

ASSEMBLY BILL

No. 889

Introduced by Assembly Member Frazier

February 22, 2013

An act to amend Sections 1342.7 and 1374.30 of the Health and Safety Code, and to amend Section 10169 of, and to add Section 10123.193 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 889, as introduced, Frazier. Health care coverage.

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. Existing law requires health care service plan contracts to provide specified coverage to enrollees and subscribers, including specified benefits regarding prescription drugs. Existing law requires the department to develop a regulation outlining standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits, and to consider alternative benefit designs in developing those standards. Existing law makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would delete those provisions regarding development of a regulation outlining the standards to be used in reviewing a plan's request for approval. The bill instead would codify the department's regulation and require every health care service plan or health insurance policy that provides coverage for outpatient prescription drug benefits, as defined, to provide coverage for all medically necessary outpatient prescription drugs, except as specified. The bill would set forth

additional standards regarding outpatient prescription drug benefits, including requiring a plan or insurer seeking to establish limitations or exclusions on outpatient prescription drug benefits to establish those limitations or exclusions consistent with up-to-date evidence-based outcomes and current published, peer-reviewed medical and pharmaceutical literature. The bill would also place restrictions on copayments, coinsurance and deductibles, including, among other things, prohibiting a copayment or percentage coinsurance from exceeding 50% of the cost to the plan or insurer.

Existing law establishes the Independent Medical Review System in the Department of Managed Health Care and the Department of Insurance. Existing law authorizes an enrollee or an insured to apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within 6 months of any specified qualifying periods or events. Existing law requires all necessary information and documents to be delivered to an independent medical review organization within 24 hours of approval of the request for review if there is an imminent and serious threat to the health of the enrollee, as specified.

This bill would authorize an enrollee or an insured or an enrollee’s or insured’s provider or the respective departments to request an expeditious medical review of denied, modified, or delayed health care services if there is an imminent and serious threat to the health of the enrollee or insured, as specified.

Because a willful violation of these requirements 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 1342.7 of the Health and Safety Code is
- 2 amended to read:

1 1342.7. (a) The Legislature finds that in enacting Sections
2 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not
3 intend to limit the department’s authority to regulate the provision
4 of medically necessary prescription drug benefits by a health care
5 service plan to the extent that the plan provides coverage for those
6 benefits.

7 (b) (1) Nothing in this chapter shall preclude a plan from filing
8 relevant information with the department pursuant to Section 1352
9 to seek the approval of a copayment, deductible, limitation, or
10 exclusion to a plan’s prescription drug benefits. If the department
11 approves an exclusion to a plan’s prescription drug benefits, the
12 exclusion shall not be subject to review through the independent
13 medical review process pursuant to Section 1374.30 on the grounds
14 of medical necessity. The department shall retain its role in
15 assessing whether issues are related to coverage or medical
16 necessity pursuant to paragraph (2) of subdivision (d) of Section
17 1374.30.

18 (2) A plan seeking approval of a copayment or deductible may
19 file an amendment pursuant to Section 1352.1. A plan seeking
20 approval of a limitation or exclusion shall file a material
21 modification pursuant to subdivision (b) of Section 1352.

22 (c) Nothing in this chapter shall prohibit a plan from charging
23 a subscriber or enrollee a copayment or deductible for a
24 prescription drug benefit or from setting forth by contract, a
25 limitation or an exclusion from, coverage of prescription drug
26 benefits, if the copayment, deductible, limitation, or exclusion is
27 reported to, and found unobjectionable by, the director and
28 disclosed to the subscriber or enrollee pursuant to the provisions
29 of Section 1363.

30 (d) *Every health care service plan that provides coverage for*
31 *outpatient prescription drug benefits shall provide coverage for*
32 *all medically necessary outpatient prescription drugs, except as*
33 *described in this section.*

34 (1) *“Outpatient prescription drugs” are self-administered drugs*
35 *approved by the federal Food and Drug Administration for sale*
36 *to the public through retail or mail order pharmacies that require*
37 *prescriptions and are not provided for use on an inpatient basis.*

38 (2) *Coverage for outpatient prescription drugs shall include*
39 *coverage for disposable devices that are medically necessary for*
40 *the administration of a covered outpatient prescription drug, such*

1 *as spacers and inhalers for the administration of aerosol outpatient*
2 *prescription drugs, and syringes for self-injectible outpatient*
3 *prescription drugs that are not dispensed in prefilled syringes.*
4 *For purposes of this paragraph, the term “disposable” includes*
5 *devices that may be used more than once before disposal. This*
6 *section does not create an obligation for a plan to provide coverage*
7 *for a durable medical equipment benefit.*

8 *(e) Standards for an outpatient prescription drug benefit shall*
9 *be as follows:*

10 *(1) An outpatient prescription drug benefit offered by a plan*
11 *shall comply with the requirements of this chapter and the*
12 *regulations promulgated by the director, including, but not limited*
13 *to, Sections 1342, 1343.5, 1342.7, 1363, 1363.01, 1363.03, 1363.5,*
14 *1367.01, 1367.06, 1367.20, 1367.21, 1367.22, 1367.24, and*
15 *subdivisions (e), (g), and (h) of Section 1367, of this chapter, and*
16 *subparagraph (A) of paragraph (3) of subdivision (a) of Section*
17 *1300.67.4 of Title 28 of the California Code of Regulations.*

18 *(2) All clinical aspects of a plan’s outpatient prescription drug*
19 *benefit shall be developed by qualified medical and pharmacy*
20 *professionals in accordance with good professional practice. The*
21 *plan shall establish and document an internal process for ongoing*
22 *review by qualified medical and pharmacy professionals of the*
23 *clinical aspects of the outpatient prescription drug benefit,*
24 *including review of limitations and exclusions, and the safety,*
25 *efficacy, and utilization of an outpatient prescription drugs,*
26 *including step therapy, if any.*

27 *(3) Plans seeking to establish limitations or exclusions on an*
28 *outpatient prescription drug benefit shall do so consistent with*
29 *up-to-date evidence-based outcomes and current published,*
30 *peer-reviewed medical and pharmaceutical literature.*

31 *(4) A plan that provides coverage for outpatient prescription*
32 *drugs through a mail order pharmacy shall have written policies*
33 *and procedures documenting that the plan’s mail order*
34 *arrangements are in compliance with the requirements of this*
35 *chapter, and applicable California and federal laws regarding*
36 *pharmacists and pharmacy services. The mail order pharmacy*
37 *process shall conform effectively and efficiently with a plan’s*
38 *processes for prior authorization for coverage of medically*
39 *necessary drugs as required by this chapter, and shall include*
40 *standards for timely delivery and a contingency mechanism for*

1 *providing the drug if a mail order provider fails to meet the*
2 *delivery standards.*

3 *(5) In reviewing copayments, coinsurance, deductibles,*
4 *limitations, or exclusions for compliance with subdivisions (e) and*
5 *(h) of Section 1367 and subparagraph (A) of paragraph (3) of*
6 *subdivision (a) of Section 1300.67.4 of Title 28 of the California*
7 *Code of Regulations, the department's approval or disapproval*
8 *may be based upon all relevant factors, including, but not limited*
9 *to, the following:*

10 *(A) The type and number of enrollees affected.*

11 *(B) The clinical efficacy of the drug or drugs proposed to be*
12 *limited or excluded.*

13 *(C) The availability of therapeutic equivalents or other drugs*
14 *medically necessary for treatment of health conditions.*

15 *(D) The specific health plan products to which the copayment,*
16 *coinsurance, deductible, limitation, or exclusion will apply.*

17 *(E) The duration of the limitation or exclusion.*

18 *(F) The rationale for the copayment, coinsurance, deductible,*
19 *limitation, or exclusion.*

20 *(G) The projected effect of the copayment, coinsurance,*
21 *deductible, limitation, or exclusion on the affordability and*
22 *accessibility of coverage.*

23 *(H) The projected comparative clinical effect, including any*
24 *potential risk of adverse health outcomes, based upon utilization*
25 *data and review of peer-reviewed professional literature.*

26 *(I) The overall copayment structure of the product, including*
27 *whether the copayment, coinsurance, or deductible contributes to*
28 *the overall out-of-pocket maximum for the product.*

29 *(J) Information regarding similar copayments, coinsurance*
30 *levels, deductibles, limitations, or exclusions previously approved*
31 *by the department.*

32 *(K) Evidence-based clinical studies and professional literature.*

33 *(L) The description of the copayment, coinsurance, deductible,*
34 *limitation, or exclusion as compared to other benefits and products*
35 *in the marketplace.*

36 *(M) Any other historical, statistical, or other information that*
37 *the submitting plan considers pertinent to the request for approval*
38 *of the copayments, coinsurance level, deductibles, limitation, or*
39 *exclusion.*

1 (f) Copayments, coinsurance, and deductibles shall be consistent
2 with Sections 1367.006, 1367.007, 1367.009, and 1366.6.

3 (1) A plan's outpatient prescription drug benefit shall provide
4 that if the pharmacy's retail price for a prescription drug is less
5 than the applicable copayment amount, the enrollee shall not be
6 required to pay any more than the retail price.

7 (2) Proposed copayment structures or ranges, coinsurance, or
8 deductibles submitted to the director for approval shall be based
9 upon a methodology that is fully described and documented, and
10 that complies with the standards set forth in this section. A plan
11 may use actual cost data on prescription drugs or, for contracted
12 services or products, nationally recognized data sources used by
13 the plan in developing the contract rates.

14 (3) A copayment or percentage coinsurance shall not exceed
15 50 percent of the cost to the plan. A percentage coinsurance shall
16 meet each of the following additional requirements:

17 (A) Have a maximum dollar amount cap on the percentage
18 coinsurance that will be charged for an individual prescription.

19 (B) Apply towards an annual out-of-pocket maximum for the
20 product.

21 (C) Apply towards an annual out-of-pocket maximum for the
22 outpatient prescription drug benefit, if any.

