

AMENDED IN ASSEMBLY MARCH 17, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2400

Introduced by Assembly Member Nazarian

February 18, 2016

An act to amend Sections 1367.24, ~~1367.241, 1367.244, 1368, 1368.01, and 1374.30~~ of the Health and Safety Code, and to amend Sections ~~10123.191, 10123.197, and 10169~~ of, and to add Section 10123.190 to, the Insurance Code, *1368, 1368.01, and 1374.30 of the Health and Safety Code, and to amend Sections 10123.191 and 10169 of the Insurance Code*, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2400, as amended, Nazarian. Prescription drug coverage: prior authorization and external review.

Existing federal law requires a group health plan and a health insurance issuer offering group or individual health insurance coverage to provide for a coverage appeals process, which includes both an internal review and an external review process, that applies if an enrollee receives an adverse benefit determination for a drug that is included on the health plan's formulary drug list.

For plan years commencing on or after January 1, 2016, existing federal law requires a health plan providing essential health benefits to have procedures in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing provider to request and gain access to clinically appropriate nonformulary drugs within certain timeframes, and have an external review if the initial request is denied by the plan.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans

by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans to establish and maintain a grievance system approved by the department under which enrollees may submit grievances to the plan and requires plans to resolve those grievances within 30 days, except as specified. Existing law requires individual, small group, and large group health care service plans and health insurers that provide prescription drug coverage to comply with the external exception request *review* process required by federal law for nonformulary drugs.

~~This bill would require those plans and insurers to also comply with that external exception request process for formulary drugs that require prior authorization by the plan or health insurer. The bill would specify that, for both nonformulary and formulary drugs, the external exception process is in lieu of the health care service plan's grievance process and the health insurer's internal review process following an adverse benefit determination.~~

The bill would specify that for nonformulary drugs, an external exception request may be filed in lieu of filing a grievance with the health care service plan or health insurer following an adverse benefit determination. With respect to formulary drugs, the bill would require the grievance system established by the plan or an insurer's internal grievance process to require a plan or insurer that provides coverage for outpatient prescription drugs to resolve grievances or complaints that involve the disapproval of a request for a formulary drug within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist.

The bill would make other conforming changes to implement these changes.

Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 **SECTION 1.** *Section 1367.24 of the Health and Safety Code*
2 *is amended to read:*

3 1367.24. (a) Every health care service plan that provides
4 prescription drug benefits shall maintain an expeditious process
5 by which prescribing providers may obtain authorization for a
6 medically necessary nonformulary prescription drug. On or before
7 July 1, 1999, every health care service plan that provides
8 prescription drug benefits shall file with the department a
9 description of its process, including timelines, for responding to
10 authorization requests for nonformulary drugs. Any changes to
11 this process shall be filed with the department pursuant to Section
12 1352. Each plan shall provide a written description of its most
13 current process, including timelines, to its prescribing providers.
14 For purposes of this section, a prescribing provider shall include
15 a provider authorized to write a prescription, pursuant to
16 subdivision (a) of Section 4040 of the Business and Professions
17 Code, to treat a medical condition of an enrollee.

18 (b) Any plan that disapproves a request made pursuant to
19 subdivision (a) by a prescribing provider to obtain authorization
20 for a nonformulary drug shall provide the reasons for the
21 disapproval in a notice provided to the enrollee. The notice shall
22 indicate that the enrollee may file a grievance with the plan if the
23 enrollee objects to the disapproval, including any alternative drug
24 or treatment offered by the plan. The notice shall comply with
25 subdivision (b) of Section 1368.02. Any health plan that is required
26 to maintain an external exception request review process pursuant
27 to subdivision (k) shall indicate in the notice required under this
28 subdivision that the enrollee may ~~file~~ *file, in lieu of filing a*
29 *grievance with the plan pursuant to Section 1368, a grievance*
30 *seeking an external exception request review. An enrollee shall*
31 *not be required to file a grievance with the plan or its contracting*
32 *provider pursuant to Section 1368 if a plan disapproves a request*
33 *to obtain authorization for a nonformulary drug under subdivision*
34 *(a). If a plan disapproves a request to obtain authorization for a*
35 *nonformulary drug and the enrollee files a grievance with the plan*
36 *pursuant to Section 1368, the plan shall treat that request as a*
37 *request to obtain an external exception request review.*

1 (c) The process described in subdivision (a) by which
2 prescribing providers may obtain authorization for medically
3 necessary nonformulary drugs shall not apply to a nonformulary
4 drug that has been prescribed for an enrollee in conformance with
5 the provisions of Section 1367.22.

6 (d) The process described in subdivision (a) by which enrollees
7 may obtain medically necessary nonformulary drugs, including
8 specified timelines for responding to prescribing provider
9 authorization requests, shall be described in evidence of coverage
10 and disclosure forms, as required by subdivision (a) of Section
11 1363, issued on or after July 1, 1999.

12 (e) Every health care service plan that provides prescription
13 drug benefits shall maintain, as part of its books and records under
14 Section 1381, all of the following information, which shall be
15 made available to the director upon request:

16 (1) The complete drug formulary or formularies of the plan, if
17 the plan maintains a formulary, including a list of the prescription
18 drugs on the formulary of the plan by major therapeutic category
19 with an indication of whether any drugs are preferred over other
20 drugs.

21 (2) Records developed by the pharmacy and therapeutic
22 committee of the plan, or by others responsible for developing,
23 modifying, and overseeing formularies, including medical groups,
24 individual practice associations, and contracting pharmaceutical
25 benefit management companies, used to guide the drugs prescribed
26 for the enrollees of the plan, that fully describe the reasoning
27 behind formulary decisions.

28 (3) Any plan arrangements with prescribing providers, medical
29 groups, individual practice associations, pharmacists, contracting
30 pharmaceutical benefit management companies, or other entities
31 that are associated with activities of the plan to encourage
32 formulary compliance or otherwise manage prescription drug
33 benefits.

34 (f) If a plan provides prescription drug benefits, the department
35 shall, as part of its periodic onsite medical survey of each plan
36 undertaken pursuant to Section 1380, review the performance of
37 the plan in providing those benefits, including, but not limited to,
38 a review of the procedures and information maintained pursuant
39 to this section, and describe the performance of the plan as part of
40 its report issued pursuant to Section 1380.

1 (g) The director shall not publicly disclose any information
2 reviewed pursuant to this section that is determined by the director
3 to be confidential pursuant to state law.

4 (h) For purposes of this section, “authorization” means approval
5 by the health care service plan to provide payment for the
6 prescription drug.

7 (i) Nonformulary prescription drugs shall include any drug for
8 which an enrollee’s copayment or out-of-pocket costs are different
9 than the copayment for a formulary prescription drug, except as
10 otherwise provided by law or regulation or in cases in which the
11 drug has been excluded in the plan contract pursuant to Section
12 1342.7.

13 (j) Nothing in this section shall be construed to restrict or impair
14 the application of any other provision of this chapter, including,
15 but not limited to, Section 1367, which includes among its
16 requirements that a health care service plan furnish services in a
17 manner providing continuity of care and demonstrate that medical
18 decisions are rendered by qualified medical providers unhindered
19 by fiscal and administrative management.

20 (k) For any individual, small group, or large health plan
21 contracts, a health care service plan’s process described in
22 subdivision (a) shall comply with the request for exception and
23 external exception request review processes described in
24 subdivision (c) of Section 156.122 of Title 45 of the Code of
25 Federal Regulations. This subdivision shall not apply to Medi-Cal
26 managed care health care service plan contracts as described in
27 subdivision (l).

28 (l) “Medi-Cal managed care health care service plan contract”
29 means any entity that enters into a contract with the State
30 Department of Health Care Services pursuant to Chapter 7
31 (commencing with Section 14000), Chapter 8 (commencing with
32 Section 14200), or Chapter 8.75 (commencing with Section 14591)
33 of Part 3 of Division 9 of the Welfare and Institutions Code.

34 (m) Nothing in this section shall be construed to affect an
35 enrollee’s or subscriber’s eligibility to submit a grievance to the
36 department for review under Section 1368 or to apply to the
37 department for an independent medical review under Section
38 1370.4, or Article 5.55 (commencing with Section 1374.30) of
39 this chapter.

1 *SEC. 2. Section 1368 of the Health and Safety Code is amended*
2 *to read:*

3 1368. (a) Every plan shall do all of the following:

4 (1) Establish and maintain a grievance system approved by the
5 department under which enrollees may submit their grievances to
6 the plan. Each system shall provide reasonable procedures in
7 accordance with department regulations that shall ensure adequate
8 consideration of enrollee grievances and rectification when
9 appropriate.

10 (2) Inform its subscribers and enrollees upon enrollment in the
11 plan and annually thereafter of the procedure for processing and
12 resolving grievances. The information shall include the location
13 and telephone number where grievances may be submitted.

14 (3) Provide forms for grievances to be given to subscribers and
15 enrollees who wish to register written grievances. The forms used
16 by plans licensed pursuant to Section 1353 shall be approved by
17 the director in advance as to format.

18 (4) (A) Provide for a written acknowledgment within five
19 calendar days of the receipt of a grievance, except as noted in
20 subparagraph (B). The acknowledgment shall advise the
21 complainant of the following:

22 (i) That the grievance has been received.

23 (ii) The date of receipt.

24 (iii) The name of the plan representative and the telephone
25 number and address of the plan representative who may be
26 contacted about the grievance.

27 (B) (i) Grievances received by telephone, by facsimile, by
28 email, or online through the plan's Internet Web site pursuant to
29 Section 1368.015, that are not coverage disputes, disputed health
30 care services involving medical necessity, or experimental or
31 investigational treatment and that are resolved by the next business
32 day following receipt are exempt from the requirements of
33 subparagraph (A) and paragraph (5). The plan shall maintain a log
34 of all these grievances. The log shall be periodically reviewed by
35 the plan and shall include the following information for each
36 complaint:

37 (I) The date of the call.

38 (II) The name of the complainant.

39 (III) The complainant's member identification number.

40 (IV) The nature of the grievance.

1 (V) The nature of the resolution.

2 (VI) The name of the plan representative who took the call and
3 resolved the grievance.

4 (ii) For health plan contracts in the individual, small group, or
5 large group markets, a health care service plan's response to
6 grievances subject to Section 1367.24 shall also comply with
7 subdivision (c) of Section 156.122 of Title 45 of the Code of
8 Federal Regulations. This paragraph shall not apply to Medi-Cal
9 managed care health care service plan contracts or any entity that
10 enters into a contract with the State Department of Health Care
11 Services pursuant to Chapter 7 (commencing with Section 14000),
12 Chapter 8 (commencing with Section 14200), or Chapter 8.75
13 (commencing with Section 14591) of Part 3 of Division 9 of the
14 Welfare and Institutions Code.

15 (5) Provide subscribers and enrollees with written responses to
16 grievances, with a clear and concise explanation of the reasons for
17 the plan's response. For grievances involving the delay, denial, or
18 modification of health care services, the plan response shall
19 describe the criteria used and the clinical reasons for its decision,
20 including all criteria and clinical reasons related to medical
21 necessity. If a plan, or one of its contracting providers, issues a
22 decision delaying, denying, or modifying health care services based
23 in whole or in part on a finding that the proposed health care
24 services are not a covered benefit under the contract that applies
25 to the enrollee, the decision shall clearly specify the provisions in
26 the contract that exclude that coverage.

