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INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] (*Division 2 enacted by Stats. 1935, Ch. 145.*)

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] (*Part 2 enacted by Stats. 1935, Ch. 145.*)

CHAPTER 1. The Contract [10110 - 10198.10] (*Chapter 1 enacted by Stats. 1935, Ch. 145.*)

ARTICLE 2.5. Discriminatory Practices [10140 - 10145.4] (*Article 2.5 added by Stats. 1969, Ch. 620.*)

10140. (a) No admitted insurer, licensed to issue life or disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefor, or issue or cancel that insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, sex, gender, gender identity, gender expression, national origin, ancestry, or sexual orientation. Race, color, religion, national origin, ancestry, or sexual orientation shall not, of itself, constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance. Unless otherwise prohibited by law, premium, price, or charge differentials because of the sex of any individual when based on objective, valid, and up-to-date statistical and actuarial data or sound underwriting practices are not prohibited.

(b) Except as otherwise permitted by law, no admitted insurer, licensed to issue disability insurance policies for hospital, medical, and surgical expenses, shall fail or refuse to accept an application for that insurance, fail or refuse to issue that insurance to an applicant therefor, cancel that insurance, refuse to renew that insurance, charge a higher rate or premium for that insurance, or offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(c) No admitted insurer, licensed to issue disability insurance for hospital, medical, and surgical expenses, shall seek information about a person's genetic characteristics for any nontherapeutic purpose.

(d) No discrimination shall be made in the fees or commissions of agents or brokers for writing or renewing a policy of disability insurance, other than disability income, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(e) It shall be deemed a violation of subdivision (a) for any insurer to consider sexual orientation in its underwriting criteria or to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification within this state, or any combination thereof for the purpose of establishing sexual orientation or determining whether to require a test for the presence of the human immunodeficiency virus or antibodies to that virus, where that testing is otherwise permitted by law. Nothing in this section shall be construed to alter, expand, or limit in any manner the existing law respecting the authority of insurers to conduct tests for the presence of human immunodeficiency virus or evidence thereof.

(f) This section shall not be construed to limit the authority of the commissioner to adopt regulations prohibiting discrimination because of sex, marital status, or sexual orientation or to enforce these regulations, whether adopted before or on or after January 1, 1991.

(g) "Genetic characteristics" as used in this section shall have the same meaning as defined in Section 10123.3.

(h) "Sex" as used in this section shall have the same meaning as "gender." "Gender" means sex, and includes a person's gender identity and gender expression. "Gender expression" means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth.

(Amended by Stats. 2011, Ch. 719, Sec. 26. (AB 887) Effective January 1, 2012.)

10140.1. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by an admitted insurer licensed to issue life or disability insurance, except life and disability income policies issued or delivered on or after January 1, 1995, that are contingent upon review or testing for other diseases or medical conditions.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics, of the person to whom the test results apply, except pursuant to a written authorization as

described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars (\$1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars (\$1,000) and no more than five thousand dollars (\$5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars (\$10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

(Amended by Stats. 2000, Ch. 857, Sec. 60. Effective January 1, 2001.)

10140.2. (a) Notwithstanding Section 10140, a health insurance policy issued, amended, or renewed on or after January 1, 2011, shall not be subject to premium, price, or charge differentials because of the sex of any contracting party, potential contracting party, or person reasonably expected to benefit from the policy as a policyholder, insured, or otherwise.

(b) For purposes of this section, "sex" shall have the same meaning as "gender." "Gender" means sex, and includes a person's gender identity and gender expression. "Gender expression" means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth.

(Amended by Stats. 2011, Ch. 719, Sec. 27. (AB 887) Effective January 1, 2012.)

10140.5. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties specified in this section against life or disability insurers for violations of Section 10140.

(b) Any life or disability insurer that violates Section 10140 is liable for administrative penalties of not more than two thousand five hundred dollars (\$2,500) for the first violation and not more than five thousand dollars (\$5,000) for each subsequent violation.

(c) Any life or disability insurer that violates Section 10140 with a frequency that indicates a general business practice or commits a knowing violation of that section, is liable for administrative penalties of not less than fifteen thousand dollars (\$15,000) and not more than one hundred thousand dollars (\$100,000) for each violation.