23 (4) In addition to compliance with this subdivision, copayments
24 and coinsurances shall comply with the standards identified at
25 subdivision (e), including that they shall be reasonable so as to
26 allow access to medically necessary outpatient prescription drugs,
27 and the department's determination may be based on all relevant
28 factors as provided in paragraph (5) of subdivision (e).

29 (5) As used in paragraph (3), the "cost to the plan" means the
30 actual cost incurred by the plan or its contracting provider to
31 acquire and dispense a covered outpatient prescription drug,
32 without subtracting or otherwise considering any copayment or
33 coinsurance amount to be paid by enrollees. The cost to the plan
34 may include average cost calculations as described in this section,
35 and shall include all discounts and other prospective cost and
36 pricing arrangements, as applicable. Plans shall account for any
37 rebates and other retrospective cost and pricing arrangements for
38 outpatient prescription drugs by verifying that the rebates and
39 other retrospective cost and pricing arrangements for outpatient

1 *prescription drugs are applied by the plan to reduce costs for the*
2 *plan's subscribers.*

3 *(g) Plans that provide coverage for outpatient prescription drug*
4 *benefits may apply the following limitations:*

5 *(1) A plan may impose prior authorization requirements on*
6 *outpatient prescription drug benefits, consistent with the*
7 *requirements of this chapter and corresponding regulations.*

8 *(2) When there is more than one drug that is appropriate for*
9 *the treatment of a medical condition, a plan may require step*
10 *therapy. A plan that requires step therapy shall have an expeditious*
11 *process in place to authorize exceptions to step therapy when*
12 *medically necessary and to conform effectively and efficiently with*
13 *continuity of care requirements of this chapter and regulations.*
14 *In circumstances where an enrollee is changing plans, the new*
15 *plan may not require the enrollee to repeat step therapy when that*
16 *enrollee is already being treated for a medical condition by an*
17 *outpatient prescription drug, provided that the drug is*
18 *appropriately prescribed and is considered safe and effective for*
19 *the enrollee's condition. Nothing in this section shall preclude the*
20 *new plan from imposing a prior authorization requirement*
21 *pursuant to Section 1367.24 for the continued coverage of an*
22 *outpatient prescription drug prescribed pursuant to step therapy*
23 *imposed by the former plan, or preclude the prescribing provider*
24 *from prescribing another drug covered by the new plan that is*
25 *medically appropriate for the enrollee. Step therapy, including the*
26 *expeditious process for exception and the instances when an*
27 *enrollee is changing plans, shall be subject to subdivision (e). For*
28 *purposes of this section, "step therapy" means a protocol that*
29 *specifies the sequence in which different prescription drugs for a*
30 *given medical condition that are medically appropriate for a*
31 *particular patient are to be prescribed.*

32 *(3) A plan shall provide coverage for the medically necessary*
33 *dosage and quantity of the drug prescribed for the treatment of a*
34 *medical condition consistent with professionally recognized*
35 *standards of practice.*

36 *(A) A plan may limit the amount of the drug dispensed at any*
37 *one time to a 30-day supply or, if the treatment is for less than 30*
38 *days, for the medically necessary amount of the drug.*

39 *(B) A plan may impose a requirement that maintenance drugs*
40 *be dispensed in a two-month or greater supply.*

1 (C) A plan may establish a mandatory mail order process for
2 maintenance drugs when dispensed in a three-month supply or
3 greater quantities, but shall not impose any fees or costs for
4 mandatory mail order prescriptions other than the applicable
5 copayment or coinsurance. A plan shall not require an enrollee
6 to fill a prescription by mail if the prescribed drug is not available
7 to be filled in that manner.

8 (D) For purposes of this section, “maintenance drugs” means
9 those outpatient prescription drugs that are prescribed for the
10 enrollee on a continual basis to treat a chronic condition.

11 (4) Plans may require enrollees who are prescribed drugs for
12 smoking cessation to be enrolled in or to have completed a smoking
13 cessation program, if covered by the plan prior to or concurrent
14 with receiving the prescription drug.

15 (5) Other limitations that the department may approve pursuant
16 to this section.

17 (h) Plans that provide coverage for outpatient prescription drug
18 benefits are not required to provide coverage for prescription
19 drugs that meet any of the following conditions:

20 (1) When prescribed for cosmetic purposes. For purposes of
21 this section “cosmetic purposes” means solely for the purpose of
22 altering or affecting normal structures of the body to improve
23 appearance rather than function.

24 (2) When prescribed solely for the treatment of hair loss, sexual
25 dysfunction, athletic performance, anti-aging for cosmetic
26 purposes, and mental performance. Drugs for mental performance
27 shall not be excluded from coverage when they are used to treat
28 diagnosed mental illness or medical conditions affecting memory,
29 including, but not limited to, treatment of the conditions or
30 symptoms of dementia or Alzheimer’s disease.

31 (3) When prescribed solely for the purposes of losing weight,
32 except when medically necessary for the treatment of morbid
33 obesity. Plans may require enrollees who are prescribed drugs
34 for morbid obesity to be enrolled in a comprehensive weight loss
35 program, if covered by the plan, for a reasonable period of time
36 prior to or concurrent with receiving the prescription drug.

37 (4) When prescribed solely for the purpose of shortening the
38 duration of the common cold.

39 (5) Drugs that are available over the counter. A plan shall not
40 exclude coverage of an entire class of prescription drugs when

1 *one drug within that class becomes available over the counter. A*
2 *plan that seeks to exclude coverage for an entire class of drugs*
3 *when more than one drug within that class become available over*
4 *the counter shall first file a notice of material modification and*
5 *obtain the department's prior approval in accordance with this*
6 *section.*

7 *(6) Replacement of lost or stolen drugs.*

8 *(7) When prescribed by noncontracting providers for*
9 *noncovered procedures that are not authorized by a plan or a plan*
10 *provider except when coverage is otherwise required in the context*
11 *of emergency services.*

12 *(8) Other categories of prescription drugs approved by the*
13 *department pursuant to this section.*

14 *(i) A plan shall have written policies and procedures for its*
15 *outpatient prescription drug benefits, and quality assurance*
16 *systems in place for the early identification and swift correction*
17 *of problems in the accessibility and availability of outpatient*
18 *prescription drug benefits. A contract between a health care service*
19 *plan and a prescription drug benefit provider shall include*
20 *provisions, terms, and conditions sufficient to ensure that the*
21 *standards and requirements of this section are met.*

22 *(j) (1) Any exclusion or limitation on an outpatient prescription*
23 *drug benefit that is not described in subdivision (g) or (h) shall*
24 *not be applied to a plan's outpatient prescription drug benefit*
25 *unless a plan has filed a notice of material modification with the*
26 *department and received approval by order to apply the exclusion*
27 *or limitation. The order of approval may be issued subject to*
28 *specified terms and conditions, or for specified periods, as the*
29 *department may determine are necessary and appropriate.*
30 *Following issuance of an order approving an exclusion or*
31 *limitation, any other health care service plan may apply the same*
32 *exclusion or limitation to its outpatient prescription drug benefit*
33 *if it files an amendment with the department not less than 30 days*
34 *prior to implementation of the exclusion or limitation, and*
35 *represents that it is exactly the same as that previously approved*
36 *by order, provides specific reference to the order number and date*
37 *issued, and addresses any specified terms and conditions upon*
38 *that order, as applicable.*

39 *(2) A plan may meet the material modification filing*
40 *requirements of paragraph (1) with respect to exclusions and*

1 *limitations contained in contracts issued, renewed, or amended*
2 *on or before January 1, 2007, by filing within six months of the*
3 *effective date of Section 1300.67.4 of Title 28 of the California*
4 *Code of Regulations a report disclosing and describing all such*
5 *exclusions and limitations on prescription drug benefits covered*
6 *under all subscriber contracts subject to the requirements of this*
7 *section. The department will provide an expeditious review of the*
8 *exclusions and limitations disclosed in the report.*

9 ~~(d) The department in developing standards for the approval of~~
10 ~~a copayment, deductible, limitation, or exclusion to a plan's~~
11 ~~prescription drug benefits, shall consider alternative benefit~~
12 ~~designs, including, but not limited to, the following:~~

13 ~~(1) Different out-of-pocket costs for consumers, including~~
14 ~~copayments and deductibles.~~

15 ~~(2) Different limitations, including caps on benefits.~~

16 ~~(3) Use of exclusions from coverage of prescription drugs to~~
17 ~~treat various conditions, including the effect of the exclusions on~~
18 ~~the plan's ability to provide basic health care services, the amount~~
19 ~~of subscriber or enrollee premiums, and the amount of~~
20 ~~out-of-pocket costs for an enrollee.~~

21 ~~(4) Different packages negotiated between purchasers and plans.~~

22 ~~(5) Different tiered pharmacy benefits, including the use of~~
23 ~~generic prescription drugs.~~

24 ~~(6) Current and past practices.~~

25 ~~(e) The department shall develop a regulation outlining the~~
26 ~~standards to be used in reviewing a plan's request for approval of~~
27 ~~its proposed copayment, deductible, limitation, or exclusion on its~~
28 ~~prescription drug benefits.~~

29 ~~(f)~~

30 ~~(k) Nothing in subdivision (b) or (c) shall permit a plan to limit~~
31 ~~prescription drug benefits provided in a manner that is inconsistent~~
32 ~~with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.~~

33 ~~(g)~~

34 ~~(l) Nothing in this section shall be construed to require or~~
35 ~~authorize a plan that contracts with the State Department of Health~~
36 ~~Services to provide services to Medi-Cal beneficiaries or with the~~
37 ~~Managed Risk Medical Insurance Board to provide services to~~
38 ~~enrollees of the Healthy Families Program to provide coverage for~~
39 ~~prescription drugs that are not required pursuant to those programs~~

1 or contracts, or to limit or exclude any prescription drugs that are
2 required by those programs or contracts.

3 ~~(h)~~

4 (m) Nothing in this section shall be construed as prohibiting or
5 otherwise affecting a plan contract that does not cover outpatient
6 prescription drugs, *as defined in subdivision (d)*, except for
7 coverage for limited classes of prescription drugs because they are
8 integral to treatments covered as basic health care services,
9 including, but not limited to, immunosuppressives, in order to
10 allow for transplants of bodily organs.

