

AMENDED IN ASSEMBLY APRIL 6, 2016  
AMENDED IN ASSEMBLY MARCH 17, 2016  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2400**

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**Introduced by Assembly Member Nazarian**  
**(Coauthor: Assembly Member Roger Hernández)**

February 18, 2016

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An act to amend Sections 1367.24, 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.

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

1 by which prescribing providers may obtain authorization for a  
2 medically necessary nonformulary prescription drug. On or before  
3 July 1, 1999, every health care service plan that provides  
4 prescription drug benefits shall file with the department a  
5 description of its process, including timelines, for responding to  
6 authorization requests for nonformulary drugs. Any changes to  
7 this process shall be filed with the department pursuant to Section  
8 1352. Each plan shall provide a written description of its most  
9 current process, including timelines, 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 enrollee.

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

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

39 (d) The process described in subdivision (a) by which enrollees  
40 may obtain medically necessary nonformulary drugs, including

1 specified timelines for responding to prescribing provider  
2 authorization requests, shall be described in evidence of coverage  
3 and disclosure forms, as required by subdivision (a) of Section  
4 1363, issued on or after July 1, 1999.

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

9 (1) The complete drug formulary or formularies of the plan, if  
10 the plan maintains a formulary, including a list of the prescription  
11 drugs on the formulary of the plan by major therapeutic category  
12 with an indication of whether any drugs are preferred over other  
13 drugs.

14 (2) Records developed by the pharmacy and therapeutic  
15 committee of the plan, or by others responsible for developing,  
16 modifying, and overseeing formularies, including medical groups,  
17 individual practice associations, and contracting pharmaceutical  
18 benefit management companies, used to guide the drugs prescribed  
19 for the enrollees of the plan, that fully describe the reasoning  
20 behind formulary decisions.

21 (3) Any plan arrangements with prescribing providers, medical  
22 groups, individual practice associations, pharmacists, contracting  
23 pharmaceutical benefit management companies, or other entities  
24 that are associated with activities of the plan to encourage  
25 formulary compliance or otherwise manage prescription drug  
26 benefits.

27 (f) If a plan provides prescription drug benefits, the department  
28 shall, as part of its periodic onsite medical survey of each plan  
29 undertaken pursuant to Section 1380, review the performance of  
30 the plan in providing those benefits, including, but not limited to,  
31 a review of the procedures and information maintained pursuant  
32 to this section, and describe the performance of the plan as part of  
33 its report issued pursuant to Section 1380.

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

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

1 (i) Nonformulary prescription drugs shall include any drug for  
2 which an enrollee’s copayment or out-of-pocket costs are different  
3 than the copayment for a formulary prescription drug, except as  
4 otherwise provided by law or regulation or in cases in which the  
5 drug has been excluded in the plan contract pursuant to Section  
6 1342.7.

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

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

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

28 (m) Nothing in this section shall be construed to affect an  
29 enrollee’s or subscriber’s eligibility to submit a grievance to the  
30 department for review under Section 1368 or to apply to the  
31 department for an independent medical review under Section  
32 1370.4, or Article 5.55 (commencing with Section 1374.30) of  
33 this chapter.

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

36 1368. (a) Every plan shall do all of the following:

37 (1) Establish and maintain a grievance system approved by the  
38 department under which enrollees may submit their grievances to  
39 the plan. Each system shall provide reasonable procedures in  
40 accordance with department regulations that shall ensure adequate

1 consideration of enrollee grievances and rectification when  
2 appropriate.

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

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

11 (4) (A) Provide for a written acknowledgment within five  
12 calendar days of the receipt of a grievance, except as noted in  
13 subparagraph (B). The acknowledgment shall advise the  
14 complainant of the following:

15 (i) That the grievance has been received.

16 (ii) The date of receipt.

17 (iii) The name of the plan representative and the telephone  
18 number and address of the plan representative who may be  
19 contacted about the grievance.

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

30 (I) The date of the call.

31 (II) The name of the complainant.

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

33 (IV) The nature of the grievance.

34 (V) The nature of the resolution.

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

37 (ii) For health plan contracts in the individual, small group, or  
38 large group markets, a health care service plan's response to  
39 grievances subject to Section 1367.24 shall also comply with  
40 subdivision (c) of Section 156.122 of Title 45 of the Code of

1 Federal Regulations. This paragraph shall not apply to Medi-Cal  
2 managed care health care service plan contracts or any entity that  
3 enters into a contract with the State Department of Health Care  
4 Services pursuant to Chapter 7 (commencing with Section 14000),  
5 Chapter 8 (commencing with Section 14200), or Chapter 8.75  
6 (commencing with Section 14591) of Part 3 of Division 9 of the  
7 Welfare and Institutions Code.