27 (6) For grievances involving the cancellation, rescission, or
28 nonrenewal of a health care service plan contract, the health care
29 service plan shall continue to provide coverage to the enrollee or
30 subscriber under the terms of the health care service plan contract
31 until a final determination of the enrollee's or subscriber's request
32 for review has been made by the health care service plan or the
33 director pursuant to Section 1365 and this section. This paragraph
34 shall not apply if the health care service plan cancels or fails to
35 renew the enrollee's or subscriber's health care service plan
36 contract for nonpayment of premiums pursuant to paragraph (1)
37 of subdivision (a) of Section 1365.

38 (7) Keep in its files all copies of grievances, and the responses
39 thereto, for a period of five years.

1 (b) (1) (A) After—~~either~~ completing the grievance process
2 described in subdivision (a), ~~or~~ participating in the process for at
3 least 30 days, *or completing the external exception request review*
4 *process described in subdivision (k) of Section 1367.24*, a
5 subscriber or enrollee may submit the grievance *or external*
6 *exception request review decision* to the department for review.
7 In any case *under the grievance process* determined by the
8 department to be a case involving an imminent and serious threat
9 to the health of the patient, including, but not limited to, severe
10 pain, the potential loss of life, limb, or major bodily function,
11 cancellations, rescissions, or the nonrenewal of a health care service
12 plan contract, or in any other case ~~where~~ *when* the department
13 determines that an earlier review is warranted, a subscriber or
14 enrollee shall not be required to complete the grievance process
15 or to participate in the process for at least 30 days before submitting
16 a grievance to the department for review.

17 (B) A *grievance or external exception request review decision*
18 may be submitted to the department for review and resolution prior
19 to any arbitration.

20 (C) Notwithstanding subparagraphs (A) and (B), the department
21 may refer any *grievance or external exception request review*
22 *decision* that does not pertain to compliance with this chapter to
23 the State Department of Public Health, the California Department
24 of Aging, the federal ~~Health Care Financing Administration~~,
25 *Centers for Medicare and Medicaid Services*, or any other
26 appropriate governmental entity for investigation and resolution.

27 (2) If the subscriber or enrollee is a minor, or is incompetent or
28 incapacitated, the parent, guardian, conservator, relative, or other
29 designee of the subscriber or enrollee, as appropriate, may submit
30 the *grievance or external exception request review decision* to the
31 department as the agent of the subscriber or enrollee. Further, a
32 provider may join with, or otherwise assist, a subscriber or enrollee,
33 or the agent, to submit the *grievance or external exception request*
34 *review decision* to the department. In addition, following
35 submission of the *grievance or external exception request review*
36 *decision* to the department, the subscriber or enrollee, or the agent,
37 may authorize the provider to assist, including advocating on behalf
38 of the subscriber or enrollee. For purposes of this section, a
39 “relative” includes the parent, stepparent, spouse, adult son or

1 daughter, grandparent, brother, sister, uncle, or aunt of the
2 subscriber or enrollee.

3 (3) The department shall review the written documents submitted
4 with the subscriber's or the enrollee's request for review, or
5 submitted by the agent on behalf of the subscriber or enrollee. The
6 department may ask for additional information, and may hold an
7 informal meeting with the involved parties, including providers
8 who have joined in submitting the grievance *or external exception*
9 *request review decision* or who are otherwise assisting or
10 advocating on behalf of the subscriber or enrollee. If after
11 reviewing the record, the department concludes that the ~~grievance,~~
12 ~~*grievance or external exception request review decision*~~, in whole
13 or in part, is eligible for review under the independent medical
14 review system established pursuant to Article 5.55 (commencing
15 with Section 1374.30), the department shall immediately notify
16 the subscriber or enrollee, or agent, of that option and shall, if
17 requested orally or in writing, assist the subscriber or enrollee in
18 participating in the independent medical review system.

19 (4) If after reviewing the record of a ~~grievance,~~ *grievance or*
20 *external exception request review decision*, the department
21 concludes that a health care service eligible for coverage and
22 payment under a health care service plan contract has been delayed,
23 denied, or modified by a plan, or by one of its contracting
24 providers, in whole or in part due to a determination that the service
25 is not medically necessary, and that determination was not
26 communicated to the enrollee in writing along with a notice of the
27 enrollee's potential right to participate in the independent medical
28 review system, as required by this chapter, the director shall, by
29 order, assess administrative penalties. A proceeding for the issuance
30 of an order assessing administrative penalties shall be subject to
31 appropriate notice of, and the opportunity for, a hearing with regard
32 to the person affected in accordance with Section 1397. The
33 administrative penalties shall not be deemed an exclusive remedy
34 available to the director. These penalties shall be paid to the
35 Managed Care Administrative Fines and Penalties Fund and shall
36 be used for the purposes specified in Section 1341.45.

37 (5) The department shall send a written notice of the final
38 disposition of the ~~grievance,~~ *grievance or external exception*
39 *request review decision*, and the reasons therefor, to the subscriber
40 or enrollee, the agent, to any provider that has joined with or is

1 otherwise assisting the subscriber or enrollee, and to the plan,
2 within 30 calendar days of receipt of the request for review unless
3 the director, in his or her discretion, determines that additional
4 time is reasonably necessary to fully and fairly evaluate the relevant
5 ~~grievance~~: *grievance or external exception request review decision*.
6 In any case not eligible for the independent medical review system
7 established pursuant to Article 5.55 (commencing with Section
8 1374.30), the department's written notice shall include, at a
9 minimum, the following:

10 (A) A summary of its findings and the reasons why the
11 department found the plan to be, or not to be, in compliance with
12 any applicable laws, regulations, or orders of the director.

13 (B) A discussion of the department's contact with any medical
14 provider, or any other independent expert relied on by the
15 department, along with a summary of the views and qualifications
16 of that provider or expert.

17 (C) If the enrollee's ~~grievance~~ *grievance or external exception*
18 *request review decision* is sustained in whole or in part, information
19 about any corrective action taken.

20 (6) In any department review of a *grievance or external*
21 *exception request review decision* involving a disputed health care
22 service, as defined in subdivision (b) of Section 1374.30, that is
23 not eligible for the independent medical review system established
24 pursuant to Article 5.55 (commencing with Section 1374.30), in
25 which the department finds that the plan has delayed, denied, or
26 modified health care services that are medically necessary, based
27 on the specific medical circumstances of the enrollee, and those
28 services are a covered benefit under the terms and conditions of
29 the health care service plan contract, the department's written
30 notice shall do either of the following:

31 (A) Order the plan to promptly offer and provide those health
32 care services to the enrollee.

33 (B) Order the plan to promptly reimburse the enrollee for any
34 reasonable costs associated with urgent care or emergency services,
35 or other extraordinary and compelling health care services, when
36 the department finds that the enrollee's decision to secure those
37 services outside of the plan network was reasonable under the
38 circumstances.

39 The department's order shall be binding on the plan.

1 (7) Distribution of the written notice shall not be deemed a
2 waiver of any exemption or privilege under existing law, including,
3 but not limited to, Section 6254.5 of the Government Code, for
4 any information in connection with and including the written
5 notice, nor shall any person employed or in any way retained by
6 the department be required to testify as to that information or
7 notice.

8 (8) The director shall establish and maintain a system of aging
9 of grievances that are pending and unresolved for 30 days or more
10 that shall include a brief explanation of the reasons each grievance
11 is pending and unresolved for 30 days or more.

12 (9) A subscriber or enrollee, or the agent acting on behalf of a
13 subscriber or enrollee, may also request voluntary mediation with
14 the plan prior to exercising the right to submit a grievance *or*
15 *external exception request review decision* to the department. The
16 use of mediation services shall not preclude the right to submit a
17 grievance *or external exception request review decision* to the
18 department upon completion of mediation. In order to initiate
19 mediation, the subscriber or enrollee, or the agent acting on behalf
20 of the subscriber or enrollee, and the plan shall voluntarily agree
21 to mediation. Expenses for mediation shall be borne equally by
22 both sides. The department shall have no administrative or
23 enforcement responsibilities in connection with the voluntary
24 mediation process authorized by this paragraph.

25 (c) The plan's grievance system shall include a system of aging
26 of grievances that are pending and unresolved for 30 days or more.
27 The plan shall provide a quarterly report to the director of
28 grievances pending and unresolved for 30 or more days with
29 separate categories of grievances for Medicare enrollees and
30 Medi-Cal enrollees. The plan shall include with the report a brief
31 explanation of the reasons each grievance is pending and
32 unresolved for 30 days or more. The plan may include the
33 following statement in the quarterly report that is made available
34 to the public by the director:

35
36 "Under Medicare and Medi-Cal law, Medicare enrollees and
37 Medi-Cal enrollees each have separate avenues of appeal that
38 are not available to other enrollees. Therefore, grievances
39 pending and unresolved may reflect enrollees pursuing their
40 Medicare or Medi-Cal appeal rights."

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 2 If requested by a plan, the director shall include this statement in
 3 a written report made available to the public and prepared by the
 4 director that describes or compares grievances that are pending
 5 and unresolved with the plan for 30 days or more. Additionally,
 6 the director shall, if requested by a plan, append to that written
 7 report a brief explanation, provided in writing by the plan, of the
 8 reasons why grievances described in that written report are pending
 9 and unresolved for 30 days or more. The director shall not be
 10 required to include a statement or append a brief explanation to a
 11 written report that the director is required to prepare under this
 12 chapter, including Sections 1380 and 1397.5.

13 (d) Subject to subparagraph (C) of paragraph (1) of subdivision
 14 (b), the grievance or resolution procedures authorized by this
 15 section shall be in addition to any other procedures that may be
 16 available to any person, and failure to pursue, exhaust, or engage
 17 in the procedures described in this section shall not preclude the
 18 use of any other remedy provided by law.

19 (e) Nothing in this section shall be construed to allow the
 20 submission to the department of any provider grievance under this
 21 section. However, as part of a provider’s duty to advocate for
 22 medically appropriate health care for his or her patients pursuant
 23 to Sections 510 and 2056 of the Business and Professions Code,
 24 nothing in this subdivision shall be construed to prohibit a provider
 25 from contacting and informing the department about any concerns
 26 he or she has regarding compliance with or enforcement of this
 27 chapter.

28 (f) To the extent required by Section 2719 of the federal Public
 29 Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent
 30 rules or regulations, there shall be an independent external review
 31 pursuant to the standards required by the United States Secretary
 32 of Health and Human Services of a health care service plan’s
 33 cancellation, rescission, or nonrenewal of an enrollee’s or
 34 subscriber’s coverage.

35 *SEC. 3. Section 1368.01 of the Health and Safety Code is*
 36 *amended to read:*

37 1368.01. (a) The grievance system shall require the plan to
 38 resolve grievances within 30 days, except as provided in
 39 ~~subdivision (e).~~ *subdivisions (c) and (d).*

1 (b) The grievance system shall include a requirement for
2 expedited plan review of grievances for cases involving an
3 imminent and serious threat to the health of the patient, including,
4 but not limited to, severe pain, potential loss of life, limb, or major
5 bodily function. When the plan has notice of a case requiring
6 expedited review, the grievance system shall require the plan to
7 immediately inform enrollees and subscribers in writing of their
8 right to notify the department of the grievance. The grievance
9 system shall also require the plan to provide enrollees, subscribers,
10 and the department with a written statement on the disposition or
11 pending status of the grievance no later than three days from receipt
12 of the grievance, except as provided in subdivision (c). Paragraph
13 (4) of subdivision (a) of Section 1368 shall not apply to grievances
14 handled pursuant to this section.