11 ~~(i)~~

12 (n) The department shall periodically review its regulations
13 developed pursuant to this section.

14 ~~(j) This section shall become operative on January 2, 2003, and~~
15 ~~shall only apply to contracts issued, amended, or renewed on or~~
16 ~~after that date.~~

17 SEC. 2. Section 1374.30 of the Health and Safety Code, as
18 amended by Section 1 of Chapter 872 of the Statutes of 2012, is
19 amended to read:

20 1374.30. (a) Commencing January 1, 2001, there is hereby
21 established in the department the Independent Medical Review
22 System.

23 (b) For the purposes of this chapter, “disputed health care
24 service” means any health care service eligible for coverage and
25 payment under a health care service plan contract that has been
26 denied, modified, or delayed by a decision of the plan, or by one
27 of its contracting providers, in whole or in part due to a finding
28 that the service is not medically necessary. A decision regarding
29 a disputed health care service relates to the practice of medicine
30 and is not a coverage decision. A disputed health care service does
31 not include services provided by a specialized health care service
32 plan, except to the extent that the service (1) involves the practice
33 of medicine, or (2) is provided pursuant to a contract with a health
34 care service plan that covers hospital, medical, or surgical benefits.
35 If a plan, or one of its contracting providers, issues a decision
36 denying, modifying, or delaying health care services, based in
37 whole or in part on a finding that the proposed health care services
38 are not a covered benefit under the contract that applies to the
39 enrollee, the statement of decision shall clearly specify the
40 provision in the contract that excludes that coverage.

1 (c) For the purposes of this chapter, “coverage decision” means
2 the approval or denial of health care services by a plan, or by one
3 of its contracting entities, substantially based on a finding that the
4 provision of a particular service is included or excluded as a
5 covered benefit under the terms and conditions of the health care
6 service plan contract. A “coverage decision” does not encompass
7 a plan or contracting provider decision regarding a disputed health
8 care service.

9 (d) (1) All enrollee grievances involving a disputed health care
10 service are eligible for review under the Independent Medical
11 Review System if the requirements of this article are met. If the
12 department finds that an enrollee grievance involving a disputed
13 health care service does not meet the requirements of this article
14 for review under the Independent Medical Review System, the
15 enrollee request for review shall be treated as a request for the
16 department to review the grievance pursuant to subdivision (b) of
17 Section 1368. All other enrollee grievances, including grievances
18 involving coverage decisions, remain eligible for review by the
19 department pursuant to subdivision (b) of Section 1368.

20 (2) In any case in which an enrollee or provider asserts that a
21 decision to deny, modify, or delay health care services was based,
22 in whole or in part, on consideration of medical necessity, the
23 department shall have the final authority to determine whether the
24 grievance is more properly resolved pursuant to an independent
25 medical review as provided under this article or pursuant to
26 subdivision (b) of Section 1368.

27 (3) The department shall be the final arbiter when there is a
28 question as to whether an enrollee grievance is a disputed health
29 care service or a coverage decision. The department shall establish
30 a process to complete an initial screening of an enrollee grievance.
31 If there appears to be any medical necessity issue, the grievance
32 shall be resolved pursuant to an independent medical review as
33 provided under this article or pursuant to subdivision (b) of Section
34 1368.

35 (e) Every health care service plan contract that is issued,
36 amended, renewed, or delivered in this state on or after January
37 1, 2000, shall, effective January 1, 2001, provide an enrollee with
38 the opportunity to seek an independent medical review whenever
39 health care services have been denied, modified, or delayed by the
40 plan, or by one of its contracting providers, if the decision was

1 based in whole or in part on a finding that the proposed health care
2 services are not medically necessary. For purposes of this article,
3 an enrollee may designate an agent to act on his or her behalf, as
4 described in paragraph (2) of subdivision (b) of Section 1368. The
5 provider may join with or otherwise assist the enrollee in seeking
6 an independent medical review, and may advocate on behalf of
7 the enrollee.

8 (f) Medi-Cal beneficiaries enrolled in a health care service plan
9 shall not be excluded from participation. Medicare beneficiaries
10 enrolled in a health care service plan shall not be excluded unless
11 expressly preempted by federal law. Reviews of cases for Medi-Cal
12 enrollees shall be conducted in accordance with statutes and
13 regulations for the Medi-Cal program.

14 (g) The department may seek to integrate the quality of care
15 and consumer protection provisions, including remedies, of the
16 Independent Medical Review System with related dispute
17 resolution procedures of other health care agency programs,
18 including the Medicare and Medi-Cal programs, in a way that
19 minimizes the potential for duplication, conflict, and added costs.
20 Nothing in this subdivision shall be construed to limit any rights
21 conferred upon enrollees under this chapter.

22 (h) The independent medical review process authorized by this
23 article is in addition to any other procedures or remedies that may
24 be available.

25 (i) No later than January 1, 2001, every health care service plan
26 shall prominently display in every plan member handbook or
27 relevant informational brochure, in every plan contract, on enrollee
28 evidence of coverage forms, on copies of plan procedures for
29 resolving grievances, on letters of denials issued by either the plan
30 or its contracting organization, on the grievance forms required
31 under Section 1368, and on all written responses to grievances,
32 information concerning the right of an enrollee to request an
33 independent medical review in cases where the enrollee believes
34 that health care services have been improperly denied, modified,
35 or delayed by the plan, or by one of its contracting providers.

36 (j) An enrollee may apply to the department for an independent
37 medical review when all of the following conditions are met:

38 (1) (A) The enrollee's provider has recommended a health care
39 service as medically necessary, or

1 (B) The enrollee has received urgent care or emergency services
2 that a provider determined was medically necessary, or

3 (C) The enrollee, in the absence of a provider recommendation
4 under subparagraph (A) or the receipt of urgent care or emergency
5 services by a provider under subparagraph (B), has been seen by
6 an in-plan provider for the diagnosis or treatment of the medical
7 condition for which the enrollee seeks independent review. The
8 plan shall expedite access to an in-plan provider upon request of
9 an enrollee. The in-plan provider need not recommend the disputed
10 health care service as a condition for the enrollee to be eligible for
11 an independent review.

12 For purposes of this article, the enrollee's provider may be an
13 out-of-plan provider. However, the plan shall have no liability for
14 payment of services provided by an out-of-plan provider, except
15 as provided pursuant to subdivision (c) of Section 1374.34.

16 (2) The disputed health care service has been denied, modified,
17 or delayed by the plan, or by one of its contracting providers, based
18 in whole or in part on a decision that the health care service is not
19 medically necessary.

20 (3) The enrollee has filed a grievance with the plan or its
21 contracting provider pursuant to Section 1368, and the disputed
22 decision is upheld or the grievance remains unresolved after 30
23 days. The enrollee shall not be required to participate in the plan's
24 grievance process for more than 30 days. In the case of a grievance
25 that requires expedited review pursuant to Section 1368.01, the
26 enrollee shall not be required to participate in the plan's grievance
27 process for more than three days.

28 (k) (1) An enrollee may apply to the department for an
29 independent medical review of a decision to deny, modify, or delay
30 health care services, based in whole or in part on a finding that the
31 disputed health care services are not medically necessary, within
32 six months of any of the qualifying periods or events under
33 subdivision (j). The director may extend the application deadline
34 beyond six months if the circumstances of a case warrant the
35 extension.

36 (2) *An enrollee or an enrollee's provider may request an*
37 *expeditious medical review pursuant to Section 1374.31 if there*
38 *is an imminent and serious threat to the health of the enrollee,*
39 *including, but not limited to, serious pain, the potential loss of life,*
40 *limb, or major bodily function, or the immediate and serious*

1 *deterioration of the health of the enrollee. Whether or not the*
2 *enrollee or the enrollee's provider requests an expeditious medical*
3 *review, if the department determines that there is an imminent and*
4 *serious threat to the health of the enrollee, the department shall*
5 *refer the decision for an expeditious medical review consistent*
6 *with Section 1374.31 without completing the requirements of*
7 *subdivision (m).*

8 (l) The enrollee shall pay no application or processing fees of
9 any kind.

10 (m) As part of its notification to the enrollee regarding a
11 disposition of the enrollee's grievance that denies, modifies, or
12 delays health care services, the plan shall provide the enrollee with
13 a one-page application form approved by the department, and an
14 addressed envelope, which the enrollee may return to initiate an
15 independent medical review. The plan shall include on the form
16 any information required by the department to facilitate the
17 completion of the independent medical review, such as the
18 enrollee's diagnosis or condition, the nature of the disputed health
19 care service sought by the enrollee, a means to identify the
20 enrollee's case, and any other material information. The form shall
21 also include the following:

22 (1) Notice that a decision not to participate in the independent
23 medical review process may cause the enrollee to forfeit any
24 statutory right to pursue legal action against the plan regarding the
25 disputed health care service.

26 (2) A statement indicating the enrollee's consent to obtain any
27 necessary medical records from the plan, any of its contracting
28 providers, and any out-of-plan provider the enrollee may have
29 consulted on the matter, to be signed by the enrollee.

30 (3) Notice of the enrollee's right to provide information or
31 documentation, either directly or through the enrollee's provider,
32 regarding any of the following:

33 (A) A provider recommendation indicating that the disputed
34 health care service is medically necessary for the enrollee's medical
35 condition.

36 (B) Medical information or justification that a disputed health
37 care service, on an urgent care or emergency basis, was medically
38 necessary for the enrollee's medical condition.

39 (C) Reasonable information supporting the enrollee's position
40 that the disputed health care service is or was medically necessary

1 for the enrollee’s medical condition, including all information
2 provided to the enrollee by the plan or any of its contracting
3 providers, still in the possession of the enrollee, concerning a plan
4 or provider decision regarding disputed health care services, and
5 a copy of any materials the enrollee submitted to the plan, still in
6 the possession of the enrollee, in support of the grievance, as well
7 as any additional material that the enrollee believes is relevant.