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

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

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

33 (b) (1) (A) After completing the grievance process described  
34 in subdivision (a), participating in the process for at least 30 days,  
35 or completing the external exception request review process  
36 described in subdivision (k) of Section 1367.24, a subscriber or  
37 enrollee may submit the grievance or external exception request  
38 review decision to the department for review. In any case under  
39 the grievance process determined by the department to be a case  
40 involving an imminent and serious threat to the health of the

1 patient, including, but not limited to, severe pain, the potential loss  
2 of life, limb, or major bodily function, cancellations, rescissions,  
3 or the nonrenewal of a health care service plan contract, or in any  
4 other case when the department determines that an earlier review  
5 is warranted, a subscriber or enrollee shall not be required to  
6 complete the grievance process or to participate in the process for  
7 at least 30 days before submitting a grievance to the department  
8 for review.

9 (B) A grievance or external exception request review decision  
10 may be submitted to the department for review and resolution prior  
11 to any arbitration.

12 (C) Notwithstanding subparagraphs (A) and (B), the department  
13 may refer any grievance or external exception request review  
14 decision that does not pertain to compliance with this chapter to  
15 the State Department of Public Health, the California Department  
16 of Aging, the federal Centers for Medicare and Medicaid Services,  
17 or any other appropriate governmental entity for investigation and  
18 resolution.

19 (2) If the subscriber or enrollee is a minor, or is incompetent or  
20 incapacitated, the parent, guardian, conservator, relative, or other  
21 designee of the subscriber or enrollee, as appropriate, may submit  
22 the grievance or external exception request review decision to the  
23 department as the agent of the subscriber or enrollee. Further, a  
24 provider may join with, or otherwise assist, a subscriber or enrollee,  
25 or the agent, to submit the grievance or external exception request  
26 review decision to the department. In addition, following  
27 submission of the grievance or external exception request review  
28 decision to the department, the subscriber or enrollee, or the agent,  
29 may authorize the provider to assist, including advocating on behalf  
30 of the subscriber or enrollee. For purposes of this section, a  
31 “relative” includes the parent, stepparent, spouse, adult son or  
32 daughter, grandparent, brother, sister, uncle, or aunt of the  
33 subscriber or enrollee.

34 (3) The department shall review the written documents submitted  
35 with the subscriber’s or the enrollee’s request for review, or  
36 submitted by the agent on behalf of the subscriber or enrollee. The  
37 department may ask for additional information, and may hold an  
38 informal meeting with the involved parties, including providers  
39 who have joined in submitting the grievance or external exception  
40 request review decision or who are otherwise assisting or



1 advocating on behalf of the subscriber or enrollee. If after  
2 reviewing the record, the department concludes that the grievance  
3 or external exception request review decision, in whole or in part,  
4 is eligible for review under the independent medical review system  
5 established pursuant to Article 5.55 (commencing with Section  
6 1374.30), the department shall immediately notify the subscriber  
7 or enrollee, or agent, of that option and shall, if requested orally  
8 or in writing, assist the subscriber or enrollee in participating in  
9 the independent medical review system.

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

28 (5) The department shall send a written notice of the final  
29 disposition of the grievance or external exception request review  
30 decision, and the reasons therefor, to the subscriber or enrollee,  
31 the agent, to any provider that has joined with or is otherwise  
32 assisting the subscriber or enrollee, and to the plan, within 30  
33 calendar days of receipt of the request for review unless the  
34 director, in his or her discretion, determines that additional time  
35 is reasonably necessary to fully and fairly evaluate the relevant  
36 grievance or external exception request review decision. In any  
37 case not eligible for the independent medical review system  
38 established pursuant to Article 5.55 (commencing with Section  
39 1374.30), the department's written notice shall include, at a  
40 minimum, the following:

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

4 (B) A discussion of the department’s contact with any medical  
5 provider, or any other independent expert relied on by the  
6 department, along with a summary of the views and qualifications  
7 of that provider or expert.

8 (C) If the enrollee’s grievance or external exception request  
9 review decision is sustained in whole or in part, information about  
10 any corrective action taken.