15 (c) A health care service plan contract in the individual, small
16 group, or large group markets that provides coverage for outpatient
17 prescription drugs shall comply with subdivision (c) of Section
18 156.122 of Title 45 of the Code of Federal Regulations. This
19 subdivision shall not apply to Medi-Cal managed care health care
20 service plan contracts or any entity that enters into a contract with
21 the State Department of Health Care Services pursuant to Chapter
22 7 (commencing with Section 14000), Chapter 8 (commencing with
23 Section 14200), or Chapter 8.75 (commencing with Section 14591)
24 of Part 3 of Division 9 of the Welfare and Institutions Code.

25 (d) *The grievance system shall require a health care service*
26 *plan that provides coverage for outpatient prescription drugs to*
27 *resolve grievances within 72 hours for nonurgent requests, and*
28 *within 24 hours if exigent circumstances exist, if the original*
29 *request was an authorization for a formulary drug that requires*
30 *prior authorization by the plan. For purposes of this subdivision,*
31 *“exigent circumstances” shall have the same meaning as set forth*
32 *in Section 1367.241.*

33 *SEC. 4. Section 1374.30 of the Health and Safety Code is*
34 *amended to read:*

35 1374.30. (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 health care service plan contract that has been

1 denied, modified, or delayed by a decision of the plan, or by one
2 of its contracting providers, in whole or in part due to a finding
3 that the service is not medically necessary. A decision regarding
4 a disputed health care service relates to the practice of medicine
5 and is not a coverage decision. A disputed health care service does
6 not include services provided by a specialized health care service
7 plan, except to the extent that the service (1) involves the practice
8 of medicine, or (2) is provided pursuant to a contract with a health
9 care service plan that covers hospital, medical, or surgical benefits.
10 If a plan, or one of its contracting providers, issues a decision
11 denying, modifying, or delaying health care services, based in
12 whole or in part on a finding that the proposed health care services
13 are not a covered benefit under the contract that applies to the
14 enrollee, the statement of decision shall clearly specify the
15 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 plan, or by one
18 of its contracting entities, substantially based on a finding that the
19 provision of a particular service is included or excluded as a
20 covered benefit under the terms and conditions of the health care
21 service plan contract. A “coverage decision” does not encompass
22 a plan or contracting provider decision regarding a disputed health
23 care service.

24 (d) (1) All enrollee 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 enrollee 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 enrollee request for review shall be treated as a request for the
31 department to review the grievance pursuant to subdivision (b) of
32 Section 1368. All other enrollee grievances, including grievances
33 involving coverage decisions, remain eligible for review by the
34 department pursuant to subdivision (b) of Section 1368.

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

1 medical review as provided under this article or pursuant to
2 subdivision (b) of Section 1368.

3 (3) The department shall be the final arbiter when there is a
4 question as to whether an enrollee grievance is a disputed health
5 care service or a coverage decision. The department shall establish
6 a process to complete an initial screening of an enrollee grievance.
7 If there appears to be any medical necessity issue, the grievance
8 shall be resolved pursuant to an independent medical review as
9 provided under this article or pursuant to subdivision (b) of Section
10 1368.

11 (e) Every health care service plan contract that is issued,
12 amended, renewed, or delivered in this state on or after January
13 1, 2000, shall provide an enrollee with the opportunity to seek an
14 independent medical review whenever health care services have
15 been denied, modified, or delayed by the plan, or by one of its
16 contracting providers, if the decision was based in whole or in part
17 on a finding that the proposed health care services are not medically
18 necessary. For purposes of this article, an enrollee may designate
19 an agent to act on his or her behalf, as described in paragraph (2)
20 of subdivision (b) of Section 1368. The provider may join with or
21 otherwise assist the enrollee in seeking an independent medical
22 review, and may advocate on behalf of the enrollee.

23 (f) Medi-Cal beneficiaries enrolled in a health care service plan
24 shall not be excluded from participation. Medicare beneficiaries
25 enrolled in a health care service plan shall not be excluded unless
26 expressly preempted by federal law. Reviews of cases for Medi-Cal
27 enrollees shall be conducted in accordance with statutes and
28 regulations for the Medi-Cal program.

29 (g) The department may seek to integrate the quality of care
30 and consumer protection provisions, including remedies, of the
31 Independent Medical Review System with related dispute
32 resolution procedures of other health care agency programs,
33 including the Medicare and Medi-Cal programs, in a way that
34 minimizes the potential for duplication, conflict, and added costs.
35 Nothing in this subdivision shall be construed to limit any rights
36 conferred upon enrollees under this chapter.

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

1 (i) Every health care service plan shall prominently display in
 2 every plan member handbook or relevant informational brochure,
 3 in every plan contract, on enrollee evidence of coverage forms, on
 4 copies of plan procedures for resolving grievances, on letters of
 5 denials issued by either the plan or its contracting organization,
 6 on the grievance forms required under Section 1368, and on all
 7 written responses to grievances, information concerning the right
 8 of an enrollee to request an independent medical review in cases
 9 where the enrollee believes that health care services have been
 10 improperly denied, modified, or delayed by the plan, or by one of
 11 its contracting providers.

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

14 (1) (A) The enrollee’s provider has recommended a health care
 15 service as medically ~~necessary~~, or *necessary*.

16 (B) The enrollee has received urgent care or emergency services
 17 that a provider determined was medically ~~necessary~~, or *necessary*.

18 (C) The enrollee, in the absence of a provider recommendation
 19 under subparagraph (A) or the receipt of urgent care or emergency
 20 services by a provider under subparagraph (B), has been seen by
 21 an in-plan provider for the diagnosis or treatment of the medical
 22 condition for which the enrollee seeks independent review. The
 23 plan shall expedite access to an in-plan provider upon request of
 24 an enrollee. The in-plan provider need not recommend the disputed
 25 health care service as a condition for the enrollee to be eligible for
 26 an independent review.

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

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

35 (3) *Either of the following:*

36 ~~(3)~~

37 (A) The enrollee has filed a grievance with the plan or its
 38 contracting provider pursuant to Section 1368, and the disputed
 39 decision is upheld or the grievance remains unresolved after 30
 40 days. The enrollee shall not be required to participate in the plan’s

1 grievance process for more than 30 days. In the case of a grievance
2 that requires expedited review pursuant to *subdivision (b) of*
3 *Section 1368.01*, the enrollee shall not be required to participate
4 in the plan's grievance process for more than three days. *In the*
5 *case of a grievance that requires expedited review pursuant to*
6 *subdivision (d) of Section 1368.01*, the enrollee shall not be
7 *required to participate in the plan's grievance process for more*
8 *than 72 hours, or more than 24 hours if exigent circumstances*
9 *exist.*

10 (B) *The enrollee has filed for an external exception request*
11 *review decision with the plan or its contracting provider pursuant*
12 *to subdivision (k) of Section 1367.24, and the disputed decision is*
13 *upheld or the external review remains unresolved after 72 hours,*
14 *or after 24 hours if exigent circumstances exist.*

15 (k) An enrollee may apply to the department for an independent
16 medical review of a decision to deny, modify, or delay health care
17 services, based in whole or in part on a finding that the disputed
18 health care services are not medically necessary, within six months
19 of any of the qualifying periods or events under subdivision (j).
20 The director may extend the application deadline beyond six
21 months if the circumstances of a case warrant the extension.

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

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

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

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

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

8 (A) A provider recommendation indicating that the disputed
9 health care service is medically necessary for the enrollee's medical
10 condition.

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

14 (C) Reasonable information supporting the enrollee's position
15 that the disputed health care service is or was medically necessary
16 for the enrollee's medical condition, including all information
17 provided to the enrollee by the plan or any of its contracting
18 providers, still in the possession of the enrollee, concerning a plan
19 or provider decision regarding disputed health care services, and
20 a copy of any materials the enrollee submitted to the plan, still in
21 the possession of the enrollee, in support of the grievance, as well
22 as any additional material that the enrollee believes is relevant.

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

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

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

32 (n) Upon notice from the department that the health care service
33 plan's enrollee has applied for an independent medical review, the
34 plan or its contracting providers shall provide to the independent
35 medical review organization designated by the department a copy
36 of all of the following documents within three business days of
37 the plan's receipt of the department's notice of a request by an
38 enrollee for an independent review:

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

- 4 (i) The enrollee’s medical condition.
- 5 (ii) The health care services being provided by the plan and its
6 contracting providers for the condition.
- 7 (iii) The disputed health care services requested by the enrollee
8 for the condition.

9 (B) Any newly developed or discovered relevant medical records
10 in the possession of the plan or its contracting providers after the
11 initial documents are provided to the independent medical review
12 organization shall be forwarded immediately to the independent
13 medical review organization. The plan shall concurrently provide
14 a copy of medical records required by this subparagraph to the
15 enrollee or the enrollee’s provider, if authorized by the enrollee,
16 unless the offer of medical records is declined or otherwise
17 prohibited by law. The confidentiality of all medical record
18 information shall be maintained pursuant to applicable state and
19 federal laws.

20 (2) A copy of all information provided to the enrollee by the
21 plan and any of its contracting providers concerning plan and
22 provider decisions regarding the enrollee’s condition and care, and
23 a copy of any materials the enrollee or the enrollee’s provider
24 submitted to the plan and to the plan’s contracting providers in
25 support of the enrollee’s request for disputed health care services.
26 This documentation shall include the written response to the
27 enrollee’s grievance, required by paragraph (4) of subdivision (a)
28 of Section 1368. The confidentiality of any enrollee medical
29 information shall be maintained pursuant to applicable state and
30 federal laws.

31 (3) A copy of any other relevant documents or information used
32 by the plan or its contracting providers in determining whether
33 disputed health care services should have been provided, and any
34 statements by the plan and its contracting providers explaining the
35 reasons for the decision to deny, modify, or delay disputed health
36 care services on the basis of medical necessity. The plan shall
37 concurrently provide a copy of documents required by this
38 paragraph, except for any information found by the director to be
39 legally privileged information, to the enrollee and the enrollee’s
40 provider. The department and the independent medical review

1 organization shall maintain the confidentiality of any information
2 found by the director to be the proprietary information of the plan.

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

4 *SEC. 5. Section 10123.191 of the Insurance Code is amended*
5 *to read:*

6 10123.191. (a) Notwithstanding any other law, on and after
7 January 1, 2013, a health insurer that provides coverage for
8 prescription drugs shall utilize and accept only the prior
9 authorization form developed pursuant to subdivision (c), or an
10 electronic prior authorization process described in subdivision (e),
11 when requiring prior authorization for prescription drugs.

12 (b) (1) If a health insurer or a contracted physician group fails
13 to respond within 72 hours for nonurgent requests, and within 24
14 hours if exigent circumstances exist, upon receipt of a completed
15 prior authorization request from a prescribing provider, the prior
16 authorization request shall be deemed to have been granted.