8 (n) Upon notice from the department that the health care service
9 plan’s enrollee has applied for an independent medical review, the
10 plan or its contracting providers shall provide to the independent
11 medical review organization designated by the department a copy
12 of all of the following documents within three business days of
13 the plan’s receipt of the department’s notice of a request by an
14 enrollee for an independent review:

15 (1) (A) A copy of all of the enrollee’s medical records in the
16 possession of the plan or its contracting providers relevant to each
17 of the following:

18 (i) The enrollee’s medical condition.

19 (ii) The health care services being provided by the plan and its
20 contracting providers for the condition.

21 (iii) The disputed health care services requested by the enrollee
22 for the condition.

23 (B) Any newly developed or discovered relevant medical records
24 in the possession of the plan or its contracting providers after the
25 initial documents are provided to the independent medical review
26 organization shall be forwarded immediately to the independent
27 medical review organization. The plan shall concurrently provide
28 a copy of medical records required by this subparagraph to the
29 enrollee or the enrollee’s provider, if authorized by the enrollee,
30 unless the offer of medical records is declined or otherwise
31 prohibited by law. The confidentiality of all medical record
32 information shall be maintained pursuant to applicable state and
33 federal laws.

34 (2) A copy of all information provided to the enrollee by the
35 plan and any of its contracting providers concerning plan and
36 provider decisions regarding the enrollee’s condition and care, and
37 a copy of any materials the enrollee or the enrollee’s provider
38 submitted to the plan and to the plan’s contracting providers in
39 support of the enrollee’s request for disputed health care services.
40 This documentation shall include the written response to the

1 enrollee’s grievance, required by paragraph (4) of subdivision (a)
2 of Section 1368. The confidentiality of any enrollee medical
3 information shall be maintained pursuant to applicable state and
4 federal laws.

5 (3) A copy of any other relevant documents or information used
6 by the plan or its contracting providers in determining whether
7 disputed health care services should have been provided, and any
8 statements by the plan and its contracting providers explaining the
9 reasons for the decision to deny, modify, or delay disputed health
10 care services on the basis of medical necessity. The plan shall
11 concurrently provide a copy of documents required by this
12 paragraph, except for any information found by the director to be
13 legally privileged information, to the enrollee and the enrollee’s
14 provider. The department and the independent medical review
15 organization shall maintain the confidentiality of any information
16 found by the director to be the proprietary information of the plan.

17 (o) This section shall become inoperative on July 1, 2015, and,
18 as of January 1, 2016, is repealed, unless a later enacted statute,
19 that becomes operative on or before January 1, 2016, deletes or
20 extends the dates on which it becomes inoperative and is repealed.

21 SEC. 3. Section 1374.30 of the Health and Safety Code, as
22 added by Section 2 of Chapter 872 of the Statutes of 2012, is
23 amended to read:

24 1374.30. (a) Commencing January 1, 2001, there is hereby
25 established in the department the Independent Medical Review
26 System.

27 (b) For the purposes of this chapter, “disputed health care
28 service” means any health care service eligible for coverage and
29 payment under a health care service plan contract that has been
30 denied, modified, or delayed by a decision of the plan, or by one
31 of its contracting providers, in whole or in part due to a finding
32 that the service is not medically necessary. A decision regarding
33 a disputed health care service relates to the practice of medicine
34 and is not a coverage decision. A disputed health care service does
35 not include services provided by a specialized health care service
36 plan, except to the extent that the service (1) involves the practice
37 of medicine, or (2) is provided pursuant to a contract with a health
38 care service plan that covers hospital, medical, or surgical benefits.
39 If a plan, or one of its contracting providers, issues a decision
40 denying, modifying, or delaying health care services, based in

1 whole or in part on a finding that the proposed health care services
2 are not a covered benefit under the contract that applies to the
3 enrollee, the statement of decision shall clearly specify the
4 provision in the contract that excludes that coverage.

5 (c) For the purposes of this chapter, “coverage decision” means
6 the approval or denial of health care services by a plan, or by one
7 of its contracting entities, substantially based on a finding that the
8 provision of a particular service is included or excluded as a
9 covered benefit under the terms and conditions of the health care
10 service plan contract. A “coverage decision” does not encompass
11 a plan or contracting provider decision regarding a disputed health
12 care service.

13 (d) (1) All enrollee grievances involving a disputed health care
14 service are eligible for review under the Independent Medical
15 Review System if the requirements of this article are met. If the
16 department finds that an enrollee grievance involving a disputed
17 health care service does not meet the requirements of this article
18 for review under the Independent Medical Review System, the
19 enrollee request for review shall be treated as a request for the
20 department to review the grievance pursuant to subdivision (b) of
21 Section 1368. All other enrollee grievances, including grievances
22 involving coverage decisions, remain eligible for review by the
23 department pursuant to subdivision (b) of Section 1368.

24 (2) In any case in which an enrollee or provider asserts that a
25 decision to deny, modify, or delay health care services was based,
26 in whole or in part, on consideration of medical necessity, the
27 department shall have the final authority to determine whether the
28 grievance is more properly resolved pursuant to an independent
29 medical review as provided under this article or pursuant to
30 subdivision (b) of Section 1368.

31 (3) The department shall be the final arbiter when there is a
32 question as to whether an enrollee grievance is a disputed health
33 care service or a coverage decision. The department shall establish
34 a process to complete an initial screening of an enrollee grievance.
35 If there appears to be any medical necessity issue, the grievance
36 shall be resolved pursuant to an independent medical review as
37 provided under this article or pursuant to subdivision (b) of Section
38 1368.

39 (e) Every health care service plan contract that is issued,
40 amended, renewed, or delivered in this state on or after January

1 1, 2000, shall provide an enrollee with the opportunity to seek an
2 independent medical review whenever health care services have
3 been denied, modified, or delayed by the plan, or by one of its
4 contracting providers, if the decision was based in whole or in part
5 on a finding that the proposed health care services are not medically
6 necessary. For purposes of this article, an enrollee may designate
7 an agent to act on his or her behalf, as described in paragraph (2)
8 of subdivision (b) of Section 1368. The provider may join with or
9 otherwise assist the enrollee in seeking an independent medical
10 review, and may advocate on behalf of the enrollee.

11 (f) Medi-Cal beneficiaries enrolled in a health care service plan
12 shall not be excluded from participation. Medicare beneficiaries
13 enrolled in a health care service plan shall not be excluded unless
14 expressly preempted by federal law. Reviews of cases for Medi-Cal
15 enrollees shall be conducted in accordance with statutes and
16 regulations for the Medi-Cal program.

17 (g) The department may seek to integrate the quality of care
18 and consumer protection provisions, including remedies, of the
19 Independent Medical Review System with related dispute
20 resolution procedures of other health care agency programs,
21 including the Medicare and Medi-Cal programs, in a way that
22 minimizes the potential for duplication, conflict, and added costs.
23 Nothing in this subdivision shall be construed to limit any rights
24 conferred upon enrollees under this chapter.

25 (h) The independent medical review process authorized by this
26 article is in addition to any other procedures or remedies that may
27 be available.

28 (i) Every health care service plan shall prominently display in
29 every plan member handbook or relevant informational brochure,
30 in every plan contract, on enrollee evidence of coverage forms, on
31 copies of plan procedures for resolving grievances, on letters of
32 denials issued by either the plan or its contracting organization,
33 on the grievance forms required under Section 1368, and on all
34 written responses to grievances, information concerning the right
35 of an enrollee to request an independent medical review in cases
36 where the enrollee believes that health care services have been
37 improperly denied, modified, or delayed by the plan, or by one of
38 its contracting providers.

39 (j) An enrollee may apply to the department for an independent
40 medical review when all of the following conditions are met:

1 (1) (A) The enrollee’s provider has recommended a health care
 2 service as medically necessary, or

3 (B) The enrollee has received urgent care or emergency services
 4 that a provider determined was medically necessary, or

5 (C) The enrollee, in the absence of a provider recommendation
 6 under subparagraph (A) or the receipt of urgent care or emergency
 7 services by a provider under subparagraph (B), has been seen by
 8 an in-plan provider for the diagnosis or treatment of the medical
 9 condition for which the enrollee seeks independent review. The
 10 plan shall expedite access to an in-plan provider upon request of
 11 an enrollee. The in-plan provider need not recommend the disputed
 12 health care service as a condition for the enrollee to be eligible for
 13 an independent review.

14 For purposes of this article, the enrollee’s provider may be an
 15 out-of-plan provider. However, the plan shall have no liability for
 16 payment of services provided by an out-of-plan provider, except
 17 as provided pursuant to subdivision (c) of Section 1374.34.

18 (2) The disputed health care service has been denied, modified,
 19 or delayed by the plan, or by one of its contracting providers, based
 20 in whole or in part on a decision that the health care service is not
 21 medically necessary.

22 (3) The enrollee has filed a grievance with the plan or its
 23 contracting provider pursuant to Section 1368, and the disputed
 24 decision is upheld or the grievance remains unresolved after 30
 25 days. The enrollee shall not be required to participate in the plan’s
 26 grievance process for more than 30 days. In the case of a grievance
 27 that requires expedited review pursuant to Section 1368.01, the
 28 enrollee shall not be required to participate in the plan’s grievance
 29 process for more than three days.

30 (k) (1) An enrollee may apply to the department for an
 31 independent medical review of a decision to deny, modify, or delay
 32 health care services, based in whole or in part on a finding that the
 33 disputed health care services are not medically necessary, within
 34 six months of any of the qualifying periods or events under
 35 subdivision (j). The director may extend the application deadline
 36 beyond six months if the circumstances of a case warrant the
 37 extension.

38 (2) *An enrollee or an enrollee’s provider may request an*
 39 *expeditious medical review pursuant to Section 1374.31 if there*
 40 *is an imminent and serious threat to the health of the enrollee,*

1 *including, but not limited to, serious pain, the potential loss of life,*
2 *limb, or major bodily function, or the immediate and serious*
3 *deterioration of the health of the enrollee. Whether or not the*
4 *enrollee or the enrollee's provider requests an expeditious medical*
5 *review, if the department determines that there is an imminent and*
6 *serious threat to the health of the enrollee, the department shall*
7 *refer the decision for an expeditious medical review consistent*
8 *with Section 1374.31 without completing the requirements of*
9 *subdivision (m).*

10 (l) The enrollee shall pay no application or processing fees of
11 any kind.