11 (6) In any department review of a grievance or external  
12 exception request review decision involving a disputed health care  
13 service, as defined in subdivision (b) of Section 1374.30, that is  
14 not eligible for the independent medical review system established  
15 pursuant to Article 5.55 (commencing with Section 1374.30), in  
16 which the department finds that the plan has delayed, denied, or  
17 modified health care services that are medically necessary, based  
18 on the specific medical circumstances of the enrollee, and those  
19 services are a covered benefit under the terms and conditions of  
20 the health care service plan contract, the department’s written  
21 notice shall do either of the following:

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

24 (B) Order the plan to promptly reimburse the enrollee for any  
25 reasonable costs associated with urgent care or emergency services,  
26 or other extraordinary and compelling health care services, when  
27 the department finds that the enrollee’s decision to secure those  
28 services outside of the plan network was reasonable under the  
29 circumstances.

30 The department’s order shall be binding on the plan.

31 (7) Distribution of the written notice shall not be deemed a  
32 waiver of any exemption or privilege under existing law, including,  
33 but not limited to, Section 6254.5 of the Government Code, for  
34 any information in connection with and including the written  
35 notice, nor shall any person employed or in any way retained by  
36 the department be required to testify as to that information or  
37 notice.

38 (8) The director shall establish and maintain a system of aging  
39 of grievances that are pending and unresolved for 30 days or more

1 that shall include a brief explanation of the reasons each grievance  
2 is pending and unresolved for 30 days or more.

3 (9) A subscriber or enrollee, or the agent acting on behalf of a  
4 subscriber or enrollee, may also request voluntary mediation with  
5 the plan prior to exercising the right to submit a grievance or  
6 external exception request review decision to the department. The  
7 use of mediation services shall not preclude the right to submit a  
8 grievance or external exception request review decision to the  
9 department upon completion of mediation. In order to initiate  
10 mediation, the subscriber or enrollee, or the agent acting on behalf  
11 of the subscriber or enrollee, and the plan shall voluntarily agree  
12 to mediation. Expenses for mediation shall be borne equally by  
13 both sides. The department shall have no administrative or  
14 enforcement responsibilities in connection with the voluntary  
15 mediation process authorized by this paragraph.

16 (c) The plan's grievance system shall include a system of aging  
17 of grievances that are pending and unresolved for 30 days or more.  
18 The plan shall provide a quarterly report to the director of  
19 grievances pending and unresolved for 30 or more days with  
20 separate categories of grievances for Medicare enrollees and  
21 Medi-Cal enrollees. The plan shall include with the report a brief  
22 explanation of the reasons each grievance is pending and  
23 unresolved for 30 days or more. The plan may include the  
24 following statement in the quarterly report that is made available  
25 to the public by the director:

26  
27 "Under Medicare and Medi-Cal law, Medicare enrollees and  
28 Medi-Cal enrollees each have separate avenues of appeal that  
29 are not available to other enrollees. Therefore, grievances  
30 pending and unresolved may reflect enrollees pursuing their  
31 Medicare or Medi-Cal appeal rights."

32  
33 If requested by a plan, the director shall include this statement in  
34 a written report made available to the public and prepared by the  
35 director that describes or compares grievances that are pending  
36 and unresolved with the plan for 30 days or more. Additionally,  
37 the director shall, if requested by a plan, append to that written  
38 report a brief explanation, provided in writing by the plan, of the  
39 reasons why grievances described in that written report are pending  
40 and unresolved for 30 days or more. The director shall not be

1 required to include a statement or append a brief explanation to a  
2 written report that the director is required to prepare under this  
3 chapter, including Sections 1380 and 1397.5.

4 (d) Subject to subparagraph (C) of paragraph (1) of subdivision  
5 (b), the grievance or resolution procedures authorized by this  
6 section shall be in addition to any other procedures that may be  
7 available to any person, and failure to pursue, exhaust, or engage  
8 in the procedures described in this section shall not preclude the  
9 use of any other remedy provided by law.

10 (e) Nothing in this section shall be construed to allow the  
11 submission to the department of any provider grievance under this  
12 section. However, as part of a provider's duty to advocate for  
13 medically appropriate health care for his or her patients pursuant  
14 to Sections 510 and 2056 of the Business and Professions Code,  
15 nothing in this subdivision shall be construed to prohibit a provider  
16 from contacting and informing the department about any concerns  
17 he or she has regarding compliance with or enforcement of this  
18 chapter.

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

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

28 1368.01. (a) The grievance system shall require the plan to  
29 resolve grievances within 30 days, except as provided in  
30 subdivisions (c) and (d).