(d) An act or omission that is inadvertent and that results in incorrect premium rates being charged to more than one subscriber shall be a single violation for the purpose of this section.

(Added by Stats. 1995, Ch. 695, Sec. 9. Effective January 1, 1996.)

10141. No application for insurance or insurance investigation report furnished by such an insurer to its agents or employees for use in determining the insurability of the applicant shall carry any identification, or any requirement therefor, of the applicant's race, color, religion, ancestry, national origin, or sexual orientation.

(Amended by Stats. 2008, Ch. 682, Sec. 6. Effective January 1, 2009.)

10142. Nothing in this article shall prohibit use in an application for life or disability insurance of a question asking for the birthplace of an applicant if such question is used only to identify the applicant and not to discriminate against him.

(Added by Stats. 1971, Ch. 50.)

10143. (a) No insurance company licensed in this state shall refuse to issue or sell or renew any policy of life or disability insurance after appropriate application solely by reason of the fact that the person to be insured carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia A. No such policy issued and delivered in this state to any association, corporation, firm, fund, individual, group, order, organization, society, or trust subject to the supervision of the commissioner shall demand or require a higher premium rate or charge by reason of the fact that the person to be insured carries such traits than is at that time required of any other association, corporation, firm, fund, individual, group, order, organization, society, or trust in an otherwise identical classification, nor shall any association, corporation, firm, fund, group, individual, order, organization, society, or trust make or require any rebate, discrimination, or discount upon the amount to be paid or the service to be rendered on such policy because the person to be insured carries such traits.

(b) No insurance company licensed in this state shall insert in a policy of life or disability insurance any condition, nor make any stipulation, whereby the person insured who carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier, including, but not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia A, shall bind himself, his heirs, executors, administrators, or assignees to accept any sum or service less than the full value or amount of the policy in case of a claim accruing thereon other than such as are imposed upon other persons in similar cases and any such stipulation or condition so made or inserted shall be void.

(c) No insurance company licensed in this state shall fix any lower rate in the fees or commissions of agents or brokers for writing or renewing a policy of life or disability insurance solely because the applicant carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes shall include, but are not limited to, Tay-Sachs trait, sickle cell trait, or X-linked hemophilia A.

(Added by Stats. 1977, Ch. 732.)

10144. No insurer issuing, providing, or administering any contract of individual or group insurance providing life, annuity, or disability benefits applied for and issued on or after January 1, 1984, shall refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual and reasonably anticipated experience.

"Physical or mental impairment" means any physical, sensory, or mental impairment which substantially limits one or more of that person's major life activities.

(Amended by Stats. 1985, Ch. 971, Sec. 1.5.)

10144.1. A disability insurer that denies coverage for an experimental medical procedure or plan of treatment for a claimant with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, under a disability insurance policy that includes hospital, medical, or surgical coverage issued in this state shall provide written notification directly to the claimant or representative, which shall include all of the following:

(a) The specific medical and scientific reasons for the denial and specific references to pertinent policy provisions upon which the denial is based.

(b) A description of the alternative medical procedures or treatments covered by the policy, if any. Compliance with this subdivision by an insurer shall not be construed to mean that the insurer is engaging in the unlawful practice of medicine.

(c) A description of the process by which the claimant or representative may exercise his or her right to appeal the denial and obtain and participate in a review of the information provided to the claimant or representative pursuant to subdivisions (a) and (b). The review shall not be limited to written communication and shall be provided by the appropriate named fiduciary or his or her designee rendering the decision. The review shall be provided to the claimant within 30 calendar days following the receipt of the request for review. However, the review required by this section shall be held within five business days if the treating physician determines, in consultation with the medical director of the insurer, based on standard medical practice, that the effectiveness of either the

proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the policy, would be materially reduced if not provided at the earliest possible date.

(Added by Stats. 1994, Ch. 582, Sec. 2. Effective January 1, 1995.)

10144.2. (a) No disability insurer covering hospital, medical, or surgical expenses shall deny, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate, exclude, or limit coverage or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic violence.

