shall be
3 communicated to the provider in a manner that is consistent with
4 current law. For purposes of this section, retrospective reviews
5 shall be for care rendered on or after January 1, 2000.

6 (2) When the insured's condition is such that the insured faces
7 an imminent and serious threat to his or her health, including, but
8 not limited to, the potential loss of life, limb, or other major bodily
9 function, or the normal timeframe for the decisionmaking process,
10 as described in paragraph (1), would be detrimental to the insured's
11 life or health or could jeopardize the insured's ability to regain
12 maximum function, decisions to approve, modify, or deny requests
13 by providers prior to, or concurrent with, the provision of health
14 care services to insureds shall be made in a timely fashion,
15 appropriate for the nature of the insured's condition, but not to
16 exceed 72 hours after the insurer's receipt of the information
17 reasonably necessary and requested by the insurer to make the
18 determination.

19 (3) Decisions to approve, modify, or deny requests by providers
20 for authorization prior to, or concurrent with, the provision of
21 health care services to insureds shall be communicated to the
22 requesting provider within 24 hours of the decision. Except for
23 concurrent review decisions pertaining to care that is underway,
24 which shall be communicated to the insured's treating provider
25 within 24 hours, decisions resulting in denial, delay, or
26 modification of all or part of the requested health care service shall
27 be communicated to the insured in writing within two business
28 days of the decision. In the case of concurrent review, care shall
29 not be discontinued until the insured's treating provider has been
30 notified of the insurer's decision and a care plan has been agreed
31 upon by the treating provider that is appropriate for the medical
32 needs of that patient.

33 (4) Communications regarding decisions to approve requests
34 by providers prior to, retrospectively, or concurrent with the
35 provision of health care services to insureds shall specify the
36 specific health care service approved. Responses regarding
37 decisions to deny, delay, or modify health care services requested
38 by providers prior to, retrospectively, or concurrent with the
39 provision of health care services to insureds shall be communicated
40 to insureds in writing, and to providers initially by telephone or

1 facsimile, except with regard to decisions rendered retrospectively,
2 and then in writing, and shall include a clear and concise
3 explanation of the reasons for the insurer's decision, a description
4 of the criteria or guidelines used, and the clinical reasons for the
5 decisions regarding medical necessity. Any written communication
6 to a physician or other health care provider of a denial, delay, or
7 modification or a request shall include the name and telephone
8 number of the health care professional responsible for the denial,
9 delay, or modification. The telephone number provided shall be a
10 direct number or an extension, to allow the physician or health
11 care provider easily to contact the professional responsible for the
12 denial, delay, or modification. Responses shall also include
13 information as to how the provider or the insured may file an appeal
14 with the insurer or seek department review under the unfair
15 practices provisions of Article 6.5 (commencing with Section 790)
16 of Chapter 1 of Part 2 of Division 1 and the regulations adopted
17 thereunder.

18 (5) If the insurer cannot make a decision to approve, modify,
19 or deny the request for authorization within the timeframes
20 specified in paragraph (1) or (2) because the insurer is not in receipt
21 of all of the information reasonably necessary and requested, or
22 because the insurer requires consultation by an expert reviewer,
23 or because the insurer has asked that an additional examination or
24 test be performed upon the insured, provided that the examination
25 or test is reasonable and consistent with good medical practice,
26 the insurer shall, immediately upon the expiration of the timeframe
27 specified in paragraph (1) or (2), or as soon as the insurer becomes
28 aware that it will not meet the timeframe, whichever occurs first,
29 notify the provider and the insured, in writing, that the insurer
30 cannot make a decision to approve, modify, or deny the request
31 for authorization within the required timeframe, and specify the
32 information requested but not received, or the expert reviewer to
33 be consulted, or the additional examinations or tests required. The
34 insurer shall also notify the provider and enrollee of the anticipated
35 date on which a decision may be rendered. Upon receipt of all
36 information reasonably necessary and requested by the insurer,
37 the insurer shall approve, modify, or deny the request for
38 authorization within the timeframes specified in paragraph (1) or
39 (2), whichever applies.