31 (b) The grievance system shall include a requirement for  
32 expedited plan review of grievances for cases involving an  
33 imminent and serious threat to the health of the patient, including,  
34 but not limited to, severe pain, potential loss of life, limb, or major  
35 bodily function. When the plan has notice of a case requiring  
36 expedited review, the grievance system shall require the plan to  
37 immediately inform enrollees and subscribers in writing of their  
38 right to notify the department of the grievance. The grievance  
39 system shall also require the plan to provide enrollees, subscribers,  
40 and the department with a written statement on the disposition or

1 pending status of the grievance no later than three days from receipt  
2 of the grievance, except as provided in subdivision (c). Paragraph  
3 (4) of subdivision (a) of Section 1368 shall not apply to grievances  
4 handled pursuant to this section.

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

15 (d) The grievance system shall require a health care service plan  
16 that provides coverage for outpatient prescription drugs to resolve  
17 grievances within 72 hours for nonurgent requests, and within 24  
18 hours if exigent circumstances exist, if the original request was an  
19 authorization for a formulary drug that requires prior authorization  
20 by the plan. For purposes of this subdivision, “exigent  
21 circumstances” shall have the same meaning as set forth in Section  
22 1367.241.

23 SEC. 4. Section 1374.30 of the Health and Safety Code is  
24 amended to read:

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

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

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

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

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

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

32 (3) The department shall be the final arbiter when there is a  
33 question as to whether an enrollee grievance is a disputed health  
34 care service or a coverage decision. The department shall establish  
35 a process to complete an initial screening of an enrollee grievance.  
36 If there appears to be any medical necessity issue, the grievance  
37 shall be resolved pursuant to an independent medical review as  
38 provided under this article or pursuant to subdivision (b) of Section  
39 1368.

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

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

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

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

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

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

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

5 (B) The enrollee has received urgent care or emergency services  
6 that a provider determined was medically ~~necessary~~: *necessary*,  
7 or

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

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

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

25 (3) Either of the following:

26 (A) The enrollee has filed a grievance with the plan or its  
27 contracting provider pursuant to Section 1368, and the disputed  
28 decision is upheld or the grievance remains unresolved after 30  
29 days. The enrollee shall not be required to participate in the plan’s  
30 grievance process for more than 30 days. In the case of a grievance  
31 that requires expedited review pursuant to subdivision (b) of  
32 Section 1368.01, the enrollee shall not be required to participate  
33 in the plan’s grievance process for more than three days. In the  
34 case of a grievance that requires expedited review pursuant to  
35 subdivision (d) of Section 1368.01, the enrollee shall not be  
36 required to participate in the plan’s grievance process for more  
37 than 72 hours, or more than 24 hours if exigent circumstances  
38 exist.

39 (B) The enrollee has filed for an external exception request  
40 review decision with the plan or its contracting provider pursuant



1 to subdivision (k) of Section 1367.24, and the disputed decision  
2 is upheld or the external review remains unresolved after 72 hours,  
3 or after 24 hours if exigent circumstances exist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (i) The enrollee's medical condition.

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

35 (iii) The disputed health care services requested by the enrollee  
36 for the condition.

37 (B) Any newly developed or discovered relevant medical records  
38 in the possession of the plan or its contracting providers after the  
39 initial documents are provided to the independent medical review  
40 organization shall be forwarded immediately to the independent

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

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

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

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

32 SEC. 5. Section 10123.191 of the Insurance Code is amended  
33 to read:

34 10123.191. (a) Notwithstanding any other law, on and after  
35 January 1, 2013, a health insurer that provides coverage for  
36 prescription drugs shall utilize and accept only the prior  
37 authorization form developed pursuant to subdivision (c), or an  
38 electronic prior authorization process described in subdivision (e),  
39 when requiring prior authorization for prescription drugs.

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

6 (2) A health insurer's internal grievance process shall require  
7 a health insurer that provides coverage for outpatient prescription  
8 drugs to resolve grievances within 72 hours for nonurgent requests,  
9 and within 24 hours if exigent circumstances exist, if the original  
10 request was an authorization for a formulary drug that requires  
11 prior authorization by the health insurer.

12 (c) On or before January 1, 2017, the department and the  
13 Department of Managed Health Care shall jointly develop a  
14 uniform prior authorization form. Notwithstanding any other law,  
15 on and after July 1, 2017, or six months after the form is completed  
16 pursuant to this section, whichever is later, every prescribing  
17 provider shall use that uniform prior authorization form, or an  
18 electronic prior authorization process described in subdivision (e),  
19 to request prior authorization for coverage of prescription drugs  
20 and every health insurer shall accept that form or electronic process  
21 as sufficient to request prior authorization for prescription drugs.

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

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

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

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

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

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

35 (A) Existing prior authorization forms established by the federal  
36 Centers for Medicare and Medicaid Services and the State  
37 Department of Health Care Services.