(b) Nothing in this section shall prevent a disability insurer covering hospital, medical, or surgical expenses from underwriting coverage on the basis of the medical condition of an individual so long as the consideration of the condition (1) does not take into account whether such an individual's medical condition was caused by an act of domestic violence, (2) is the same with respect to an applicant or insured who is not the subject of domestic violence as with an applicant or insured who is the subject of domestic violence, and (3) does not violate any other act, regulation, or rule of law. The fact that an individual is, has been, or may be the subject of domestic violence shall not be considered a medical condition.

(c) As used in this section, "domestic violence" means domestic violence, as defined in Section 6211 of the Family Code.

(Added by Stats. 1995, Ch. 603, Sec. 2. Effective January 1, 1996.)

10144.3. (a) No admitted insurer licensed to issue life insurance shall refuse to accept an application for insurance, refuse to issue or renew a policy, cancel a policy, or deny coverage under a policy because the applicant for insurance or any person who is or would be insured is, or has been, a victim of domestic violence.

(b) Nothing in this section shall prevent a life insurer from taking any of the actions set forth in subdivision (a) on the basis of criteria not otherwise made invalid by this section or any other act, regulation, or rule of law. If discrimination by a life insurer is not in violation of this section but is based on any other criteria that are allowable by law, the fact that the applicant or insured is, has been, or may be the subject of domestic violence shall be irrelevant.

(c) Nothing in this section shall require a life insurer to pay for any loss if that payment is prohibited by Section 533.

(d) As used in this section, "domestic violence" means domestic violence as defined in Section 6211 of the Family Code.

(Added by Stats. 1997, Ch. 176, Sec. 1. Effective January 1, 1998.)

10144.4. (a) A large group health insurance policy shall provide all covered mental health and substance use disorder benefits in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(b) An individual or small group health insurance policy shall provide all covered mental health and substance use disorder benefits in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26), and Section 10112.27.

(Added by Stats. 2017, Ch. 162, Sec. 1. (SB 374) Effective January 1, 2018.)

10144.5. (a) (1) Every disability insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- (i) In accordance with the generally accepted standards of mental health and substance use disorder care.
- (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- (iii) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an insured or policyholder under this chapter.

(4) "Health care provider" means any of the following:

- (A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
- (B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
- (C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51.
- (D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
- (E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- (F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
- (G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
- (H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 10144.52.

(6) A disability insurer shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations made by the disability insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 10144.52.

(8) A disability insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This section shall not be construed to expand or alter the benefits available to the insured or policyholder under an insurance policy.

(b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:

- (1) Basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code.
- (2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.
- (3) Prescription drugs, if the policy includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, all of the following patient financial responsibilities:

- (1) Maximum and annual lifetime benefits, if not prohibited by applicable law.
- (2) Copayments and coinsurance.
- (3) Individual and family deductibles.
- (4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the disability insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from an in-network provider.

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

(f) (1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health insurance policy or mental health policy. This paragraph shall not apply to policies that are subject to Section 10112.27.

(2) A disability insurer shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurance policies that provide benefits to insureds through preferred provider contracting arrangements are not precluded from requiring insureds who reside or work in geographic areas served by specialized health insurance policies or mental health insurance policies to secure all or part of their mental health services within those geographic areas served by specialized health insurance policies or mental health insurance policies, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a disability insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 10144.4 of this code, and Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure a disability insurer's compliance with this code.

(h) A disability insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A disability insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(j) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars (\$5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each violation.

(Repealed and added by Stats. 2020, Ch. 151, Sec. 7. (SB 855) Effective January 1, 2021.)

10144.51. (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.

(B) Is supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is either of the following:

(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.

(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.

(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(d) This section shall not apply to the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(e) This section does not limit the obligation to provide services under Section 10144.5.

(f) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(Amended by Stats. 2023, Ch. 635, Sec. 2. (SB 805) Effective January 1, 2024.)

10144.52. (a) A disability insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a disability insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a disability insurer shall not apply different, additional, conflicting, or more

restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a disability insurer from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a disability insurer purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the insurer shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every disability insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the disability insurer's staff, including any third parties contracted with the disability insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 10144.51. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a disability insurance policy is covered as medically necessary for an insured.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a disability insurer to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a disability insurance policy, including prescription drugs.

(h) This section applies to a disability insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(i) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars (\$5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each violation.