12 (m) As part of its notification to the enrollee regarding a
13 disposition of the enrollee's grievance that denies, modifies, or
14 delays health care services, the plan shall provide the enrollee with
15 a one- or two-page application form approved by the department,
16 and an addressed envelope, which the enrollee may return to initiate
17 an independent medical review. The plan shall include on the form
18 any information required by the department to facilitate the
19 completion of the independent medical review, such as the
20 enrollee's diagnosis or condition, the nature of the disputed health
21 care service sought by the enrollee, a means to identify the
22 enrollee's case, and any other material information. The form shall
23 also include the following:

24 (1) Notice that a decision not to participate in the independent
25 medical review process may cause the enrollee to forfeit any
26 statutory right to pursue legal action against the plan regarding the
27 disputed health care service.

28 (2) A statement indicating the enrollee's consent to obtain any
29 necessary medical records from the plan, any of its contracting
30 providers, and any out-of-plan provider the enrollee may have
31 consulted on the matter, to be signed by the enrollee.

32 (3) Notice of the enrollee's right to provide information or
33 documentation, either directly or through the enrollee's provider,
34 regarding any of the following:

35 (A) A provider recommendation indicating that the disputed
36 health care service is medically necessary for the enrollee's medical
37 condition.

38 (B) Medical information or justification that a disputed health
39 care service, on an urgent care or emergency basis, was medically
40 necessary for the enrollee's medical condition.

1 (C) Reasonable information supporting the enrollee's position
2 that the disputed health care service is or was medically necessary
3 for the enrollee's medical condition, including all information
4 provided to the enrollee by the plan or any of its contracting
5 providers, still in the possession of the enrollee, concerning a plan
6 or provider decision regarding disputed health care services, and
7 a copy of any materials the enrollee submitted to the plan, still in
8 the possession of the enrollee, in support of the grievance, as well
9 as any additional material that the enrollee believes is relevant.

10 (4) A section designed to collect information on the enrollee's
11 ethnicity, race, and primary language spoken that includes both of
12 the following:

13 (A) A statement of intent indicating that the information is used
14 for statistics only, in order to ensure that all enrollees get the best
15 care possible.

16 (B) A statement indicating that providing this information is
17 optional and will not affect the independent medical review process
18 in any way.

19 (n) Upon notice from the department that the health care service
20 plan's enrollee has applied for an independent medical review, the
21 plan or its contracting providers shall provide to the independent
22 medical review organization designated by the department a copy
23 of all of the following documents within three business days of
24 the plan's receipt of the department's notice of a request by an
25 enrollee for an independent review:

26 (1) (A) A copy of all of the enrollee's medical records in the
27 possession of the plan or its contracting providers relevant to each
28 of the following:

29 (i) The enrollee's medical condition.

30 (ii) The health care services being provided by the plan and its
31 contracting providers for the condition.

32 (iii) The disputed health care services requested by the enrollee
33 for the condition.

34 (B) Any newly developed or discovered relevant medical records
35 in the possession of the plan or its contracting providers after the
36 initial documents are provided to the independent medical review
37 organization shall be forwarded immediately to the independent
38 medical review organization. The plan shall concurrently provide
39 a copy of medical records required by this subparagraph to the
40 enrollee or the enrollee's provider, if authorized by the enrollee,

1 unless the offer of medical records is declined or otherwise
2 prohibited by law. The confidentiality of all medical record
3 information shall be maintained pursuant to applicable state and
4 federal laws.

5 (2) A copy of all information provided to the enrollee by the
6 plan and any of its contracting providers concerning plan and
7 provider decisions regarding the enrollee's condition and care, and
8 a copy of any materials the enrollee or the enrollee's provider
9 submitted to the plan and to the plan's contracting providers in
10 support of the enrollee's request for disputed health care services.
11 This documentation shall include the written response to the
12 enrollee's grievance, required by paragraph (4) of subdivision (a)
13 of Section 1368. The confidentiality of any enrollee medical
14 information shall be maintained pursuant to applicable state and
15 federal laws.

16 (3) A copy of any other relevant documents or information used
17 by the plan or its contracting providers in determining whether
18 disputed health care services should have been provided, and any
19 statements by the plan and its contracting providers explaining the
20 reasons for the decision to deny, modify, or delay disputed health
21 care services on the basis of medical necessity. The plan shall
22 concurrently provide a copy of documents required by this
23 paragraph, except for any information found by the director to be
24 legally privileged information, to the enrollee and the enrollee's
25 provider. The department and the independent medical review
26 organization shall maintain the confidentiality of any information
27 found by the director to be the proprietary information of the plan.

28 (o) This section shall become operative on July 1, 2015.

29 SEC. 4. Section 10123.193 is added to the Insurance Code, to
30 read:

31 10123.193. (a) Every health insurer that provides coverage
32 for outpatient prescription drug benefits shall provide coverage
33 for all medically necessary outpatient prescription drugs, except
34 as described in this section.

35 (1) "Outpatient prescription drugs" are self-administered drugs
36 approved by the federal Food and Drug Administration for sale to
37 the public through retail or mail order pharmacies that require
38 prescriptions and are not provided for use on an inpatient basis.

39 (2) Coverage for outpatient prescription drugs shall include
40 coverage for disposable devices that are medically necessary for

1 the administration of a covered outpatient prescription drug,
2 including spacers and inhalers for the administration of aerosol
3 outpatient prescription drugs, and syringes for self-injectible
4 outpatient prescription drugs that are not dispensed in prefilled
5 syringes. For purposes of this paragraph, the term “disposable”
6 includes devices that may be used more than once before disposal.
7 This section does not create an obligation for a plan to provide
8 coverage for a durable medical equipment benefit.

9 (b) Standards for an outpatient prescription drug benefit shall
10 be as follows:

11 (1) An outpatient prescription drug benefit offered by a health
12 insurer policy shall comply with the requirements of this part and
13 the regulations promulgated by the commissioner.

14 (2) All clinical aspects of a policy’s outpatient prescription drug
15 benefit shall be developed by qualified medical and pharmacy
16 professionals in accordance with good professional practice. The
17 insurer shall establish and document an internal process for ongoing
18 review by qualified medical and pharmacy professionals of the
19 clinical aspects of the outpatient prescription drug benefit,
20 including review of limitations and exclusions, and the safety,
21 efficacy, and utilization of outpatient prescription drugs, including
22 step therapy, if any.

23 (3) Insurers seeking to establish limitations or exclusions on an
24 outpatient prescription drug benefit shall do so consistent with
25 up-to-date evidence-based outcomes and current published,
26 peer-reviewed medical and pharmaceutical literature.

27 (4) A health insurance policy that provides coverage for
28 outpatient prescription drugs through a mail order pharmacy shall
29 have written policies and procedures documenting that the health
30 insurance policy’s mail order arrangements are in compliance with
31 the requirements of this part, and applicable California and federal
32 laws regarding pharmacists and pharmacy services. The mail order
33 pharmacy process shall conform effectively and efficiently with
34 an insurer’s processes for prior authorization for coverage of
35 medically necessary drugs as required by this part, and shall include
36 standards for timely delivery and a contingency mechanism for
37 providing the drug if a mail order provider fails to meet the delivery
38 standards.

39 (5) In reviewing copayments, coinsurance, deductibles,
40 limitations, or exclusions, the department’s approval or disapproval

1 may be based upon all relevant factors, including, but not limited
2 to, the following:

- 3 (A) The type and number of insureds affected.
 - 4 (B) The clinical efficacy of the drug or drugs proposed to be
5 limited or excluded.
 - 6 (C) The availability of therapeutic equivalents or other drugs
7 medically necessary for treatment of health conditions.
 - 8 (D) The specific health insurance products to which the
9 copayment, coinsurance, deductible, limitation, or exclusion will
10 apply.
 - 11 (E) The duration of the limitation or exclusion.
 - 12 (F) The rationale for the copayment, coinsurance, deductible,
13 limitation or exclusion.
 - 14 (G) The projected effect of the copayment, coinsurance,
15 deductible, limitation, or exclusion on the affordability and
16 accessibility of coverage.
 - 17 (H) The projected comparative clinical effect, including any
18 potential risk of adverse health outcomes, based upon utilization
19 data and review of peer-reviewed professional literature.
 - 20 (I) The overall copayment structure of the product, including
21 whether the copayment, coinsurance, or deductible contributes to
22 the overall out-of-pocket maximum for the product.
 - 23 (J) Information regarding similar copayments, coinsurance
24 levels, deductibles, limitations, or exclusions previously approved
25 by the department.
 - 26 (K) Evidence-based clinical studies and professional literature.
 - 27 (L) The description of the copayment, coinsurance, deductible,
28 limitation, or exclusion as compared to other benefits and products
29 in the marketplace.
 - 30 (M) Any other historical, statistical, or other information that
31 the submitting insurer considers pertinent to the request for
32 approval of the copayments, coinsurance level, deductibles,
33 limitation, or exclusion.
- 34 (c) Copayments, coinsurance and deductibles shall be consistent
35 with Sections 10112.28, 10112.29, and 10112.3.
- 36 (1) A policy's outpatient prescription drug benefit shall provide
37 that if the pharmacy's retail price for a prescription drug is less
38 than the applicable copayment amount, the insured shall not be
39 required to pay any more than the retail price.

1 (2) Proposed copayment structures or ranges, coinsurance, or
 2 deductibles submitted to the commissioner for approval shall be
 3 based upon a methodology that is fully described and documented,
 4 and that complies with the standards set forth in this section. A
 5 health insurer may use actual cost data on prescription drugs or,
 6 for contracted services or products, nationally recognized data
 7 sources used by the health insurer in developing the policy rates.

8 (3) A copayment or percentage coinsurance shall not exceed 50
 9 percent of the cost to the insurer. A percentage coinsurance shall
 10 meet each of the following additional requirements:

11 (A) Have a maximum dollar amount cap on the percentage
 12 coinsurance that will be charged for an individual prescription.