1 (6) If the commissioner determines that an insurer has failed to
2 meet any of the timeframes in this section, or has failed to meet
3 any other requirement of this section, the commissioner may assess,
4 by order, administrative penalties for each failure. A proceeding
5 for the issuance of an order assessing administrative penalties shall
6 be subject to appropriate notice to, and an opportunity for a hearing
7 with regard to, the person affected. The administrative penalties
8 shall not be deemed an exclusive remedy for the commissioner.
9 These penalties shall be paid to the Insurance Fund.

10 (i) Every insurer subject to this section shall maintain telephone
11 access for providers to request authorization for health care
12 services.

13 (j) Nothing in this section shall cause a disability insurer to be
14 defined as a health care provider for purposes of any provision of
15 law, including, but not limited to, Section 6146 of the Business
16 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
17 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
18 Code of Civil Procedure.

19 SEC. 9. Section 10123.147 of the Insurance Code is amended
20 to read:

21 10123.147. (a) Every insurer issuing group or individual
22 policies of health insurance that covers hospital, medical, or
23 surgical expenses, including those telemedicine services covered
24 by the insurer as defined in subdivision (a) of Section 2290.5 of
25 the Business and Professions Code, shall reimburse each complete
26 claim, or portion thereof, whether in state or out of state, as soon
27 as practical, but no later than 30 working days after receipt of the
28 complete claim by the insurer. However, an insurer may contest
29 or deny a claim, or portion thereof, by notifying the claimant, in
30 writing, that the claim is contested or denied, within 30 working
31 days after receipt of the complete claim by the insurer. The notice
32 that a claim, or portion thereof, is contested shall identify the
33 portion of the claim that is contested, by revenue code, and the
34 specific information needed from the provider to reconsider the
35 claim. The notice that a claim, or portion thereof, is denied shall
36 identify the portion of the claim that is denied, by revenue code,
37 and the specific reasons for the denial, including the factual and
38 legal basis known at that time by the insurer for each reason. If
39 the reason is based solely on facts or solely on law, the insurer is
40 required to provide only the factual or legal basis for its reason to

1 deny the claim. The insurer shall provide a copy of the notice
2 required by this subdivision to each insured who received services
3 pursuant to the claim that was contested or denied and to the
4 insured's health care provider that provided the services at issue.
5 The notice required by this subdivision shall include a statement
6 advising the provider who submitted the claim on behalf of the
7 insured or pursuant to a contract for alternative rates of payment
8 and the insured that either may seek review by the department of
9 a claim that was contested or denied by the insurer and the address,
10 Internet Web site address, and telephone number of the unit within
11 the department that performs this review function. The notice to
12 the provider may be included on either the explanation of benefits
13 or remittance advice and shall also contain a statement advising
14 the provider of its right to enter into the dispute resolution process
15 described in Section 10123.137. An insurer may delay payment
16 of an uncontested portion of a complete claim for reconsideration
17 of a contested portion of that claim so long as the insurer pays
18 those charges specified in subdivision (b).

19 (b) If a complete claim, or portion thereof, that is neither
20 contested nor denied, is not reimbursed by delivery to the
21 claimant's address of record within the 30 working days after
22 receipt, the insurer shall pay the greater of fifteen dollars (\$15)
23 per year or interest at the rate of 10 percent per annum beginning
24 with the first calendar day after the 30-working-day period. An
25 insurer shall automatically include the fifteen dollars (\$15) per
26 year or interest due in the payment made to the claimant, without
27 requiring a request therefor.