17 (2) *A health insurer's internal grievance process shall require*
18 *a health insurer that provides coverage for outpatient prescription*
19 *drugs to resolve grievances within 72 hours for nonurgent requests,*
20 *and within 24 hours if exigent circumstances exist, if the original*
21 *request was an authorization for a formulary drug that requires*
22 *prior authorization by the health insurer.*

23 (c) On or before January 1, 2017, the department and the
24 Department of Managed Health Care shall jointly develop a
25 uniform prior authorization form. Notwithstanding any other law,
26 on and after July 1, 2017, or six months after the form is completed
27 pursuant to this section, whichever is later, every prescribing
28 provider shall use that uniform prior authorization form, or an
29 electronic prior authorization process described in subdivision (e),
30 to request prior authorization for coverage of prescription drugs
31 and every health insurer shall accept that form or electronic process
32 as sufficient to request prior authorization for prescription drugs.

33 (d) The prior authorization form developed pursuant to
34 subdivision (c) shall meet the following criteria:

35 (1) The form shall not exceed two pages.

36 (2) The form shall be made electronically available by the
37 department and the health insurer.

38 (3) The completed form may also be electronically submitted
39 from the prescribing provider to the health insurer.

1 (4) The department and the Department of Managed Health
2 Care shall develop the form with input from interested parties from
3 at least one public meeting.

4 (5) The department and the Department of Managed Health
5 Care, in development of the standardized form, shall take into
6 consideration the following:

7 (A) Existing prior authorization forms established by the federal
8 Centers for Medicare and Medicaid Services and the State
9 Department of Health Care Services.

10 (B) National standards pertaining to electronic prior
11 authorization.

12 (e) A prescribing provider may use an electronic prior
13 authorization system utilizing the standardized form described in
14 subdivision (c) or an electronic process developed specifically for
15 transmitting prior authorization information that meets the National
16 Council for Prescription Drug Programs' SCRIPT standard for
17 electronic prior authorization transactions.

18 (f) Subdivision (a) does not apply if any of the following occurs:

19 (1) A contracted physician group is delegated the financial risk
20 for the pharmacy or medical drug benefit by a health insurer.

21 (2) A contracted physician group uses its own internal prior
22 authorization process rather than the health insurer's prior
23 authorization process for the health insurer's insureds.

24 (3) A contracted physician group is delegated a utilization
25 management function by the health insurer concerning any
26 prescription drug, regardless of the delegation of financial risk.

27 (g) For prescription drugs, prior authorization requirements
28 described in subdivisions (c) and (e) apply regardless of how that
29 benefit is classified under the terms of the health insurer's group
30 or individual policy.

31 (h) (1) A health insurer shall maintain a process for an external
32 exception request review that complies with subdivision (c) of
33 Section 156.122 of Title 45 of the Code of Federal Regulations.

34 (2) *An insured shall not be required to file a complaint with the*
35 *health insurer or its contracting provider pursuant to its internal*
36 *grievance process if a health insurer disapproves a request to*
37 *obtain authorization for a nonformulary drug under subdivision*

38 *(i). If a health insurer disapproves a request to obtain authorization*
39 *for a nonformulary drug and the insured files a complaint with*

1 *the health insurer, the health insurer shall treat that as a request*
2 *to obtain an external exception request review.*

3 (i) For an individual, small group, or large group health
4 insurance policy, a health insurer that provides coverage for
5 outpatient prescription drugs shall comply with subdivision (c) of
6 Section 156.122 of Title 45 of the Code of Federal Regulations.

7 (j) *Nothing in this section shall be construed to affect an*
8 *insured’s or policyholder’s eligibility to submit a complaint to the*
9 *department for review or to apply to the department for an*
10 *independent medical review under Article 3.5 (commencing with*
11 *Section 10169).*

12 (j)
13 (k) For purposes of this section:

14 (1) “Prescribing provider” shall include a provider authorized
15 to write a prescription, pursuant to subdivision (a) of Section 4040
16 of the Business and Professions Code, to treat a medical condition
17 of an insured.

18 (2) “Exigent circumstances” exist when an insured is suffering
19 from a health condition that may seriously jeopardize the insured’s
20 life, health, or ability to regain maximum function or when an
21 insured is undergoing a current course of treatment using a
22 nonformulary drug.

23 (3) “Completed prior authorization request” means a completed
24 uniform prior authorization form developed pursuant to subdivision
25 (c), or a completed request submitted using an electronic prior
26 authorization system described in subdivision (e), or, for contracted
27 physician groups described in subdivision (f), the process used by
28 the contracted physician group.

29 *SEC. 6. Section 10169 of the Insurance Code, as added by*
30 *Section 19 of Chapter 348 of the Statutes of 2015, is amended to*
31 *read:*

32 10169. (a) Commencing January 1, 2001, there is hereby
33 established in the department the Independent Medical Review
34 System.

35 (b) For the purposes of this chapter, “disputed health care
36 service” means any health care service eligible for coverage and
37 payment under a disability insurance contract that has been denied,
38 modified, or delayed by a decision of the insurer, or by one of its
39 contracting providers, in whole or in part due to a finding that the
40 service is not medically necessary. A decision regarding a disputed

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

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

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

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

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

1 If there appears to be any medical necessity issue, the grievance
2 shall be resolved pursuant to an independent medical review as
3 provided under this article.

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

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

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

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

29 (i) Every disability insurer shall prominently display in every
30 insurer member handbook or relevant informational brochure, in
31 every insurance contract, on insured evidence of coverage forms,
32 on copies of insurer procedures for resolving grievances, on letters
33 of denials issued by either the insurer or its contracting
34 organization, and on all written responses to grievances,
35 information concerning the right of an insured to request an
36 independent medical review when the insured believes that health
37 care services have been improperly denied, modified, or delayed
38 by the insurer, or by one of its contracting providers. The
39 department's telephone number, 1-800-927-4357, and Internet
40 Web site, www.insurance.ca.gov, shall also be displayed.

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) *Either of the following:*

25 ~~(3)~~

26 (A) The insured has filed a grievance with the insurer or its
27 contracting provider, and the disputed decision is upheld or the
28 grievance remains unresolved after 30 days. The insured shall not
29 be required to participate in the insurer’s grievance process for
30 more than 30 days. In the case of a grievance that requires
31 expedited review, the insured shall not be required to participate
32 in the insurer’s grievance process for more than three days. *In the*
33 *case of a grievance that requires expedited review pursuant to*
34 *paragraph (2) of subdivision (b) of Section 10123.191, the insured*
35 *shall not be required to participate in the insured’s grievance*
36 *process for more than 72 hours, or more than 24 hours if exigent*
37 *circumstances exist.*

38 (B) *The insured has filed for an external exception request*
39 *review decision with the insurer or its contracting provider*
40 *pursuant to subdivision (h) of Section 10123.191, and the disputed*

1 *decision is upheld or the external review remains unresolved after*
2 *72 hours, or after 24 hours if exigent circumstances exist.*

3 (k) An insured may apply to the department for an independent
4 medical review of a decision to deny, modify, or delay health care
5 services, based in whole or in part on a finding that the disputed
6 health care services are not medically necessary, within six months
7 of any of the qualifying periods or events under subdivision (j).
8 The commissioner may extend the application deadline beyond
9 six months if the circumstances of a case warrant the extension.

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

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

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

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

32 (3) Notice of the insured's right to provide information or
33 documentation, either directly or through the insured'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 insured'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 insured's medical condition.

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

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

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

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

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

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

30 (i) The insured's medical condition.

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

33 (iii) The disputed health care services requested by the insured
34 for the condition.

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

1 subparagraph to the insured or the insured’s provider, if authorized
2 by the insured, unless the offer of medical records is declined or
3 otherwise prohibited by law. The confidentiality of all medical
4 record information shall be maintained pursuant to applicable state
5 and federal laws.

6 (2) A copy of all information provided to the insured by the
7 insurer and any of its contracting providers concerning insurer and
8 provider decisions regarding the insured’s condition and care, and
9 a copy of any materials the insured or the insured’s provider
10 submitted to the insurer and to the insurer’s contracting providers
11 in support of the insured’s request for disputed health care services.
12 This documentation shall include the written response to the
13 insured’s grievance. The confidentiality of any insured 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 insurer or its contracting providers in determining whether
18 disputed health care services should have been provided, and any
19 statements by the insurer and its contracting providers explaining
20 the reasons for the decision to deny, modify, or delay disputed
21 health care services on the basis of medical necessity. The insurer
22 shall concurrently provide a copy of documents required by this
23 paragraph, except for any information found by the commissioner
24 to be legally privileged information, to the insured and the insured’s
25 provider. The department and the independent medical review
26 organization shall maintain the confidentiality of any information
27 found by the commissioner to be the proprietary information of
28 the insurer.

29 ~~(e) This section shall become operative on January 1, 2017.~~

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

39 ~~SECTION 1. Section 1367.24 of the Health and Safety Code~~
40 ~~is amended to read:~~

1 ~~1367.24. (a) (1) Every health care service plan that provides~~
2 ~~prescription drug benefits shall maintain an expeditious process;~~
3 ~~as described in this subdivision, by which enrollees, enrollees'~~
4 ~~designees, or prescribing providers may request and obtain~~
5 ~~authorization for medically necessary nonformulary prescription~~
6 ~~drugs and medically necessary formulary prescription drugs that~~
7 ~~require prior authorization by the plan. The plan shall provide that~~
8 ~~the enrollee, the enrollee's designee, or the enrollee's prescribing~~
9 ~~provider may seek a prior authorization for a prescription drug~~
10 ~~under this subdivision.~~

11 ~~(2) Each plan shall respond to a prior authorization request~~
12 ~~within 72 hours following receipt of the prior authorization request.~~
13 ~~A plan that grants a prior authorization request under this paragraph~~
14 ~~shall provide coverage of the prescription drug for the duration of~~
15 ~~the prescription, including refills.~~

16 ~~(3) Each plan shall provide that a prior authorization may be~~
17 ~~obtained within 24 hours if an enrollee is suffering from a health~~
18 ~~condition that may seriously jeopardize the enrollee's life, health,~~
19 ~~or ability to regain maximum function or if an enrollee is~~
20 ~~undergoing a current course of treatment using a nonformulary~~
21 ~~drug. A plan that grants a prior authorization request under this~~
22 ~~paragraph based on exigent circumstances shall provide coverage~~
23 ~~of the prescription drug for the duration of the exigency.~~

24 ~~(4) If a plan fails to respond within 72 hours for a prior~~
25 ~~authorization request, or within 24 hours if exigent circumstances~~
26 ~~exist, upon receipt of a completed prior authorization request, the~~
27 ~~prior authorization request shall be deemed to have been granted.~~

28 ~~(5) Each plan shall provide a written description of the process~~
29 ~~described in paragraph (1) to its prescribing providers. For purposes~~
30 ~~of this section, a prescribing provider shall include a provider~~
31 ~~authorized to write a prescription, pursuant to subdivision (a) of~~
32 ~~Section 4040 of the Business and Professions Code, to treat a~~
33 ~~medical condition of an enrollee.~~

34 ~~(b) If a plan disapproves a prior authorization request made~~
35 ~~pursuant to subdivision (a), the plan shall maintain an expeditious~~
36 ~~process to authorize an enrollee to obtain an external review.~~

37 ~~(1) A determination on an external review shall be made no~~
38 ~~later than 72 hours following receipt of the request, if the original~~
39 ~~request was an authorization request under paragraph (2) of~~
40 ~~subdivision (a), and no later than 24 hours following receipt of the~~