13 (B) Apply towards an annual out-of-pocket maximum for the
 14 product.

15 (C) Apply towards an annual out-of-pocket maximum for the
 16 outpatient prescription drug benefit, if any.

17 (4) In addition to compliance with this subdivision, copayments
 18 and coinsurances shall comply with the standards identified in
 19 subdivision (b), including that they shall be reasonable so as to
 20 allow access to medically necessary outpatient prescription drugs,
 21 and the department’s determination may be based on all relevant
 22 factors as provided in paragraph (5) of subdivision (b).

23 (5) As used in paragraph (3), the “cost to the insurer” means
 24 the actual cost incurred by the insurer or its contracting provider
 25 to acquire and dispense a covered outpatient prescription drug,
 26 without subtracting or otherwise considering any copayment or
 27 coinsurance amount to be paid by insureds. The cost to the insurer
 28 may include average cost calculations as described in this section,
 29 and shall include all discounts and other prospective cost and
 30 pricing arrangements, as applicable. Insurers shall account for any
 31 rebates and other retrospective cost and pricing arrangements for
 32 outpatient prescription drugs by verifying that the rebates and other
 33 retrospective cost and pricing arrangements for outpatient
 34 prescription drugs are applied by the insurer to reduce costs for
 35 the policyholders.

36 (d) Policies that provide coverage for outpatient prescription
 37 drug benefits may apply the following limitations:

38 (1) A policy may impose prior authorization requirements on
 39 outpatient prescription drug benefits, consistent with the
 40 requirements of this part and corresponding regulations.

1 (2) When there is more than one drug that is appropriate for the
2 treatment of a medical condition, a policy may require step therapy.
3 A policy that requires step therapy shall have an expeditious
4 process in place to authorize exceptions to step therapy when
5 medically necessary and to conform effectively and efficiently
6 with continuity of care requirements of this part and regulations.
7 In circumstances where an insured is changing policies, the new
8 policy may not require the insured to repeat step therapy when that
9 insured is already being treated for a medical condition by an
10 outpatient prescription drug, provided that the drug is appropriately
11 prescribed and is considered safe and effective for the insured's
12 condition. Nothing in this section shall preclude the new policy
13 from imposing a prior authorization requirement pursuant for the
14 continued coverage of an outpatient prescription drug prescribed
15 pursuant to step therapy imposed by the former policy, or preclude
16 the prescribing provider from prescribing another drug covered
17 by the new policy that is medically appropriate for the insured.
18 Step therapy, including the expeditious process for exception and
19 the instances when an insured is changing policies, shall be subject
20 to subdivision (b). For purposes of this section, "step therapy"
21 means a protocol that specifies the sequence in which different
22 prescription drugs for a given medical condition that are medically
23 appropriate for a particular patient are to be prescribed.

24 (3) A policy shall provide coverage for the medically necessary
25 dosage and quantity of the drug prescribed for the treatment of a
26 medical condition consistent with professionally recognized
27 standards of practice.

28 (A) A policy may limit the amount of the drug dispensed at any
29 one time to a 30-day supply or, if the treatment is for less than 30
30 days, for the medically necessary amount of the drug.

31 (B) A policy may impose a requirement that maintenance drugs
32 be dispensed in a two-month or greater supply.

33 (C) A policy may establish a mandatory mail order process for
34 maintenance drugs when dispensed in a three-month supply or
35 greater quantities, but shall not impose any fees or costs for
36 mandatory mail order prescriptions other than the applicable
37 copayment or coinsurance. A policy shall not require an insured
38 to fill a prescription by mail if the prescribed drug is not available
39 to be filled in that manner.

1 (D) For purposes of this section, “maintenance drugs” means
2 those outpatient prescription drugs that are prescribed for the
3 insured on a continual basis to treat a chronic condition.

4 (4) Policies may require an insured who is prescribed drugs for
5 smoking cessation to be enrolled in or to have completed a smoking
6 cessation program, if covered by the policy prior to or concurrent
7 with receiving the prescription drug.

8 (5) Other limitations that the department may approve pursuant
9 to this section.

10 (e) Policies that provide coverage for outpatient prescription
11 drug benefits are not required to provide coverage for prescription
12 drugs that meet the following conditions:

13 (1) When prescribed for cosmetic purposes. For purposes of
14 this section “cosmetic purposes” means solely for the purpose of
15 altering or affecting normal structures of the body to improve
16 appearance rather than function.

17 (2) When prescribed solely for the treatment of hair loss, sexual
18 dysfunction, athletic performance, anti-aging for cosmetic
19 purposes, and mental performance. Drugs for mental performance
20 shall not be excluded from coverage when they are used to treat
21 diagnosed mental illness or medical conditions affecting memory,
22 including, but not limited to, treatment of the conditions or
23 symptoms of dementia or Alzheimer’s disease.

24 (3) When prescribed solely for the purposes of losing weight,
25 except when medically necessary for the treatment of morbid
26 obesity. Policies may require insureds who are prescribed drugs
27 for morbid obesity to be enrolled in a comprehensive weight loss
28 program, if covered by the policy, for a reasonable period of time
29 prior to or concurrent with receiving the prescription drug.

30 (4) When prescribed solely for the purpose of shortening the
31 duration of the common cold.

32 (5) Drugs that are available over the counter. A policy shall not
33 exclude coverage of an entire class of prescription drugs when one
34 drug within that class becomes available over the counter. A policy
35 that seeks to exclude coverage for an entire class of drugs when
36 more than one drug within that class become available over the
37 counter shall first file a notice of material modification and obtain
38 the department’s prior approval in accordance with subdivision
39 (g).

40 (6) Replacement of lost or stolen drugs.

1 (7) Drugs when prescribed by noncontracting providers for
2 noncovered procedures that are not authorized by an insurer or a
3 provider except when coverage is otherwise required in the context
4 of emergency services.

5 (8) Other categories of prescription drugs approved by the
6 department pursuant to this section.

7 (f) A health insurer policy shall have written policies and
8 procedures for its outpatient prescription drug benefits and quality
9 assurance systems in place for the early identification and swift
10 correction of problems in the accessibility and availability of
11 outpatient prescription drug benefits. A contract between a health
12 insurer and a prescription drug benefit provider shall include
13 provisions, terms, and conditions sufficient to ensure that the
14 standards and requirements of this section are met.

15 (g) Any exclusion or limitation on an outpatient prescription
16 drug benefit that is not described in subdivision (d) or (e) shall not
17 be applied to a policy's outpatient prescription drug benefit unless
18 an insurer has filed a notice of material modification with the
19 department and received approval by order to apply the exclusion
20 or limitation. The order of approval may be issued subject to
21 specified terms and conditions, or for specified periods, as the
22 department may determine are necessary and appropriate.
23 Following issuance of an order approving an exclusion or
24 limitation, any other insurer may apply the same exclusion or
25 limitation to its outpatient prescription drug benefit if it files an
26 amendment with the department not less than 30 days prior to
27 implementation of the exclusion or limitation, represents that it is
28 exactly the same as that previously approved by order, provides
29 specific reference to the order number and date issued, and
30 addresses any specified terms and conditions upon that order, as
31 applicable.

32 SEC. 5. Section 10169 of the Insurance Code, as amended by
33 Section 7 of Chapter 872 of the Statutes of 2012, is amended to
34 read:

35 10169. (a) Commencing January 1, 2001, there is hereby
36 established in the department the Independent Medical Review
37 System.

38 (b) For the purposes of this chapter, "disputed health care
39 service" means any health care service eligible for coverage and
40 payment under a disability insurance contract that has been denied,

1 modified, or delayed by a decision of the insurer, or by one of its
2 contracting providers, in whole or in part due to a finding that the
3 service is not medically necessary. A decision regarding a disputed
4 health care service relates to the practice of medicine and is not a
5 coverage decision. A disputed health care service does not include
6 services provided by a group or individual policy of vision-only
7 or dental-only coverage, except to the extent that (1) the service
8 involves the practice of medicine, or (2) is provided pursuant to a
9 contract with a disability insurer that covers hospital, medical, or
10 surgical benefits. If an insurer, or one of its contracting providers,
11 issues a decision denying, modifying, or delaying health care
12 services, based in whole or in part on a finding that the proposed
13 health care services are not a covered benefit under the contract
14 that applies to the insured, the statement of decision shall clearly
15 specify the provision in the contract that excludes that coverage.

16 (c) For the purposes of this chapter, “coverage decision” means
17 the approval or denial of health care services by a disability insurer,
18 or by one of its contracting entities, substantially based on a finding
19 that the provision of a particular service is included or excluded
20 as a covered benefit under the terms and conditions of the disability
21 insurance contract. A coverage decision does not encompass a
22 disability insurer or contracting provider decision regarding a
23 disputed health care service.

24 (d) (1) All insured grievances involving a disputed health care
25 service are eligible for review under the Independent Medical
26 Review System if the requirements of this article are met. If the
27 department finds that an insured grievance involving a disputed
28 health care service does not meet the requirements of this article
29 for review under the Independent Medical Review System, the
30 insured request for review shall be treated as a request for the
31 department to review the grievance. All other insured grievances,
32 including grievances involving coverage decisions, remain eligible
33 for review by the department.

34 (2) In any case in which an insured or provider asserts that a
35 decision to deny, modify, or delay health care services was based,
36 in whole or in part, on consideration of medical necessity, the
37 department shall have the final authority to determine whether the
38 grievance is more properly resolved pursuant to an independent
39 medical review as provided under this article.

1 (3) The department shall be the final arbiter when there is a
2 question as to whether an insured grievance is a disputed health
3 care service or a coverage decision. The department shall establish
4 a process to complete an initial screening of an insured grievance.
5 If there appears to be any medical necessity issue, the grievance
6 shall be resolved pursuant to an independent medical review as
7 provided under this article.