(j) A disability insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(Added by Stats. 2020, Ch. 151, Sec. 8. (SB 855) Effective January 1, 2021.)

10144.53. (a) (1) A disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that is required to provide coverage for medically necessary treatment of mental health and substance use disorders pursuant to Sections 10144.5, 10144.51, and 10144.52 shall cover the provision of the services identified in the fee-for-service reimbursement schedule published by the State Department of Health Care Services, as described in subparagraph (B) of paragraph (5) of subdivision (c), when those services are delivered at schoolsites pursuant to this section, regardless of the network status of the local educational agency, institution of higher education, or health care provider.

(2) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

(b) The following definitions apply for purposes of this section:

(1) "Health care provider" has the same meaning as defined in paragraph (4) of subdivision (a) of Section 10144.5 and paragraph (5) of subdivision (c) of Section 10144.51.

(2) "Institution of higher education" means the California Community Colleges, the California State University, or the University of California.

(3) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(4) "Medically necessary treatment of a mental health or substance use disorder" has the same meaning as defined in paragraph (3) of subdivision (a) of Section 10144.5.

(5) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(6) "Schoolsite" means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. "Schoolsite" also includes a location not owned or operated by a public school, or public school district if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

(7) "Utilization review" has the same meaning as defined in paragraph (3) of subdivision (f) of Section 10144.52.

(c) If a local educational agency or institution of higher education provides or arranges for the provision of treatment of a mental health or substance use disorder services subject to this section by a health care provider at a schoolsite for an individual 25 years of age or younger, the student's disability insurer shall reimburse the local educational agency or institution of higher education for those services.

(1) A disability insurer shall not require prior authorization for services provided pursuant to this section.

(2) A disability insurer may conduct a postclaim review to determine appropriate payment of the claim. Payment for services subject to this section may be denied only if the disability insurer reasonably determines that the services were provided to a

student not covered by the insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a disability insurer may require prior authorization for services as authorized by the commissioner, pursuant to subdivision (d).

(4) A local educational agency, community college district, the California State University system, or the Regents of the University of California may consolidate claims for purposes of submission to a disability insurer.

(5) A disability insurer shall provide reimbursement for services provided to students pursuant to this section at the greater of either of the following amounts:

(A) The disability insurer's contracted rate with the local educational agency, institution of higher education, or health care provider, if any.

(B) The fee-for-service reimbursement rate published by the State Department of Health Care Services for the same or similar services provided in an outpatient setting, pursuant to Section 5961.4 of the Welfare and Institutions Code.

(6) A disability insurer shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims as required by this chapter.

(7) Services provided pursuant to this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(8) An individual or entity shall not bill the policyholder or insured, nor seek reimbursement from the policyholder or insured, for services provided pursuant to this section.

(d) The commissioner shall issue guidance to disability insurers regarding compliance with this section, as well as requirements necessary to comply with Section 5961.4 of the Welfare and Institutions Code. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the commissioner adopts regulations pursuant to the Administrative Procedure Act.

(Amended by Stats. 2024, Ch. 999, Sec. 4. (AB 177) Effective September 30, 2024.)

10144.54. (a) An insurance policy issued, amended, renewed, or delivered on or after July 1, 2023, shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services for an insured when required or recommended for the insured pursuant to a CARE agreement or CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code, regardless of whether the service is delivered by an in-network or out-of-network provider.

(b) (1) An insurer shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) An insurer may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the insurer reasonably determines the insured was not insured at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), an insurer may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) An insurer shall provide for reimbursement of services provided to an insured pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The insurer's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) An insurer shall provide for reimbursement of prescription drugs provided to an insured pursuant to this section at the insurer's contracted rate.

(3) An insurer shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an insured pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the insured, nor seek reimbursement from the insured, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

(e) No later than July 1, 2023, the department may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse an insurer from complying with Section 10144.5.

(Added by Stats. 2022, Ch. 319, Sec. 3. (SB 1338) Effective January 1, 2023.)

10144.55. (a) Every policy of disability income insurance, as defined in subdivision (c) of Section 799.01, that is of a short-term limited duration of two years or less, that is issued, amended, or renewed on or after July 1, 2014, and that provides disability income benefits shall provide coverage for disability caused by severe mental illnesses.