28 (c) For the purposes of this section, a claim, or portion thereof,
29 is reasonably contested if the insurer has not received the completed
30 claim. A paper claim from an institutional provider shall be deemed
31 complete upon submission of a legible emergency department
32 report and a completed UB 92 or other format adopted by the
33 National Uniform Billing Committee, and reasonable relevant
34 information requested by the insurer within 30 working days of
35 receipt of the claim. An electronic claim from an institutional
36 provider shall be deemed complete upon submission of an
37 electronic equivalent to the UB 92 or other format adopted by the
38 National Uniform Billing Committee, and reasonable relevant
39 information requested by the insurer within 30 working days of
40 receipt of the claim. However, if the insurer requests a copy of the

1 emergency department report within the 30 working days after
2 receipt of the electronic claim from the institutional provider, the
3 insurer may also request additional reasonable relevant information
4 within 30 working days of receipt of the emergency department
5 report, at which time the claim shall be deemed complete. A claim
6 from a professional provider shall be deemed complete upon
7 submission of a completed HCFA 1500 or its electronic equivalent
8 or other format adopted by the National Uniform Billing
9 Committee, and reasonable relevant information requested by the
10 insurer within 30 working days of receipt of the claim. The provider
11 shall provide the insurer reasonable relevant information within
12 15 working days of receipt of a written request that is clear and
13 specific regarding the information sought. If, as a result of
14 reviewing the reasonable relevant information, the insurer requires
15 further information, the insurer shall have an additional 15 working
16 days after receipt of the reasonable relevant information to request
17 the further information, notwithstanding any time limit to the
18 contrary in this section, at which time the claim shall be deemed
19 complete.

20 (d) This section shall not apply to claims about which there is
21 evidence of fraud and misrepresentation, to eligibility
22 determinations, or in instances where the plan has not been granted
23 reasonable access to information under the provider's control. An
24 insurer shall specify, in a written notice to the provider within 30
25 working days of receipt of the claim, which, if any, of these
26 exceptions applies to a claim.

27 (e) If a claim or portion thereof is contested on the basis that
28 the insurer has not received information reasonably necessary to
29 determine payer liability for the claim or portion thereof, both of
30 the following shall apply:

31 (1) Within three working days of receipt of any of this additional
32 information, the insurer shall provide acknowledgment of receipt
33 of that information to the claimant. The acknowledgment of receipt
34 shall be provided via electronic mail unless the claimant has opted
35 out of the electronic method of transmittal and requested that all
36 acknowledgments of receipt be transmitted in writing. The
37 acknowledgment of receipt shall include the tracking number
38 assigned to the claim pursuant to Section 10123.125.

39 (2) The insurer shall have 30 working days after receipt of all
40 of the information necessary to determine payer liability to

1 complete reconsideration of the claim. If a claim, or portion thereof,
2 undergoing reconsideration is not reimbursed by delivery to the
3 claimant's address of record within the 30 working days after
4 receipt of all of the information necessary to determine payer
5 liability, the insurer shall pay the greater of fifteen dollars (\$15)
6 per year or interest at the rate of 10 percent per annum beginning
7 with the first calendar day after the 30-working-day period. An
8 insurer shall automatically include the fifteen dollars (\$15) per
9 year or interest due in the payment made to the claimant, without
10 requiring a request therefor.

11 (f) An insurer shall not delay payment on a claim from a
12 physician or other provider to await the submission of a claim from
13 a hospital or other provider, without citing specific rationale as to
14 why the delay was necessary and providing a monthly update
15 regarding the status of the claim and the insurer's actions to resolve
16 the claim, to the provider that submitted the claim.

17 (g) An insurer shall not request or require that a provider waive
18 its rights pursuant to this section.

19 (h) This section shall apply only to claims for services rendered
20 to a patient who was provided emergency services and care as
21 defined in Section 1317.1 of the Health and Safety Code in the
22 United States on or after September 1, 1999.

23 (i) This section shall not be construed to affect the rights or
24 obligations of any person pursuant to Section 10123.13.

25 (j) This section shall not be construed to affect a written
26 agreement, if any, of a provider to submit bills within a specified
27 time period.