1 request, if the original request was an authorization request under
2 paragraph (3) of subdivision (a):

3 (2) ~~If an external review decision of a prior authorization request~~
4 ~~under paragraph (2) of subdivision (a) is granted, the plan shall~~
5 ~~provide coverage of the prescription drug for the duration of the~~
6 ~~prescription, including refills. If an external review decision of a~~
7 ~~prior authorization request under paragraph (3) of subdivision (a)~~
8 ~~is granted, the plan shall provide coverage of the prescription drug~~
9 ~~for the duration of the exigency.~~

10 (e) ~~Any plan that disapproves a request made pursuant to~~
11 ~~subdivision (a) to obtain authorization for a nonformulary or~~
12 ~~formulary drug shall provide the reasons for the disapproval in a~~
13 ~~notice provided to the enrollee. The notice shall indicate that the~~
14 ~~enrollee may file, in lieu of filing a grievance with the plan, a~~
15 ~~request for an external review pursuant to subdivision (b) if the~~
16 ~~enrollee objects to the disapproval, including any alternative drug~~
17 ~~or treatment offered by the plan. The notice shall comply with~~
18 ~~subdivision (b) of Section 1368.02. If a plan disapproves a request~~
19 ~~made pursuant to subdivision (a), an enrollee shall not be required~~
20 ~~to file a grievance with the plan or its contracting provider pursuant~~
21 ~~to Section 1368.~~

22 (d) ~~The process described in subdivisions (a) and (b) by which~~
23 ~~enrollee's, enrollees' designees, and prescribing providers may~~
24 ~~obtain authorization for medically necessary nonformulary drugs~~
25 ~~shall not apply to a nonformulary drug that has been prescribed~~
26 ~~for an enrollee in conformance with the provisions of Section~~
27 ~~1367.22.~~

28 (e) ~~The process described in subdivisions (a) and (b) by which~~
29 ~~enrollees may obtain medically necessary nonformulary drugs and~~
30 ~~formulary drugs shall be described in evidence of coverage and~~
31 ~~disclosure forms, as required by subdivision (a) of Section 1363,~~
32 ~~issued on or after July 1, 2017.~~

33 (f) ~~Every health care service plan that provides prescription~~
34 ~~drug benefits shall maintain, as part of its books and records under~~
35 ~~Section 1381, all of the following information, which shall be~~
36 ~~made available to the director upon request:~~

37 (1) ~~The complete drug formulary or formularies of the plan, if~~
38 ~~the plan maintains a formulary, including a list of the prescription~~
39 ~~drugs on the formulary of the plan by major therapeutic category~~

1 with an indication of whether any drugs are preferred over other
2 drugs.

3 (2) Records developed by the pharmacy and therapeutic
4 committee of the plan, or by others responsible for developing,
5 modifying, and overseeing formularies, including medical groups,
6 individual practice associations, and contracting pharmaceutical
7 benefit management companies, used to guide the drugs prescribed
8 for the enrollees of the plan, that fully describe the reasoning
9 behind formulary decisions.

10 (3) Any plan arrangements with prescribing providers, medical
11 groups, individual practice associations, pharmacists, contracting
12 pharmaceutical benefit management companies, or other entities
13 that are associated with activities of the plan to encourage
14 formulary compliance or otherwise manage prescription drug
15 benefits.

16 (g) If a plan provides prescription drug benefits, the department
17 shall, as part of its periodic onsite medical survey of each plan
18 undertaken pursuant to Section 1380, review the performance of
19 the plan in providing those benefits, including, but not limited to,
20 a review of the procedures and information maintained pursuant
21 to this section, and describe the performance of the plan as part of
22 its report issued pursuant to Section 1380.

23 (h) The director shall not publicly disclose any information
24 reviewed pursuant to this section that is determined by the director
25 to be confidential pursuant to state law.

26 (i) For purposes of this section, “authorization” means approval
27 by the health care service plan to provide payment for the
28 prescription drug.

29 (j) Nonformulary prescription drugs shall include any drug for
30 which an enrollee’s copayment or out-of-pocket costs are different
31 than the copayment for a formulary prescription drug, except as
32 otherwise provided by law or regulation or in cases in which the
33 drug has been excluded in the plan contract pursuant to Section
34 1342.7.

35 (k) Nothing in this section shall be construed to restrict or impair
36 the application of any other provision of this chapter, including,
37 but not limited to, Section 1367, which includes among its
38 requirements that a health care service plan furnish services in a
39 manner providing continuity of care and demonstrate that medical

1 decisions are rendered by qualified medical providers unhindered
2 by fiscal and administrative management.

3 ~~(l) A health care service plan contract in the individual, small
4 group, and large group markets that provides coverage for
5 outpatient prescription drugs shall comply with this section. This
6 section shall not apply to Medi-Cal managed care health care
7 service plan contracts.~~

8 ~~(m) “Medi-Cal managed care health care service plan contract”
9 means any entity that enters into a contract with the State
10 Department of Health Care Services pursuant to Chapter 7
11 (commencing with Section 14000), Chapter 8 (commencing with
12 Section 14200), or Chapter 8.75 (commencing with Section 14591)
13 of Part 3 of Division 9 of the Welfare and Institutions Code.~~

14 ~~(n) Nothing in this section shall be construed to affect an
15 enrollee’s or subscriber’s eligibility to submit a grievance to the
16 department for review under Section 1368 or to apply to the
17 department for an independent medical review under Section
18 1370.4, or Article 5.55 (commencing with Section 1374.30) of
19 this chapter.~~

20 ~~SEC. 2. Section 1367.241 of the Health and Safety Code is
21 amended to read:~~

22 ~~1367.241. (a) Notwithstanding any other law, on and after
23 January 1, 2013, a health care service plan that provides coverage
24 for prescription drugs shall accept only the prior authorization
25 form developed pursuant to subdivision (b), or an electronic prior
26 authorization process described in subdivision (d), when requiring
27 prior authorization for prescription drugs. This section does not
28 apply in the event that a physician or physician group has been
29 delegated the financial risk for prescription drugs by a health care
30 service plan and does not use a prior authorization process. This
31 section does not apply to a health care service plan, or to its
32 affiliated providers, if the health care service plan owns and
33 operates its pharmacies and does not use a prior authorization
34 process for prescription drugs.~~

35 ~~(b) On or before January 1, 2017, the department and the
36 Department of Insurance shall jointly develop a uniform prior
37 authorization form. Notwithstanding any other law, on and after
38 July 1, 2017, or six months after the form is completed pursuant
39 to this section, whichever is later, every prescribing provider shall
40 use that uniform prior authorization form, or an electronic prior~~

1 authorization process described in subdivision (d), to request prior
2 authorization for coverage of prescription drugs and every health
3 care service plan shall accept that form or electronic process as
4 sufficient to request prior authorization for prescription drugs.

5 ~~(e) The prior authorization form developed pursuant to~~
6 ~~subdivision (b) shall meet the following criteria:~~

7 ~~(1) The form shall not exceed two pages.~~

8 ~~(2) The form shall be made electronically available by the~~
9 ~~department and the health care service plan.~~

10 ~~(3) The completed form may also be electronically submitted~~
11 ~~from the prescribing provider to the health care service plan.~~

12 ~~(4) The department and the Department of Insurance shall~~
13 ~~develop the form with input from interested parties from at least~~
14 ~~one public meeting.~~

15 ~~(5) The department and the Department of Insurance, in~~
16 ~~development of the standardized form, shall take into consideration~~
17 ~~the following:~~

18 ~~(A) Existing prior authorization forms established by the federal~~
19 ~~Centers for Medicare and Medicaid Services and the State~~
20 ~~Department of Health Care Services:~~

21 ~~(B) National standards pertaining to electronic prior~~
22 ~~authorization.~~

23 ~~(d) A prescribing provider may use an electronic prior~~
24 ~~authorization system utilizing the standardized form described in~~
25 ~~subdivision (b) or an electronic process developed specifically for~~
26 ~~transmitting prior authorization information that meets the National~~
27 ~~Council for Prescription Drug Programs' SCRIPT standard for~~
28 ~~electronic prior authorization transactions.~~

29 ~~(e) Subdivision (a) does not apply if any of the following occurs:~~

30 ~~(1) A contracted physician group is delegated the financial risk~~
31 ~~for prescription drugs by a health care service plan.~~

32 ~~(2) A contracted physician group uses its own internal prior~~
33 ~~authorization process rather than the health care service plan's~~
34 ~~prior authorization process for plan enrollees.~~

35 ~~(3) A contracted physician group is delegated a utilization~~
36 ~~management function by the health care service plan concerning~~
37 ~~any prescription drug, regardless of the delegation of financial~~
38 ~~risk.~~

39 ~~(f) For prescription drugs, prior authorization requirements~~
40 ~~described in subdivisions (b) and (d) apply regardless of how that~~

1 benefit is classified under the terms of the health plan's group or
2 individual contract.

3 (g) For purposes of this section:

4 (1) "Prescribing provider" shall include a provider authorized
5 to write a prescription, pursuant to subdivision (a) of Section 4040
6 of the Business and Professions Code, to treat a medical condition
7 of an enrollee.

8 (2) "Completed prior authorization request" means a completed
9 uniform prior authorization form developed pursuant to subdivision
10 (b), or a completed request submitted using an electronic prior
11 authorization system described in subdivision (d), or, for contracted
12 physician groups described in subdivision (c), the process used by
13 the contracted physician group.

14 SEC. 3. Section 1367.244 of the Health and Safety Code is
15 amended to read:

16 1367.244. (a) A request for an exception to a health care
17 service plan's step therapy process for prescription drugs may be
18 submitted in the same manner as a request for prior authorization
19 for prescription drugs pursuant to Section 1367.24, and shall be
20 treated in the same manner, and shall be responded to by the health
21 care service plan in the same manner, as a request for prior
22 authorization for prescription drugs.

23 (b) The department and the Department of Insurance shall
24 include a provision for step therapy exception requests in the
25 uniform prior authorization form developed pursuant to subdivision
26 (b) of Section 1367.241.

27 SEC. 4. Section 1368 of the Health and Safety Code is amended
28 to read:

29 1368. (a) Every plan shall do all of the following:

30 (1) Establish and maintain a grievance system approved by the
31 department under which enrollees may submit their grievances to
32 the plan. Each system shall provide reasonable procedures in
33 accordance with department regulations that shall ensure adequate
34 consideration of enrollee grievances and rectification when
35 appropriate.

36 (2) Inform its subscribers and enrollees upon enrollment in the
37 plan and annually thereafter of the procedure for processing and
38 resolving grievances. The information shall include the location
39 and telephone number where grievances may be submitted.