8 (e) Every disability insurance contract that is issued, amended,
9 renewed, or delivered in this state on or after January 1, 2000,
10 shall, effective, January 1, 2001, provide an insured with the
11 opportunity to seek an independent medical review whenever
12 health care services have been denied, modified, or delayed by the
13 insurer, or by one of its contracting providers, if the decision was
14 based in whole or in part on a finding that the proposed health care
15 services are not medically necessary. For purposes of this article,
16 an insured may designate an agent to act on his or her behalf. The
17 provider may join with or otherwise assist the insured in seeking
18 an independent medical review, and may advocate on behalf of
19 the insured.

20 (f) Medicare beneficiaries enrolled in Medicare + Choice
21 products shall not be excluded unless expressly preempted by
22 federal law.

23 (g) The department may seek to integrate the quality of care
24 and consumer protection provisions, including remedies, of the
25 Independent Medical Review System with related dispute
26 resolution procedures of other health care agency programs,
27 including the Medicare program, in a way that minimizes the
28 potential for duplication, conflict, and added costs. Nothing in this
29 subdivision shall be construed to limit any rights conferred upon
30 insureds under this chapter.

31 (h) The independent medical review process authorized by this
32 article is in addition to any other procedures or remedies that may
33 be available.

34 (i) No later than January 1, 2001, every disability insurer shall
35 prominently display in every insurer member handbook or relevant
36 informational brochure, in every insurance contract, on insured
37 evidence of coverage forms, on copies of insurer procedures for
38 resolving grievances, on letters of denials issued by either the
39 insurer or its contracting organization, and on all written responses
40 to grievances, information concerning the right of an insured to

1 request an independent medical review in cases where the insured
2 believes that health care services have been improperly denied,
3 modified, or delayed by the insurer, or by one of its contracting
4 providers.

5 (j) An insured may apply to the department for an independent
6 medical review when all of the following conditions are met:

7 (1) (A) The insured's provider has recommended a health care
8 service as medically necessary, or

9 (B) The insured has received urgent care or emergency services
10 that a provider determined was medically necessary, or

11 (C) The insured, in the absence of a provider recommendation
12 under subparagraph (A) or the receipt of urgent care or emergency
13 services by a provider under subparagraph (B), has been seen by
14 a contracting provider for the diagnosis or treatment of the medical
15 condition for which the insured seeks independent review. The
16 insurer shall expedite access to a contracting provider upon request
17 of an insured. The contracting provider need not recommend the
18 disputed health care service as a condition for the insured to be
19 eligible for an independent review.

20 For purposes of this article, the insured's provider may be a
21 noncontracting provider. However, the insurer shall have no
22 liability for payment of services provided by a noncontracting
23 provider, except as provided pursuant to Section 10169.3.

24 (2) The disputed health care service has been denied, modified,
25 or delayed by the insurer, or by one of its contracting providers,
26 based in whole or in part on a decision that the health care service
27 is not medically necessary.

28 (3) The insured has filed a grievance with the insurer or its
29 contracting provider, and the disputed decision is upheld or the
30 grievance remains unresolved after 30 days. The insured shall not
31 be required to participate in the insurer's grievance process for
32 more than 30 days. In the case of a grievance that requires
33 expedited review, the insured shall not be required to participate
34 in the insurer's grievance process for more than three days.

35 (k) (1) An insured may apply to the department for an
36 independent medical review of a decision to deny, modify, or delay
37 health care services, based in whole or in part on a finding that the
38 disputed health care services are not medically necessary, within
39 six months of any of the qualifying periods or events under
40 subdivision (j). The commissioner may extend the application

1 deadline beyond six months if the circumstances of a case warrant
2 the extension.

3 (2) *An insured or an insured's provider may request an*
4 *expeditious medical review pursuant to Section 10169.1 if there*
5 *is an imminent and serious threat to the health of the insured,*
6 *including, but not limited to, serious pain, the potential loss of life,*
7 *limb, or major bodily function, or the immediate and serious*
8 *deterioration of the health of the insured. Whether or not the*
9 *insured or the insured's provider requests an expeditious medical*
10 *review, if the department determines that there is an imminent and*
11 *serious threat to the health of the insured, then the department*
12 *shall refer the decision for an expeditious medical review consistent*
13 *with Section 10169.1 without completing the requirements of*
14 *subdivision (m).*

15 (l) The insured shall pay no application or processing fees of
16 any kind.

17 (m) As part of its notification to the insured regarding a
18 disposition of the insured's grievance that denies, modifies, or
19 delays health care services, the insurer shall provide the insured
20 with a one-page application form approved by the department, and
21 an addressed envelope, which the insured may return to initiate an
22 independent medical review. The insurer shall include on the form
23 any information required by the department to facilitate the
24 completion of the independent medical review, such as the
25 insured's diagnosis or condition, the nature of the disputed health
26 care service sought by the insured, a means to identify the insured's
27 case, and any other material information. The form shall also
28 include the following:

29 (1) Notice that a decision not to participate in the independent
30 review process may cause the insured to forfeit any statutory right
31 to pursue legal action against the insurer regarding the disputed
32 health care service.

33 (2) A statement indicating the insured's consent to obtain any
34 necessary medical records from the insurer, any of its contracting
35 providers, and any noncontracting provider the insured may have
36 consulted on the matter, to be signed by the insured.

37 (3) Notice of the insured's right to provide information or
38 documentation, either directly or through the insured's provider,
39 regarding any of the following:

1 (A) A provider recommendation indicating that the disputed
2 health care service is medically necessary for the insured's medical
3 condition.

4 (B) Medical information or justification that a disputed health
5 care service, on an urgent care or emergency basis, was medically
6 necessary for the insured's medical condition.

7 (C) Reasonable information supporting the insured's position
8 that the disputed health care service is or was medically necessary
9 for the insured's medical condition, including all information
10 provided to the insured by the insurer or any of its contracting
11 providers, still in the possession of the insured, concerning an
12 insurer or provider decision regarding disputed health care services,
13 and a copy of any materials the insured submitted to the insurer,
14 still in the possession of the insured, in support of the grievance,
15 as well as any additional material that the insured believes is
16 relevant.

17 (n) Upon notice from the department that the insured has applied
18 for an independent medical review, the insurer or its contracting
19 providers, shall provide to the independent medical review
20 organization designated by the department a copy of all of the
21 following documents within three business days of the insurer's
22 receipt of the department's notice of a request by an insured for
23 an independent review:

24 (1) (A) A copy of all of the insured's medical records in the
25 possession of the insurer or its contracting providers relevant to
26 each of the following:

27 (i) The insured's medical condition.

28 (ii) The health care services being provided by the insurer and
29 its contracting providers for the condition.

30 (iii) The disputed health care services requested by the insured
31 for the condition.

32 (B) Any newly developed or discovered relevant medical records
33 in the possession of the insurer or its contracting providers after
34 the initial documents are provided to the independent medical
35 review organization shall be forwarded immediately to the
36 independent medical review organization. The insurer shall
37 concurrently provide a copy of medical records required by this
38 subparagraph to the insured or the insured's provider, if authorized
39 by the insured, unless the offer of medical records is declined or
40 otherwise prohibited by law. The confidentiality of all medical

1 record information shall be maintained pursuant to applicable state
2 and federal laws.

3 (2) A copy of all information provided to the insured by the
4 insurer and any of its contracting providers concerning insurer and
5 provider decisions regarding the insured's condition and care, and
6 a copy of any materials the insured or the insured's provider
7 submitted to the insurer and to the insurer's contracting providers
8 in support of the insured's request for disputed health care services.
9 This documentation shall include the written response to the
10 insured's grievance. The confidentiality of any insured medical
11 information shall be maintained pursuant to applicable state and
12 federal laws.

13 (3) A copy of any other relevant documents or information used
14 by the insurer or its contracting providers in determining whether
15 disputed health care services should have been provided, and any
16 statements by the insurer and its contracting providers explaining
17 the reasons for the decision to deny, modify, or delay disputed
18 health care services on the basis of medical necessity. The insurer
19 shall concurrently provide a copy of documents required by this
20 paragraph, except for any information found by the commissioner
21 to be legally privileged information, to the insured and the insured's
22 provider. The department and the independent medical review
23 organization shall maintain the confidentiality of any information
24 found by the commissioner to be the proprietary information of
25 the insurer.

26 (o) This section shall become inoperative on July 1, 2015, and,
27 as of January 1, 2016, is repealed, unless a later enacted statute,
28 that becomes operative on or before January 1, 2016, deletes or
29 extends the dates on which it becomes inoperative and is repealed.

30 SEC. 6. Section 10169 of the Insurance Code, as added by
31 Section 8 of Chapter 872 of the Statutes of 2012, is amended to
32 read:

33 10169. (a) Commencing January 1, 2001, there is hereby
34 established in the department the Independent Medical Review
35 System.

36 (b) For the purposes of this chapter, "disputed health care
37 service" means any health care service eligible for coverage and
38 payment under a disability insurance contract that has been denied,
39 modified, or delayed by a decision of the insurer, or by one of its
40 contracting providers, in whole or in part due to a finding that the

1 service is not medically necessary. A decision regarding a disputed
2 health care service relates to the practice of medicine and is not a
3 coverage decision. A disputed health care service does not include
4 services provided by a group or individual policy of vision-only
5 or dental-only coverage, except to the extent that (1) the service
6 involves the practice of medicine, or (2) is provided pursuant to a
7 contract with a disability insurer that covers hospital, medical, or
8 surgical benefits. If an insurer, or one of its contracting providers,
9 issues a decision denying, modifying, or delaying health care
10 services, based in whole or in part on a finding that the proposed
11 health care services are not a covered benefit under the contract
12 that applies to the insured, the statement of decision shall clearly
13 specify the provision in the contract that excludes that coverage.

14 (c) For the purposes of this chapter, “coverage decision” means
15 the approval or denial of health care services by a disability insurer,
16 or by one of its contracting entities, substantially based on a finding
17 that the provision of a particular service is included or excluded
18 as a covered benefit under the terms and conditions of the disability
19 insurance contract. A coverage decision does not encompass a
20 disability insurer or contracting provider decision regarding a
21 disputed health care service.