28 SEC. 10. Section 10144.5 of the Insurance Code is amended
29 to read:

30 10144.5. (a) Every policy of health insurance that is issued,
31 amended, or renewed on or after July 1, 2000, shall provide
32 coverage for the diagnosis and medically necessary treatment of
33 severe mental illnesses of a person of any age, and of serious
34 emotional disturbances of a child, as specified in subdivisions (d)
35 and (e), under the same terms and conditions applied to other
36 medical conditions, as specified in subdivision (c).

37 (b) These benefits shall include the following:

38 (1) Outpatient services.

39 (2) Inpatient hospital services.

40 (3) Partial hospital services.

1 (4) Prescription drugs, if the policy or contract includes coverage
2 for prescription drugs.

3 (c) The terms and conditions applied to the benefits required
4 by this section, that shall be applied equally to all benefits under
5 the health insurance policy, include, but are not limited to, any
6 form of treatment limitation or other action by an insurer that may
7 limit the receipt of benefits required by this section. These
8 treatment limitations or actions include, but are not limited to, the
9 use of any of the following:

10 (1) Maximum lifetime benefits.

11 (2) Copayments and coinsurance.

12 (3) Individual and family deductibles.

13 (d) For the purposes of this section, “severe mental illnesses”
14 shall include:

15 (1) Schizophrenia.

16 (2) Schizoaffective disorder.

17 (3) Bipolar disorder (manic-depressive illness).

18 (4) Major depressive disorders.

19 (5) Panic disorder.

20 (6) Obsessive-compulsive disorder.

21 (7) Pervasive developmental disorder or autism.

22 (8) Anorexia nervosa.

23 (9) Bulimia nervosa.

24 (e) For the purposes of this section, a child suffering from,
25 “serious emotional disturbances of a child” shall be defined as a
26 child who (1) has one or more mental disorders as identified in the
27 most recent edition of the Diagnostic and Statistical Manual of
28 Mental Disorders, other than a primary substance use disorder or
29 developmental disorder, that result in behavior inappropriate to
30 the child’s age according to expected developmental norms, and
31 (2) who meets the criteria in paragraph (2) of subdivision (a) of
32 Section 5600.3 of the Welfare and Institutions Code.

33 (f) (1) For the purpose of compliance with this section, a health
34 insurer may provide coverage for all or part of the mental health
35 services required by this section through a separate specialized
36 health care service plan or mental health plan, and shall not be
37 required to obtain an additional or specialized license for this
38 purpose.

39 (2) A health insurer shall provide the mental health coverage
40 required by this section in its entire in-state service area and in

1 emergency situations as may be required by applicable laws and
2 regulations. For purposes of this section, health insurers are not
3 precluded from requiring insureds who reside or work in
4 geographic areas served by specialized health care service plans
5 or mental health plans to secure all or part of their mental health
6 services within those geographic areas served by specialized health
7 care service plans or mental health plans.

8 (3) Notwithstanding any other provision of law, in the provision
9 of benefits required by this section, a health insurer may utilize
10 case management, managed care, or utilization review, subject to
11 the limitation imposed under subdivision (c).

12 (4) Any action that a health insurer takes to implement this
13 section, including, but not limited to, contracting with preferred
14 provider organizations, shall not be deemed to be an action that
15 would otherwise require licensure as a health care service plan
16 under the Knox-Keene Health Care Service Plan Act of 1975
17 (Chapter 2.2 (commencing with Section 1340) of Division 2 of
18 the Health and Safety Code).

19 (g) This section shall not apply to accident-only, specified
20 disease, hospital indemnity, Medicare supplement, dental-only, or
21 vision-only insurance policies.

22 SEC. 11. No reimbursement is required by this act pursuant to
23 Section 6 of Article XIII B of the California Constitution because
24 the only costs that may be incurred by a local agency or school
25 district will be incurred because this act creates a new crime or
26 infraction, eliminates a crime or infraction, or changes the penalty
27 for a crime or infraction, within the meaning of Section 17556 of
28 the Government Code, or changes the definition of a crime within
29 the meaning of Section 6 of Article XIII B of the California
30 Constitution.