1 ~~(3) Provide forms for grievances to be given to subscribers and~~
2 ~~enrollees who wish to register written grievances. The forms used~~
3 ~~by plans licensed pursuant to Section 1353 shall be approved by~~
4 ~~the director in advance as to format.~~

5 ~~(4) (A) Provide for a written acknowledgment within five~~
6 ~~calendar days of the receipt of a grievance, except as noted in~~
7 ~~subparagraph (B). The acknowledgment shall advise the~~
8 ~~complainant of the following:~~

9 ~~(i) That the grievance has been received.~~

10 ~~(ii) The date of receipt.~~

11 ~~(iii) The name of the plan representative and the telephone~~
12 ~~number and address of the plan representative who may be~~
13 ~~contacted about the grievance.~~

14 ~~(B) Grievances received by telephone, by facsimile, by email,~~
15 ~~or online through the plan's Internet Web site pursuant to Section~~
16 ~~1368.015, that are not coverage disputes, disputed health care~~
17 ~~services involving medical necessity, or experimental or~~
18 ~~investigational treatment and that are resolved by the next business~~
19 ~~day following receipt are exempt from the requirements of~~
20 ~~subparagraph (A) and paragraph (5). The plan shall maintain a log~~
21 ~~of all these grievances. The log shall be periodically reviewed by~~
22 ~~the plan and shall include the following information for each~~
23 ~~complaint:~~

24 ~~(i) The date of the call.~~

25 ~~(ii) The name of the complainant.~~

26 ~~(iii) The complainant's member identification number.~~

27 ~~(iv) The nature of the grievance.~~

28 ~~(v) The nature of the resolution.~~

29 ~~(vi) The name of the plan representative who took the call and~~
30 ~~resolved the grievance.~~

31 ~~(5) Provide subscribers and enrollees with written responses to~~
32 ~~grievances, with a clear and concise explanation of the reasons for~~
33 ~~the plan's response. For grievances involving the delay, denial, or~~
34 ~~modification of health care services, the plan response shall~~
35 ~~describe the criteria used and the clinical reasons for its decision,~~
36 ~~including all criteria and clinical reasons related to medical~~
37 ~~necessity. If a plan, or one of its contracting providers, issues a~~
38 ~~decision delaying, denying, or modifying health care services based~~
39 ~~in whole or in part on a finding that the proposed health care~~
40 ~~services are not a covered benefit under the contract that applies~~

1 to the enrollee, the decision shall clearly specify the provisions in
2 the contract that exclude that coverage.

3 ~~(6) For grievances involving the cancellation, rescission, or~~
4 ~~nonrenewal of a health care service plan contract, the health care~~
5 ~~service plan shall continue to provide coverage to the enrollee or~~
6 ~~subscriber under the terms of the health care service plan contract~~
7 ~~until a final determination of the enrollee's or subscriber's request~~
8 ~~for review has been made by the health care service plan or the~~
9 ~~director pursuant to Section 1365 and this section. This paragraph~~
10 ~~shall not apply if the health care service plan cancels or fails to~~
11 ~~renew the enrollee's or subscriber's health care service plan~~
12 ~~contract for nonpayment of premiums pursuant to paragraph (1)~~
13 ~~of subdivision (a) of Section 1365.~~

14 ~~(7) Keep in its files all copies of grievances, and the responses~~
15 ~~thereto, for a period of five years.~~

16 ~~(b) (1) (A) After either completing the grievance process~~
17 ~~described in subdivision (a), participating in the process for at least~~
18 ~~30 days, or completing the external review process described in~~
19 ~~subdivision (b) of Section 1367.24, a subscriber or enrollee may~~
20 ~~submit the grievance or external review decision to the department~~
21 ~~for review. In any case under the grievance process determined~~
22 ~~by the department to be a case involving an imminent and serious~~
23 ~~threat to the health of the patient, including, but not limited to,~~
24 ~~severe pain, the potential loss of life, limb, or major bodily~~
25 ~~function, cancellations, rescissions, or the nonrenewal of a health~~
26 ~~care service plan contract, or in any other case where the~~
27 ~~department determines that an earlier review is warranted, a~~
28 ~~subscriber or enrollee shall not be required to complete the~~
29 ~~grievance process or to participate in the process for at least 30~~
30 ~~days before submitting a grievance to the department for review.~~

31 ~~(B) A grievance or external review decision may be submitted~~
32 ~~to the department for review and resolution prior to any arbitration.~~

33 ~~(C) Notwithstanding subparagraphs (A) and (B), the department~~
34 ~~may refer any grievance or external review decision that does not~~
35 ~~pertain to compliance with this chapter to the State Department of~~
36 ~~Public Health, the California Department of Aging, the federal~~
37 ~~Centers for Medicare and Medicaid Services, or any other~~
38 ~~appropriate governmental entity for investigation and resolution.~~

39 ~~(2) If the subscriber or enrollee is a minor, or is incompetent or~~
40 ~~incapacitated, the parent, guardian, conservator, relative, or other~~

1 designee of the subscriber or enrollee, as appropriate, may submit
2 the grievance or external review decision to the department as the
3 agent of the subscriber or enrollee. Further, a provider may join
4 with, or otherwise assist, a subscriber or enrollee, or the agent, to
5 submit the grievance or external review decision to the department.
6 In addition, following submission of the grievance or external
7 review decision to the department, the subscriber or enrollee, or
8 the agent, may authorize the provider to assist, including
9 advocating on behalf of the subscriber or enrollee. For purposes
10 of this section, a “relative” includes the parent, stepparent, spouse,
11 adult son or daughter, grandparent, brother, sister, uncle, or aunt
12 of the subscriber or enrollee.

13 (3) The department shall review the written documents submitted
14 with the subscriber’s or the enrollee’s request for review, or
15 submitted by the agent on behalf of the subscriber or enrollee. The
16 department may ask for additional information, and may hold an
17 informal meeting with the involved parties, including providers
18 who have joined in submitting the grievance or external review
19 decision or who are otherwise assisting or advocating on behalf
20 of the subscriber or enrollee. If after reviewing the record, the
21 department concludes that the grievance or external review
22 decision, in whole or in part, is eligible for review under the
23 independent medical review system established pursuant to Article
24 5.55 (commencing with Section 1374.30), the department shall
25 immediately notify the subscriber or enrollee, or agent, of that
26 option and shall, if requested orally or in writing, assist the
27 subscriber or enrollee in participating in the independent medical
28 review system.

29 (4) If after reviewing the record of a grievance or external review
30 decision, the department concludes that a health care service
31 eligible for coverage and payment under a health care service plan
32 contract has been delayed, denied, or modified by a plan, or by
33 one of its contracting providers, in whole or in part due to a
34 determination that the service is not medically necessary, and that
35 determination was not communicated to the enrollee in writing
36 along with a notice of the enrollee’s potential right to participate
37 in the independent medical review system, as required by this
38 chapter, the director shall, by order, assess administrative penalties.
39 A proceeding for the issuance of an order assessing administrative
40 penalties shall be subject to appropriate notice of, and the

1 opportunity for, a hearing with regard to the person affected in
2 accordance with Section 1397. The administrative penalties shall
3 not be deemed an exclusive remedy available to the director. These
4 penalties shall be paid to the Managed Care Administrative Fines
5 and Penalties Fund and shall be used for the purposes specified in
6 Section 1341.45.

7 (5) The department shall send a written notice of the final
8 disposition of the grievance or external review decision, and the
9 reasons therefor, to the subscriber or enrollee, the agent, to any
10 provider that has joined with or is otherwise assisting the subscriber
11 or enrollee, and to the plan, within 30 calendar days of receipt of
12 the request for review unless the director, in his or her discretion,
13 determines that additional time is reasonably necessary to fully
14 and fairly evaluate the relevant grievance or external review
15 decision. In any case not eligible for the independent medical
16 review system established pursuant to Article 5.55 (commencing
17 with Section 1374.30), the department’s written notice shall
18 include, at a minimum, the following:

19 (A) A summary of its findings and the reasons why the
20 department found the plan to be, or not to be, in compliance with
21 any applicable laws, regulations, or orders of the director.

22 (B) A discussion of the department’s contact with any medical
23 provider, or any other independent expert relied on by the
24 department, along with a summary of the views and qualifications
25 of that provider or expert.

26 (C) If the enrollee’s grievance or external review decision is
27 sustained in whole or in part, information about any corrective
28 action taken.

29 (6) In any department review of a grievance or external review
30 decision involving a disputed health care service, as defined in
31 subdivision (b) of Section 1374.30, that is not eligible for the
32 independent medical review system established pursuant to Article
33 5.55 (commencing with Section 1374.30), in which the department
34 finds that the plan has delayed, denied, or modified health care
35 services that are medically necessary, based on the specific medical
36 circumstances of the enrollee, and those services are a covered
37 benefit under the terms and conditions of the health care service
38 plan contract, the department’s written notice shall do either of
39 the following:

1 (A) Order the plan to promptly offer and provide those health
2 care services to the enrollee.

3 (B) Order the plan to promptly reimburse the enrollee for any
4 reasonable costs associated with urgent care or emergency services,
5 or other extraordinary and compelling health care services, when
6 the department finds that the enrollee's decision to secure those
7 services outside of the plan network was reasonable under the
8 circumstances.

9 The department's order shall be binding on the plan.

10 (7) Distribution of the written notice shall not be deemed a
11 waiver of any exemption or privilege under existing law, including,
12 but not limited to, Section 6254.5 of the Government Code, for
13 any information in connection with and including the written
14 notice, nor shall any person employed or in any way retained by
15 the department be required to testify as to that information or
16 notice.

17 (8) The director shall establish and maintain a system of aging
18 of grievances that are pending and unresolved for 30 days or more
19 that shall include a brief explanation of the reasons each grievance
20 is pending and unresolved for 30 days or more.

21 (9) A subscriber or enrollee, or the agent acting on behalf of a
22 subscriber or enrollee, may also request voluntary mediation with
23 the plan prior to exercising the right to submit a grievance or
24 external review decision to the department. The use of mediation
25 services shall not preclude the right to submit a grievance or
26 external review decision to the department upon completion of
27 mediation. In order to initiate mediation, the subscriber or enrollee,
28 or the agent acting on behalf of the subscriber or enrollee, and the
29 plan shall voluntarily agree to mediation. Expenses for mediation
30 shall be borne equally by both sides. The department shall have
31 no administrative or enforcement responsibilities in connection
32 with the voluntary mediation process authorized by this paragraph.

33 (e) The plan's grievance system shall include a system of aging
34 of grievances that are pending and unresolved for 30 days or more.
35 The plan shall provide a quarterly report to the director of
36 grievances pending and unresolved for 30 or more days with
37 separate categories of grievances for Medicare enrollees and
38 Medi-Cal enrollees. The plan shall include with the report a brief
39 explanation of the reasons each grievance is pending and
40 unresolved for 30 days or more. The plan may include the

1 following statement in the quarterly report that is made available
2 to the public by the director:

3
4 “Under Medicare and Medi-Cal law, Medicare enrollees and
5 Medi-Cal enrollees each have separate avenues of appeal that
6 are not available to other enrollees. Therefore, grievances
7 pending and unresolved may reflect enrollees pursuing their
8 Medicare or Medi-Cal appeal rights.”

9
10 If requested by a plan, the director shall include this statement in
11 a written report made available to the public and prepared by the
12 director that describes or compares grievances that are pending
13 and unresolved with the plan for 30 days or more. Additionally,
14 the director shall, if requested by a plan, append to that written
15 report a brief explanation, provided in writing by the plan, of the
16 reasons why grievances described in that written report are pending
17 and unresolved for 30 days or more. The director shall not be
18 required to include a statement or append a brief explanation to a
19 written report that the director is required to prepare under this
20 chapter, including Sections 1380 and 1397.5.

21 (d) Subject to subparagraph (C) of paragraph (1) of subdivision
22 (b), the grievance or resolution procedures authorized by this
23 section shall be in addition to any other procedures that may be
24 available to any person, and failure to pursue, exhaust, or engage
25 in the procedures described in this section shall not preclude the
26 use of any other remedy provided by law.