(b) For the purposes of this section, "severe mental illnesses" shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders, including postpartum depression.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism.
- (8) Anorexia nervosa.
- (9) Bulimia nervosa.

(Amended by Stats. 2022, Ch. 424, Sec. 26. (SB 1242) Effective January 1, 2023.)

10144.56. (a) For provider contracts issued, amended, or renewed on and after January 1, 2023, a disability insurer that provides coverage for mental health and substance use disorders and that credentials health care providers of those services for its networks shall assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the disability insurer shall notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete. The 60-day timeline shall apply only to the credentialing process and does not include contracting completion.

(b) For the purposes of this section, "mental health and substance use disorder" and "health care provider" have the same meanings as defined in Section 10144.5.

(Added by Stats. 2022, Ch. 533, Sec. 2. (AB 2581) Effective January 1, 2023.)

10144.57. (a) Coverage of mental health and substance use disorder treatment pursuant to Section 10144.5 includes behavioral health crisis services that are provided to an insured by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, as set forth in Chapter 1 (commencing with Section 53123.1) of Part 1 of Division 2 of Title 5 of the Government Code, regardless of whether the service is provided by an in-network or out-of-network provider or facility. With respect to behavioral health crisis services that are provided to an insured by a 988 center or mobile crisis team, a health insurance policy shall cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.

(b) (1) An insurer shall not require prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(2) Notwithstanding any other law, payment for behavioral health crisis stabilization services and care pursuant to this section shall not be denied unless a health insurer reasonably determines that care was not rendered.

(3) If its prior authorization requirements comply with Section 10144.4, a health insurer may require prior authorization for poststabilization care. If there is a disagreement between a health insurer and behavioral health crisis services provider or facility regarding the need for poststabilization care, an insurer shall assume responsibility for care of the insured by promptly arranging for care pursuant to Section 10144.5 at a level of care determined in accordance with utilization review criteria under Section 10144.52.

(4) An insurer shall not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an insured before stabilization has occurred or before it has conducted utilization review in accordance with Sections 10144.5 and 10144.52.

(c) (1) If prior authorization is required for poststabilization care, a health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall, within 30 minutes of the time the provider makes the initial contact, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the insured's care to another provider.

(2) A health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall reimburse the provider or facility for poststabilization care rendered to the insured if any of the following occur:

(A) The health insurer authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care.

(B) The health insurer did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the insured's care within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the insured's care to another provider, and the provider determines that the insured requires poststabilization care.

(3) A health insurer shall prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized insured's care to another provider or authorization to provide poststabilization care. The health insurer shall ensure the telephone number published on its internet website is the correct telephone number for purposes of this paragraph. The health insurer shall update the telephone number on its internet website within one business day if the telephone number changes. A health insurer shall provide the telephone number to the department.

(4) A health insurer shall not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one telephone call to the number provided in advance by the health insurer. The representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the telephone call may be, but is not required to be, a physician or surgeon.

(5) A 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill a patient who is an insured of a health insurer for poststabilization care, except for the in-network cost-sharing amount as defined in paragraph (2) of subdivision (d). An insured who is billed in violation of this section may report receipt of the bill to the health insurer and the department. The department shall forward that report to the State Department of Public Health.

(d) (1) An insurer shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency or nonemergency behavioral health crisis services and care pursuant to this section, consistent with the requirements of Sections 10123.13, 10123.147, and any other applicable requirement of this part.

(2) If an insured receives behavioral health crisis services and care pursuant to this section from a 988 center, mobile crisis team, or other provider of behavioral health crisis services that is an out-of-network provider, the insured shall pay no more than the same cost sharing that the insured would pay for the same items or services received from an in-network provider. This amount shall be referred to as the "in-network cost-sharing amount." An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the insured for services subject to this section except for the in-network cost-sharing amount.

(e) For purposes of this section:

(1) "Behavioral health crisis services" has the same meaning as set forth in Section 53123.1.5 of the Government Code.

(2) "Behavioral health crisis stabilization services" means health care items and services that are necessary to determine if a behavioral health crisis exists and, if a behavioral health crisis does exist, the care and treatment that is necessary to stabilize the behavioral health crisis, within the capability of the 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(3) "Poststabilization care" means medically necessary care provided after a behavioral health crisis has been stabilized.