38 (B) National standards pertaining to electronic prior  
39 authorization.

1 (e) A prescribing provider may use an electronic prior  
2 authorization system utilizing the standardized form described in  
3 subdivision (c) or an electronic process developed specifically for  
4 transmitting prior authorization information that meets the National  
5 Council for Prescription Drug Programs' SCRIPT standard for  
6 electronic prior authorization transactions.

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

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

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

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

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

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

23 (2) An insured shall not be required to file a complaint with the  
24 health insurer or its contracting provider pursuant to its internal  
25 grievance process if a health insurer disapproves a request to obtain  
26 authorization for a nonformulary drug under subdivision (i). If a  
27 health insurer disapproves a request to obtain authorization for a  
28 nonformulary drug and the insured files a complaint with the health  
29 insurer, the health insurer shall treat that as a request to obtain an  
30 external exception request review.

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

35 (j) Nothing in this section shall be construed to affect an  
36 insured's or policyholder's eligibility to submit a complaint to the  
37 department for review or to apply to the department for an  
38 independent medical review under Article 3.5 (commencing with  
39 Section 10169).

40 (k) For purposes of this section:

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

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

10 (3) “Completed prior authorization request” means a completed  
11 uniform prior authorization form developed pursuant to subdivision  
12 (c), or a completed request submitted using an electronic prior  
13 authorization system described in subdivision (e), or, for contracted  
14 physician groups described in subdivision (f), the process used by  
15 the contracted physician group.

16 SEC. 6. 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 (c) 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](http://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) Either of the following:

13 (A) The insured has filed a grievance with the insurer or its  
14 contracting provider, and the disputed decision is upheld or the  
15 grievance remains unresolved after 30 days. The insured shall not  
16 be required to participate in the insurer's grievance process for  
17 more than 30 days. In the case of a grievance that requires  
18 expedited review, the insured shall not be required to participate  
19 in the insurer's grievance process for more than three days. In the  
20 case of a grievance that requires expedited review pursuant to  
21 paragraph (2) of subdivision (b) of Section 10123.191, the insured  
22 shall not be required to participate in the insured's grievance  
23 process for more than 72 hours, or more than 24 hours if exigent  
24 circumstances exist.

25 (B) The insured has filed for an external exception request  
26 review decision with the insurer or its contracting provider pursuant  
27 to subdivision (h) of Section 10123.191, and the disputed decision  
28 is upheld or the external review remains unresolved after 72 hours,  
29 or after 24 hours if exigent circumstances exist.

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

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

39 (m) As part of its notification to the insured regarding a  
40 disposition of the insured's grievance that denies, modifies, or

1 delays health care services, the insurer shall provide the insured  
2 with a one- or two-page application form approved by the  
3 department, and an addressed envelope, which the insured may  
4 return to initiate an independent medical review. The insurer shall  
5 include on the form any information required by the department  
6 to facilitate the completion of the independent medical review,  
7 such as the insured’s diagnosis or condition, the nature of the  
8 disputed health care service sought by the insured, a means to  
9 identify the insured’s case, and any other material information.

10 The form shall also include the following:

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

15 (2) A statement indicating the insured’s consent to obtain any  
16 necessary medical records from the insurer, any of its contracting  
17 providers, and any noncontracting provider the insured may have  
18 consulted on the matter, to be signed by the insured.

19 (3) Notice of the insured’s right to provide information or  
20 documentation, either directly or through the insured’s provider,  
21 regarding any of the following:

22 (A) A provider recommendation indicating that the disputed  
23 health care service is medically necessary for the insured’s medical  
24 condition.

25 (B) Medical information or justification that a disputed health  
26 care service, on an urgent care or emergency basis, was medically  
27 necessary for the insured’s medical condition.

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

38 (4) A section designed to collect information on the insured’s  
39 ethnicity, race, and primary language spoken that includes both of  
40 the following:

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

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

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

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

17 (i) The insured's medical condition.

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

20 (iii) The disputed health care services requested by the insured  
21 for the condition.

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

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

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

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

16 SEC. 7. No reimbursement is required by this act pursuant to  
17 Section 6 of Article XIII B of the California Constitution because  
18 the only costs that may be incurred by a local agency or school  
19 district will be incurred because this act creates a new crime or  
20 infraction, eliminates a crime or infraction, or changes the penalty  
21 for a crime or infraction, within the meaning of Section 17556 of  
22 the Government Code, or changes the definition of a crime within  
23 the meaning of Section 6 of Article XIII B of the California  
24 Constitution.