27 (e) Nothing in this section shall be construed to allow the
28 submission to the department of any provider grievance under this
29 section. However, as part of a provider’s duty to advocate for
30 medically appropriate health care for his or her patients pursuant
31 to Sections 510 and 2056 of the Business and Professions Code,
32 nothing in this subdivision shall be construed to prohibit a provider
33 from contacting and informing the department about any concerns
34 he or she has regarding compliance with or enforcement of this
35 chapter.

36 (f) To the extent required by Section 2719 of the federal Public
37 Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent
38 rules or regulations, there shall be an independent external review
39 pursuant to the standards required by the United States Secretary
40 of Health and Human Services of a health care service plan’s

1 cancellation, rescission, or nonrenewal of an enrollee's or
2 subscriber's coverage.

3 SEC. 5. Section 1368.01 of the Health and Safety Code is
4 amended to read:

5 1368.01. (a) The grievance system shall require the plan to
6 resolve grievances within 30 days.

7 (b) The grievance system shall include a requirement for
8 expedited plan review of grievances for cases involving an
9 imminent and serious threat to the health of the patient, including,
10 but not limited to, severe pain, potential loss of life, limb, or major
11 bodily function. When the plan has notice of a case requiring
12 expedited review, the grievance system shall require the plan to
13 immediately inform enrollees and subscribers in writing of their
14 right to notify the department of the grievance. The grievance
15 system shall also require the plan to provide enrollees, subscribers,
16 and the department with a written statement on the disposition or
17 pending status of the grievance no later than three days from receipt
18 of the grievance. Paragraph (4) of subdivision (a) of Section 1368
19 shall not apply to grievances handled pursuant to this section.

20 SEC. 6. Section 1374.30 of the Health and Safety Code is
21 amended to read:

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

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

1 enrollee, the statement of decision shall clearly specify the
2 provision in the contract that excludes that coverage.

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

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

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

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

37 (e) Every health care service plan contract that is issued,
38 amended, renewed, or delivered in this state on or after January
39 1, 2000, shall provide an enrollee with the opportunity to seek an
40 independent medical review whenever health care services have

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

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

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

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

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

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

39 ~~(1) (A) The enrollee's provider has recommended a health care~~
40 ~~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) (A) 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, or~~

28 ~~(B) The enrollee has filed for an external review decision with~~
29 ~~the plan or its contracting provider pursuant to subdivision (b) of~~
30 ~~Section 1367.24, and the disputed decision is upheld or the external~~
31 ~~review remains unresolved after 72 hours, or 24 hours if exigent~~
32 ~~circumstances exist.~~

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

1 ~~(l) The enrollee shall pay no application or processing fees of~~
2 ~~any kind.~~

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

15 ~~(1) Notice that a decision not to participate in the independent~~
16 ~~medical review process may cause the enrollee to forfeit any~~
17 ~~statutory right to pursue legal action against the plan regarding the~~
18 ~~disputed health care service.~~

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

23 ~~(3) Notice of the enrollee's right to provide information or~~
24 ~~documentation, either directly or through the enrollee's provider,~~
25 ~~regarding any of the following:~~

26 ~~(A) A provider recommendation indicating that the disputed~~
27 ~~health care service is medically necessary for the enrollee's medical~~
28 ~~condition.~~

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

32 ~~(C) Reasonable information supporting the enrollee's position~~
33 ~~that the disputed health care service is or was medically necessary~~
34 ~~for the enrollee's medical condition, including all information~~
35 ~~provided to the enrollee by the plan or any of its contracting~~
36 ~~providers, still in the possession of the enrollee, concerning a plan~~
37 ~~or provider decision regarding disputed health care services, and~~
38 ~~a copy of any materials the enrollee submitted to the plan, still in~~
39 ~~the possession of the enrollee, in support of the grievance, as well~~
40 ~~as any additional material that the enrollee believes is relevant.~~

1 ~~(4) A section designed to collect information on the enrollee's~~
2 ~~ethnicity, race, and primary language spoken that includes both of~~
3 ~~the following:~~

4 ~~(A) A statement of intent indicating that the information is used~~
5 ~~for statistics only, in order to ensure that all enrollees get the best~~
6 ~~care possible.~~

7 ~~(B) A statement indicating that providing this information is~~
8 ~~optional and will not affect the independent medical review process~~
9 ~~in any way.~~

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

17 ~~(1) (A) A copy of all of the enrollee's medical records in the~~
18 ~~possession of the plan or its contracting providers relevant to each~~
19 ~~of the following:~~

20 ~~(i) The enrollee's medical condition.~~

21 ~~(ii) The health care services being provided by the plan and its~~
22 ~~contracting providers for the condition.~~

23 ~~(iii) The disputed health care services requested by the enrollee~~
24 ~~for the condition.~~

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

36 ~~(2) A copy of all information provided to the enrollee by the~~
37 ~~plan and any of its contracting providers concerning plan and~~
38 ~~provider decisions regarding the enrollee's condition and care, and~~
39 ~~a copy of any materials the enrollee or the enrollee's provider~~
40 ~~submitted to the plan and to the plan's contracting providers in~~

1 support of the enrollee's request for disputed health care services.
2 This documentation shall include the written response to the
3 enrollee's grievance, required by paragraph (4) of subdivision (a)
4 of Section 1368. The confidentiality of any enrollee medical
5 information shall be maintained pursuant to applicable state and
6 federal laws.

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

19 ~~SEC. 7. Section 10123.190 is added to the Insurance Code,~~
20 ~~immediately following Section 10123.19, to read:~~

21 ~~10123.190. (a) (1) Every health insurer that provides~~
22 ~~prescription drug benefits shall maintain an expeditious process,~~
23 ~~as described in this subdivision, by which insureds, insureds'~~
24 ~~designees, or prescribing providers may request and obtain~~
25 ~~authorization for medically necessary nonformulary prescription~~
26 ~~drugs and medically necessary formulary drugs that require prior~~
27 ~~authorization by the health insurer. The health insurer shall provide~~
28 ~~that the insured, the insured's designee, or the insured's prescribing~~
29 ~~provider may seek a prior authorization for a prescription drug~~
30 ~~under this subdivision.~~

31 ~~(2) Each health insurer shall respond to a prior authorization~~
32 ~~request within 72 hours following receipt of the prior authorization~~
33 ~~request. A health insurer that grants a prior authorization request~~
34 ~~under this paragraph shall provide coverage of the prescription~~
35 ~~drug for the duration of the prescription, including refills.~~

36 ~~(3) Each health insurer shall provide that a prior authorization~~
37 ~~may be obtained within 24 hours if an insured is suffering from a~~
38 ~~health condition that may seriously jeopardize the insured's life,~~
39 ~~health, or ability to regain maximum function or if an insured is~~
40 ~~undergoing a current course of treatment using a nonformulary~~

1 ~~drug. A health insurer that grants a prior authorization request~~
2 ~~under this paragraph based on exigent circumstances shall provide~~
3 ~~coverage of the prescription drug for the duration of the exigency.~~

4 ~~(4) If a health insurer fails to respond within 72 hours for a prior~~
5 ~~authorization request, or within 24 hours if exigent circumstances~~
6 ~~exist, upon receipt of a completed prior authorization request, the~~
7 ~~prior authorization request shall be deemed to have been granted.~~

8 ~~(5) Each health insurer shall provide a written description of~~
9 ~~the process described in paragraph (1) to its prescribing providers.~~
10 ~~For purposes of this section, a prescribing provider shall include~~
11 ~~a provider authorized to write a prescription, pursuant to~~
12 ~~subdivision (a) of Section 4040 of the Business and Professions~~
13 ~~Code, to treat a medical condition of an insured.~~

14 ~~(b) If a health insurer disapproves a prior authorization request~~
15 ~~made pursuant to subdivision (a), the health insurer shall maintain~~
16 ~~an expeditious process to authorize an insured to obtain an external~~
17 ~~review.~~

18 ~~(1) A determination on an external review shall be made no~~
19 ~~later than 72 hours following receipt of the request, if the original~~
20 ~~request was an authorization request under paragraph (2) of~~
21 ~~subdivision (a), and no later than 24 hours following receipt of the~~
22 ~~request, if the original request was an authorization request under~~
23 ~~paragraph (3) of subdivision (a).~~

24 ~~(2) If an external review decision of a prior authorization request~~
25 ~~under paragraph (2) of subdivision (a) is granted, the health insurer~~
26 ~~shall provide coverage of the prescription drug for the duration of~~
27 ~~the prescription, including refills. If an external review decision~~
28 ~~of a prior authorization request under paragraph (3) of subdivision~~
29 ~~(a) is granted, the health insurer shall provide coverage of the~~
30 ~~prescription drug for the duration of the exigency.~~

31 ~~(c) Any health insurer that disapproves a request made pursuant~~
32 ~~to subdivision (a) to obtain authorization for a nonformulary or~~
33 ~~formulary drug shall provide the reasons for the disapproval in a~~
34 ~~notice provided to the insured. The notice shall indicate that the~~
35 ~~insured may file, in lieu of filing a grievance with the health~~
36 ~~insurer, a request for an external review pursuant to subdivision~~
37 ~~(b) if the insured objects to the disapproval, including any~~
38 ~~alternative drug or treatment offered by the health insurer. If a~~
39 ~~health insurer disapproves a request made pursuant to subdivision~~
40 ~~(a), an insured shall not be required to file a grievance with the~~

1 health insurer or its contracting provider pursuant the grievance
2 process established by the health insurer.

3 (d) ~~The process described in subdivisions (a) and (b) by which~~
4 ~~insureds may obtain medically necessary nonformulary and~~
5 ~~formulary drugs shall be described in the evidence of coverage or~~
6 ~~certificate of insurance issued by the health insurer on or after July~~
7 ~~1, 2017.~~

8 (e) ~~A health insurance policy in the individual, small group, and~~
9 ~~large group markets that provides coverage for outpatient~~
10 ~~prescription drugs shall comply with this section.~~

11 (f) ~~Nothing in this section shall be construed to affect an~~
12 ~~insured's or policyholder's eligibility to submit a complaint to the~~
13 ~~department for review or to apply to the department for an~~
14 ~~independent medical review under Article 3.5 (commencing with~~
15 ~~Section 10169).~~

16 SEC. 8. ~~Section 10123.191 of the Insurance Code is amended~~
17 ~~to read:~~

18 ~~10123.191. (a) Notwithstanding any other law, on and after~~
19 ~~January 1, 2013, a health insurer that provides coverage for~~
20 ~~prescription drugs shall utilize and accept only the prior~~
21 ~~authorization form developed pursuant to subdivision (b), or an~~
22 ~~electronic prior authorization process described in subdivision (d),~~
23 ~~when requiring prior authorization for prescription drugs.~~

24 (b) ~~On or before January 1, 2017, the department and the~~
25 ~~Department of Managed Health Care shall jointly develop a~~
26 ~~uniform prior authorization form. Notwithstanding any other law,~~
27 ~~on and after July 1, 2017, or six months after the form is completed~~
28 ~~pursuant to this section, whichever is later, every prescribing~~
29 ~~provider shall use that uniform prior authorization form, or an~~
30 ~~electronic prior authorization process described in subdivision (d),~~
31 ~~to request prior authorization for coverage of prescription drugs~~
32 ~~and every health insurer shall accept that form or electronic process~~
33 ~~as sufficient to request prior authorization for prescription drugs.~~