(4) An insured is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider or facility, the insured's condition is such that, within reasonable medical probability, both of the following criteria are satisfied:

(A) Material deterioration of the insured's condition is unlikely to result from, or occur during, the discharge or transfer of the insured to the care of another provider or facility.

(B) The insured is able to travel safely from the site of care using nonmedical transportation or nonemergency medical transportation. The health insurer shall continue to cover all services and care as behavioral health crisis stabilization services until the insured is discharged or transferred.

(f) This section does not excuse a disability insurer from complying with Section 10144.5 or any other requirement of this part.

(g) This section does not apply to Medicare supplement, dental-only, or vision-only health insurance policies.

(h) The commissioner may promulgate regulations subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to implement this section, and Section 10144.4, 10144.5, 10144.51, or 10144.52 of this code. This subdivision shall not be construed to impair or restrict the commissioner's rulemaking authority pursuant to another provision of this code or the Administrative Procedure Act.

(Amended by Stats. 2023, Ch. 42, Sec. 56. (AB 118) Effective July 10, 2023.)

10144.58. For services provided to an insured under a disability insurance policy issued, amended, or renewed on or after July 1, 2025, a disability insurer subject to Section 10144.5, and its delegates, shall establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services. A process required under this section may be based upon federal rules or guidance issued for the Medicare program.

(Added by Stats. 2024, Ch. 135, Sec. 2. (SB 1320) Effective January 1, 2025.)

10144.6. No disability insurer may utilize any information regarding whether a beneficiary's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement.

(Added by Stats. 2001, Ch. 506, Sec. 4. Effective January 1, 2002.)

10145. No insurer issuing, providing, or administering any contract of individual or group insurance providing life, annuity, or disability benefits applied for and issued on or after January 1, 1986, shall refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of blindness or partial blindness.

"Blindness or partial blindness" means central visual acuity of not more than 20/200 in the better eye, after correction, or visual acuity greater than 20/200 but with a limitation in the fields of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees, certified by a licensed physician and surgeon who specializes in diseases of the eye or a licensed optometrist.

(Added by Stats. 1985, Ch. 971, Sec. 2.)

10145.2. (a) Every policy of disability insurance that is issued, amended, or renewed on or after July 1, 2002, that covers hospital, medical, or surgery expenses shall provide coverage for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

(b) This section may not be construed to require a policy to provide coverage for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

(c) This section shall not apply to vision only, dental only, accident only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, or disability income insurance. For hospital indemnity, accident only, or specified disease insurance coverage, benefits under this section shall apply only to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or certificate. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, hospital indemnity, or specified disease insurance.

(d) Nothing in this section is to be construed in any manner to limit or impede a disability insurer's power or responsibility to negotiate the most cost-effective price for vaccine purchases.

(Added by Stats. 2001, Ch. 634, Sec. 3. Effective January 1, 2002.)

10145.3. (a) Every disability insurer that covers hospital, medical, or surgical benefits shall provide an external, independent review process to examine the insurer's coverage decisions regarding experimental or investigational therapies for individual insureds who meet all of the following criteria:

(1) (A) The insured has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, "life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(2) The insured's physician certifies that the insured has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the insured, for which standard therapies would not be medically appropriate for the insured, or for which there is no more beneficial standard therapy covered by the insurer than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the insured's contracting physician has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the insured than any available standard therapies, or (B) the insured, or the insured's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the insured than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the insurer to pay for the services of a noncontracting physician, provided pursuant to this subdivision, that are not otherwise covered pursuant to the contract.

(4) The insured has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3), unless coverage for the specific therapy has been excluded by the insurer's contract.

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service except for the insurer's determination that the therapy is experimental or under investigation.

(b) The insurer's decision to deny, delay, or modify experimental or investigational therapies shall be subject to the independent medical review process established under Article 3.5 (commencing with Section 10169) of Chapter 1 of Part 2 of Division 2, except that in lieu of the information specified in subdivision (b) of Section 10169.3, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The insurer shall notify eligible insureds in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the insured's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 10169.3.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the insured than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be covered by the insurer, citing the insured's specific medical condition, the relevant documents, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the contract.