22 (d) (1) All insured grievances involving a disputed health care
23 service are eligible for review under the Independent Medical
24 Review System if the requirements of this article are met. If the
25 department finds that an insured grievance involving a disputed
26 health care service does not meet the requirements of this article
27 for review under the Independent Medical Review System, the
28 insured request for review shall be treated as a request for the
29 department to review the grievance. All other insured grievances,
30 including grievances involving coverage decisions, remain eligible
31 for review by the department.

32 (2) In any case in which an insured or provider asserts that a
33 decision to deny, modify, or delay health care services was based,
34 in whole or in part, on consideration of medical necessity, the
35 department shall have the final authority to determine whether the
36 grievance is more properly resolved pursuant to an independent
37 medical review as provided under this article.

38 (3) The department shall be the final arbiter when there is a
39 question as to whether an insured grievance is a disputed health
40 care service or a coverage decision. The department shall establish

1 a process to complete an initial screening of an insured grievance.
2 If there appears to be any medical necessity issue, the grievance
3 shall be resolved pursuant to an independent medical review as
4 provided under this article.

5 (e) Every disability insurance contract that is issued, amended,
6 renewed, or delivered in this state on or after January 1, 2000, shall
7 provide an insured with the opportunity to seek an independent
8 medical review whenever health care services have been denied,
9 modified, or delayed by the insurer, or by one of its contracting
10 providers, if the decision was based in whole or in part on a finding
11 that the proposed health care services are not medically necessary.
12 For purposes of this article, an insured may designate an agent to
13 act on his or her behalf. The provider may join with or otherwise
14 assist the insured in seeking an independent medical review, and
15 may advocate on behalf of the insured.

16 (f) Medicare beneficiaries enrolled in Medicare + Choice
17 products shall not be excluded unless expressly preempted by
18 federal law.

19 (g) The department may seek to integrate the quality of care
20 and consumer protection provisions, including remedies, of the
21 Independent Medical Review System with related dispute
22 resolution procedures of other health care agency programs,
23 including the Medicare program, in a way that minimizes the
24 potential for duplication, conflict, and added costs. Nothing in this
25 subdivision shall be construed to limit any rights conferred upon
26 insureds under this chapter.

27 (h) The independent medical review process authorized by this
28 article is in addition to any other procedures or remedies that may
29 be available.

30 (i) Every disability insurer shall prominently display in every
31 insurer member handbook or relevant informational brochure, in
32 every insurance contract, on insured evidence of coverage forms,
33 on copies of insurer procedures for resolving grievances, on letters
34 of denials issued by either the insurer or its contracting
35 organization, and on all written responses to grievances,
36 information concerning the right of an insured to request an
37 independent medical review in cases where the insured believes
38 that health care services have been improperly denied, modified,
39 or delayed by the insurer, or by one of its contracting providers.

1 (j) An insured may apply to the department for an independent
 2 medical review when all of the following conditions are met:

3 (1) (A) The insured’s provider has recommended a health care
 4 service as medically necessary, or

5 (B) The insured has received urgent care or emergency services
 6 that a provider determined was medically necessary, or

7 (C) The insured, in the absence of a provider recommendation
 8 under subparagraph (A) or the receipt of urgent care or emergency
 9 services by a provider under subparagraph (B), has been seen by
 10 a contracting provider for the diagnosis or treatment of the medical
 11 condition for which the insured seeks independent review. The
 12 insurer shall expedite access to a contracting provider upon request
 13 of an insured. The contracting provider need not recommend the
 14 disputed health care service as a condition for the insured to be
 15 eligible for an independent review.

16 For purposes of this article, the insured’s provider may be a
 17 noncontracting provider. However, the insurer shall have no
 18 liability for payment of services provided by a noncontracting
 19 provider, except as provided pursuant to Section 10169.3.

20 (2) The disputed health care service has been denied, modified,
 21 or delayed by the insurer, or by one of its contracting providers,
 22 based in whole or in part on a decision that the health care service
 23 is not medically necessary.

24 (3) The insured has filed a grievance with the insurer or its
 25 contracting provider, and the disputed decision is upheld or the
 26 grievance remains unresolved after 30 days. The insured shall not
 27 be required to participate in the insurer’s grievance process for
 28 more than 30 days. In the case of a grievance that requires
 29 expedited review, the insured shall not be required to participate
 30 in the insurer’s grievance process for more than three days.

31 (k) (1) An insured may apply to the department for an
 32 independent medical review of a decision to deny, modify, or delay
 33 health care services, based in whole or in part on a finding that the
 34 disputed health care services are not medically necessary, within
 35 six months of any of the qualifying periods or events under
 36 subdivision (j). The commissioner may extend the application
 37 deadline beyond six months if the circumstances of a case warrant
 38 the extension.

39 (2) *An insured or an insured’s provider may request an*
 40 *expeditious medical review pursuant to Section 10169.1 if there*

1 *is an imminent and serious threat to the health of the insured,*
2 *including, but not limited to, serious pain, the potential loss of life,*
3 *limb, or major bodily function, or the immediate and serious*
4 *deterioration of the health of the insured. Whether or not the*
5 *insured or the insured's provider requests an expeditious medical*
6 *review, if the department determines that there is an imminent and*
7 *serious threat to the health of the insured, then the department*
8 *shall refer the decision for an expeditious medical review consistent*
9 *with Section 10169.1 without completing the requirements of*
10 *subdivision (m).*

11 (l) The insured shall pay no application or processing fees of
12 any kind.

13 (m) As part of its notification to the insured regarding a
14 disposition of the insured's grievance that denies, modifies, or
15 delays health care services, the insurer shall provide the insured
16 with a one- or two-page application form approved by the
17 department, and an addressed envelope, which the insured may
18 return to initiate an independent medical review. The insurer shall
19 include on the form any information required by the department
20 to facilitate the completion of the independent medical review,
21 such as the insured's diagnosis or condition, the nature of the
22 disputed health care service sought by the insured, a means to
23 identify the insured's case, and any other material information.
24 The form shall also include the following:

25 (1) Notice that a decision not to participate in the independent
26 review process may cause the insured to forfeit any statutory right
27 to pursue legal action against the insurer regarding the disputed
28 health care service.

29 (2) A statement indicating the insured's consent to obtain any
30 necessary medical records from the insurer, any of its contracting
31 providers, and any noncontracting provider the insured may have
32 consulted on the matter, to be signed by the insured.

33 (3) Notice of the insured's right to provide information or
34 documentation, either directly or through the insured's provider,
35 regarding any of the following:

36 (A) A provider recommendation indicating that the disputed
37 health care service is medically necessary for the insured's medical
38 condition.

1 (B) Medical information or justification that a disputed health
2 care service, on an urgent care or emergency basis, was medically
3 necessary for the insured's medical condition.

4 (C) Reasonable information supporting the insured's position
5 that the disputed health care service is or was medically necessary
6 for the insured's medical condition, including all information
7 provided to the insured by the insurer or any of its contracting
8 providers, still in the possession of the insured, concerning an
9 insurer or provider decision regarding disputed health care services,
10 and a copy of any materials the insured submitted to the insurer,
11 still in the possession of the insured, in support of the grievance,
12 as well as any additional material that the insured believes is
13 relevant.

14 (4) A section designed to collect information on the insured's
15 ethnicity, race, and primary language spoken that includes both of
16 the following:

17 (A) A statement of intent indicating that the information is used
18 for statistics only, in order to ensure that all insureds get the best
19 care possible.

20 (B) A statement indicating that providing this information is
21 optional and will not affect the independent medical review process
22 in any way.

23 (n) Upon notice from the department that the insured has applied
24 for an independent medical review, the insurer or its contracting
25 providers, shall provide to the independent medical review
26 organization designated by the department a copy of all of the
27 following documents within three business days of the insurer's
28 receipt of the department's notice of a request by an insured for
29 an independent review:

30 (1) (A) A copy of all of the insured's medical records in the
31 possession of the insurer or its contracting providers relevant to
32 each of the following:

33 (i) The insured's medical condition.

34 (ii) The health care services being provided by the insurer and
35 its contracting providers for the condition.

36 (iii) The disputed health care services requested by the insured
37 for the condition.

38 (B) Any newly developed or discovered relevant medical records
39 in the possession of the insurer or its contracting providers after
40 the initial documents are provided to the independent medical

1 review organization shall be forwarded immediately to the
2 independent medical review organization. The insurer shall
3 concurrently provide a copy of medical records required by this
4 subparagraph to the insured or the insured's provider, if authorized
5 by the insured, unless the offer of medical records is declined or
6 otherwise prohibited by law. The confidentiality of all medical
7 record information shall be maintained pursuant to applicable state
8 and federal laws.

9 (2) A copy of all information provided to the insured by the
10 insurer and any of its contracting providers concerning insurer and
11 provider decisions regarding the insured's condition and care, and
12 a copy of any materials the insured or the insured's provider
13 submitted to the insurer and to the insurer's contracting providers
14 in support of the insured's request for disputed health care services.
15 This documentation shall include the written response to the
16 insured's grievance. The confidentiality of any insured medical
17 information shall be maintained pursuant to applicable state and
18 federal laws.

19 (3) A copy of any other relevant documents or information used
20 by the insurer or its contracting providers in determining whether
21 disputed health care services should have been provided, and any
22 statements by the insurer and its contracting providers explaining
23 the reasons for the decision to deny, modify, or delay disputed
24 health care services on the basis of medical necessity. The insurer
25 shall concurrently provide a copy of documents required by this
26 paragraph, except for any information found by the commissioner
27 to be legally privileged information, to the insured and the insured's
28 provider. The department and the independent medical review
29 organization shall maintain the confidentiality of any information
30 found by the commissioner to be the proprietary information of
31 the insurer.

32 (o) This section shall become operative on July 1, 2015.

33 SEC. 7. No reimbursement is required by this act pursuant to
34 Section 6 of Article XIII B of the California Constitution because
35 the only costs that may be incurred by a local agency or school
36 district will be incurred because this act creates a new crime or
37 infraction, eliminates a crime or infraction, or changes the penalty
38 for a crime or infraction, within the meaning of Section 17556 of
39 the Government Code, or changes the definition of a crime within

- 1 the meaning of Section 6 of Article XIII B of the California
- 2 Constitution.

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