34 (e) ~~The prior authorization form developed pursuant to~~
35 ~~subdivision (b) shall meet the following criteria:~~

36 (1) ~~The form shall not exceed two pages.~~

37 (2) ~~The form shall be made electronically available by the~~
38 ~~department and the health insurer.~~

39 (3) ~~The completed form may also be electronically submitted~~
40 ~~from the prescribing provider to the health insurer.~~

1 ~~(4) The department and the Department of Managed Health~~
2 ~~Care shall develop the form with input from interested parties from~~
3 ~~at least one public meeting.~~

4 ~~(5) The department and the Department of Managed Health~~
5 ~~Care, in development of the standardized form, shall take into~~
6 ~~consideration the following:~~

7 ~~(A) Existing prior authorization forms established by the federal~~
8 ~~Centers for Medicare and Medicaid Services and the State~~
9 ~~Department of Health Care Services.~~

10 ~~(B) National standards pertaining to electronic prior~~
11 ~~authorization.~~

12 ~~(d) A prescribing provider may use an electronic prior~~
13 ~~authorization system utilizing the standardized form described in~~
14 ~~subdivision (b) or an electronic process developed specifically for~~
15 ~~transmitting prior authorization information that meets the National~~
16 ~~Council for Prescription Drug Programs’ SCRIPT standard for~~
17 ~~electronic prior authorization transactions.~~

18 ~~(e) Subdivision (a) does not apply if any of the following occurs:~~

19 ~~(1) A contracted physician group is delegated the financial risk~~
20 ~~for the pharmacy or medical drug benefit by a health insurer.~~

21 ~~(2) A contracted physician group uses its own internal prior~~
22 ~~authorization process rather than the health insurer’s prior~~
23 ~~authorization process for the health insurer’s insureds.~~

24 ~~(3) A contracted physician group is delegated a utilization~~
25 ~~management function by the health insurer concerning any~~
26 ~~prescription drug, regardless of the delegation of financial risk.~~

27 ~~(f) For prescription drugs, prior authorization requirements~~
28 ~~described in subdivisions (b) and (d) apply regardless of how that~~
29 ~~benefit is classified under the terms of the health insurer’s group~~
30 ~~or individual policy.~~

31 ~~(g) For purposes of this section:~~

32 ~~(1) “Prescribing provider” shall include a provider authorized~~
33 ~~to write a prescription, pursuant to subdivision (a) of Section 4040~~
34 ~~of the Business and Professions Code, to treat a medical condition~~
35 ~~of an insured.~~

36 ~~(2) “Completed prior authorization request” means a completed~~
37 ~~uniform prior authorization form developed pursuant to subdivision~~
38 ~~(b), or a completed request submitted using an electronic prior~~
39 ~~authorization system described in subdivision (d), or, for contracted~~

1 physician groups described in subdivision (c), the process used by
2 the contracted physician group.

3 SEC. 9. Section 10123.197 of the Insurance Code is amended
4 to read:

5 10123.197. (a) A request for an exception to a health insurer's
6 step therapy process for prescription drugs may be submitted in
7 the same manner as a request for prior authorization for prescription
8 drugs pursuant to Section 10123.190 and shall be treated in the
9 same manner, and shall be responded to by the health insurer in
10 the same manner, as a request for prior authorization for
11 prescription drugs.

12 (b) The department and the Department of Managed Health
13 Care shall include a provision for step therapy exception requests
14 in the uniform prior authorization form developed pursuant to
15 subdivision (b) of Section 10123.191.

16 SEC. 10. Section 10169 of the Insurance Code, as added by
17 Section 19 of Chapter 348 of the Statutes of 2015, is amended to
18 read:

19 10169. (a) Commencing January 1, 2001, there is hereby
20 established in the department the Independent Medical Review
21 System.

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

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

9 ~~(d) (1) All insured 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 insured 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 ~~insured request for review shall be treated as a request for the~~
16 ~~department to review the grievance. All other insured grievances,~~
17 ~~including grievances involving coverage decisions, remain eligible~~
18 ~~for review by the department.~~

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

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

32 ~~(e) Every disability insurance contract that is issued, amended,~~
33 ~~renewed, or delivered in this state on or after January 1, 2000, shall~~
34 ~~provide an insured with the opportunity to seek an independent~~
35 ~~medical review whenever health care services have been denied,~~
36 ~~modified, or delayed by the insurer, or by one of its contracting~~
37 ~~providers, if the decision was based in whole or in part on a finding~~
38 ~~that the proposed health care services are not medically necessary.~~
39 ~~For purposes of this article, an insured may designate an agent to~~
40 ~~act on his or her behalf. The provider may join with or otherwise~~

1 assist the insured in seeking an independent medical review, and
2 may advocate on behalf of the insured.

3 (f) Medicare beneficiaries enrolled in Medicare + Choice
4 products shall not be excluded unless expressly preempted by
5 federal law.

6 (g) The department may seek to integrate the quality of care
7 and consumer protection provisions, including remedies, of the
8 Independent Medical Review System with related dispute
9 resolution procedures of other health care agency programs,
10 including the Medicare program, in a way that minimizes the
11 potential for duplication, conflict, and added costs. Nothing in this
12 subdivision shall be construed to limit any rights conferred upon
13 insureds under this chapter.

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

17 (i) Every disability insurer shall prominently display in every
18 insurer member handbook or relevant informational brochure, in
19 every insurance contract, on insured evidence of coverage forms,
20 on copies of insurer procedures for resolving grievances, on letters
21 of denials issued by either the insurer or its contracting
22 organization, and on all written responses to grievances,
23 information concerning the right of an insured to request an
24 independent medical review when the insured believes that health
25 care services have been improperly denied, modified, or delayed
26 by the insurer, or by one of its contracting providers. The
27 department's telephone number, 1-800-927-4357, and Internet
28 Web site, www.insurance.ca.gov, shall also be displayed.

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

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

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

35 (C) The insured, in the absence of a provider recommendation
36 under subparagraph (A) or the receipt of urgent care or emergency
37 services by a provider under subparagraph (B), has been seen by
38 a contracting provider for the diagnosis or treatment of the medical
39 condition for which the insured seeks independent review. The
40 insurer shall expedite access to a contracting provider upon request

1 of an insured. The contracting provider need not recommend the
2 disputed health care service as a condition for the insured to be
3 eligible for an independent review.

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

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

12 (3) (A) The insured has filed a grievance with the insurer or its
13 contracting provider, and the disputed decision is upheld or the
14 grievance remains unresolved after 30 days. The insured shall not
15 be required to participate in the insurer's grievance process for
16 more than 30 days. In the case of a grievance that requires
17 expedited review, the insured shall not be required to participate
18 in the insurer's grievance process for more than three days, or

19 (B) The insured has filed for an external review decision with
20 the insurer or its contracting provider pursuant to subdivision (b)
21 of Section 10123.190, and the disputed decision is upheld or the
22 external review remains unresolved after 72 hours, or 24 hours if
23 exigent circumstances exist.

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

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

33 (m) As part of its notification to the insured regarding a
34 disposition of the insured's grievance that denies, modifies, or
35 delays health care services, the insurer shall provide the insured
36 with a one- or two-page application form approved by the
37 department, and an addressed envelope, which the insured may
38 return to initiate an independent medical review. The insurer shall
39 include on the form any information required by the department
40 to facilitate the completion of the independent medical review,

1 such as the insured's diagnosis or condition, the nature of the
2 disputed health care service sought by the insured, a means to
3 identify the insured's case, and any other material information.
4 The form shall also include the following:

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

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

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

16 (A) A provider recommendation indicating that the disputed
17 health care service is medically necessary for the insured's medical
18 condition.

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

22 (C) Reasonable information supporting the insured's position
23 that the disputed health care service is or was medically necessary
24 for the insured's medical condition, including all information
25 provided to the insured by the insurer or any of its contracting
26 providers, still in the possession of the insured, concerning an
27 insurer or provider decision regarding disputed health care services,
28 and a copy of any materials the insured submitted to the insurer,
29 still in the possession of the insured, in support of the grievance,
30 as well as any additional material that the insured believes is
31 relevant.

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

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

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

1 ~~(n) Upon notice from the department that the insured has applied~~
2 ~~for an independent medical review, the insurer or its contracting~~
3 ~~providers, shall provide to the independent medical review~~
4 ~~organization designated by the department a copy of all of the~~
5 ~~following documents within three business days of the insurer's~~
6 ~~receipt of the department's notice of a request by an insured for~~
7 ~~an independent review:~~

8 ~~(1) (A) A copy of all of the insured's medical records in the~~
9 ~~possession of the insurer or its contracting providers relevant to~~
10 ~~each of the following:~~

11 ~~(i) The insured's medical condition.~~
12 ~~(ii) The health care services being provided by the insurer and~~
13 ~~its contracting providers for the condition.~~
14 ~~(iii) The disputed health care services requested by the insured~~
15 ~~for the condition.~~

16 ~~(B) Any newly developed or discovered relevant medical records~~
17 ~~in the possession of the insurer or its contracting providers after~~
18 ~~the initial documents are provided to the independent medical~~
19 ~~review organization shall be forwarded immediately to the~~
20 ~~independent medical review organization. The insurer shall~~
21 ~~concurrently provide a copy of medical records required by this~~
22 ~~subparagraph to the insured or the insured's provider, if authorized~~
23 ~~by the insured, unless the offer of medical records is declined or~~
24 ~~otherwise prohibited by law. The confidentiality of all medical~~
25 ~~record information shall be maintained pursuant to applicable state~~
26 ~~and federal laws.~~

27 ~~(2) A copy of all information provided to the insured by the~~
28 ~~insurer and any of its contracting providers concerning insurer and~~
29 ~~provider decisions regarding the insured's condition and care, and~~
30 ~~a copy of any materials the insured or the insured's provider~~
31 ~~submitted to the insurer and to the insurer's contracting providers~~
32 ~~in support of the insured's request for disputed health care services.~~
33 ~~This documentation shall include the written response to the~~
34 ~~insured's grievance. The confidentiality of any insured medical~~
35 ~~information shall be maintained pursuant to applicable state and~~
36 ~~federal laws.~~

37 ~~(3) A copy of any other relevant documents or information used~~
38 ~~by the insurer or its contracting providers in determining whether~~
39 ~~disputed health care services should have been provided, and any~~
40 ~~statements by the insurer and its contracting providers explaining~~

1 the reasons for the decision to deny, modify, or delay disputed
2 health care services on the basis of medical necessity. The insurer
3 shall concurrently provide a copy of documents required by this
4 paragraph, except for any information found by the commissioner
5 to be legally privileged information, to the insured and the insured's
6 provider. The department and the independent medical review
7 organization shall maintain the confidentiality of any information
8 found by the commissioner to be the proprietary information of
9 the insurer.

10 SEC. 11. No reimbursement is required by this act pursuant to
11 Section 6 of Article XIII B of the California Constitution because
12 the only costs that may be incurred by a local agency or school
13 district will be incurred because this act creates a new crime or
14 infraction, eliminates a crime or infraction, or changes the penalty
15 for a crime or infraction, within the meaning of Section 17556 of
16 the Government Code, or changes the definition of a crime within
17 the meaning of Section 6 of Article XIII B of the California
18 Constitution.