(d) For the purposes of subdivision (b), "medical and scientific evidence" means the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database of Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) Either of the following reference compendia:

(A) The American Hospital Formulary Service's Drug Information.

(B) The American Dental Association Accepted Dental Therapeutics.

(5) Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(A) The Elsevier Gold Standard's Clinical Pharmacology.

(B) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(C) The Thomson Micromedex DrugDex.

(6) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

(Amended by Stats. 2009, Ch. 479, Sec. 4. (AB 830) Effective January 1, 2010.)

10145.4. (a) An individual or group health insurance policy that is issued, amended, or renewed on or after January 1, 2020, shall not:

(1) Deny a qualified insured's participation in an approved clinical trial.

(2) Deny, limit, or impose additional conditions on the coverage of routine patient care costs for items and services furnished in connection with a qualified insured's participation in an approved clinical trial.

(3) Discriminate against an insured based on the qualified insured's participation in an approved clinical trial.

(b) (1) Subdivision (a) applies to:

(A) A qualified insured participating in an approved clinical trial conducted by a participating provider.

(B) A qualified insured participating in an approved clinical trial conducted by a nonparticipating provider, including a nonparticipating provider located outside this state, if the clinical trial is not offered or available through a participating provider.

(2) If one or more participating providers is conducting an approved clinical trial, a health insurer may require a qualified insured to participate in the clinical trial through a participating provider if the participating provider accepts the insured as a clinical trial participant.

(3) A health insurer may restrict coverage to an approved clinical trial in this state, unless the clinical trial is not offered or available through a participating provider in this state.

(c) (1) The payment rate for routine patient care costs provided by a nonparticipating provider under a policy that is issued, amended, or renewed on or after January 1, 2020, shall be the negotiated rate the health insurer would otherwise pay a participating provider for the same services, less applicable cost sharing.

(2) Cost sharing for routine patient care costs shall be the same as that applied to the same services not delivered in a clinical trial, except that the in-network cost sharing and out-of-pocket maximum shall apply if the clinical trial is not offered or available through a participating provider.

(3) This section does not limit or modify any existing requirements under this chapter or prevent application of cost-sharing provisions in a policy, except as provided in paragraph (2).

(d) For purposes of this section:

(1) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:

(i) The National Institutes of Health.

(ii) The federal Centers for Disease Control and Prevention.

(iii) The Agency for Healthcare Research and Quality.

(iv) The federal Centers for Medicare and Medicaid Services.

(v) A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs.

(vi) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(I) The United States Department of Veterans Affairs.

(II) The United States Department of Defense.

(III) The United States Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

(2) "Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

(3) "Qualified insured" means an insured who meets both of the following conditions:

(A) The insured is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

(B) Either of the following applies:

(i) The referring health care professional is a participating provider and has concluded that the insured's participation in the clinical trial would be appropriate because the insured meets the conditions of subparagraph (A).

(ii) The insured provides medical and scientific information establishing that the insured's participation in the clinical trial would be appropriate because the insured meets the conditions of subparagraph (A).

(4) "Routine patient care costs" include drugs, items, devices, and services provided consistent with coverage under the policy for an insured who is not enrolled in an approved clinical trial, including the following:

(A) Drugs, items, devices, and services typically covered absent a clinical trial.

(B) Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service.

(C) Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.

(D) Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

(5) "Routine patient care costs" does not include the following:

(A) The investigational drug, item, device, or service itself.

(B) Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the insured.

(C) Drugs, items, devices, and services specifically excluded from coverage in the policy, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.

(D) Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

(e) This section shall not be construed to limit coverage provided by a health insurance policy with respect to clinical trials.

(f) The provision of services required by this section shall not, in itself, give rise to liability on the part of the health insurer.

(g) This section does not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, or disability income insurance policies, except that for specified disease and hospital indemnity insurance, coverage for benefits under this section shall apply, but only to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. This section shall not be construed as imposing a new benefit mandate on specified disease or hospital indemnity insurance.

(h) This section does not limit, prohibit, or modify an insured's rights to the independent review process available under Section 10145.3 or to the Independent Medical Review System available under Article 3.5 (commencing with Section 10169).

(Repealed and added by Stats. 2019, Ch. 482, Sec. 4. (SB 583) Effective January 1, 2020.)