AMENDED IN ASSEMBLY JUNE 18, 2015

AMENDED IN SENATE APRIL 9, 2015

# SENATE BILL No. 282

**Introduced by Senator Hernandez**

February 19, 2015

An act to amend Section 1367.241 of the Health and Safety Code, and to amend Section 10123.191 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 282, as amended, Hernandez. Health care coverage: prescription drugs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the 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. Commonly referred to as utilization review, existing law governs the procedures that apply to every health care service plan and health insurer that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees or insureds, as specified. Existing law requires every prescribing provider, as defined, when requesting prior authorization for prescription drug benefits, to submit a prior authorization form developed jointly by the Department of Managed Health Care and the Department of Insurance to the health care service plan or health insurer, and requires those plans and insurers to accept only those prior authorization forms for prescription drug benefits. Existing law

authorizes a prescribing provider to submit the form electronically to the plan or insurer.

This bill would authorize the prescribing provider to additionally use an electronic process developed specifically for transmitting prior authorization information ~~that is consistent with the standardized form described above and~~ that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions. To the extent that the bill would thereby require plans ~~and insurers~~ to accept that form of submission, the bill would expand the scope of a crime and would impose a state-mandated local program. The bill would specify that the provisions described above relating to prior authorization for prescription drug benefits do not apply if a contracted network physician group is delegated the financial risk for the pharmacy or medical drug benefit by a health care service plan or health insurer, if a contracted network physician group uses its own internal prior authorization process rather than the health care service plan's or the health insurer's prior authorization process for its enrollees or insureds, or if a contracted network physician group is delegated a utilization management function by the health care service plan or the health insurer concerning any pharmacy or medical drug benefit, regardless of the delegation of financial risk.

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:*

SECTION 1. Section 1367.241 of the Health and Safety Code is amended to read:

1367.241. (a) Notwithstanding any other ~~provision of~~ law, on and after January 1, 2013, a health care service plan that provides prescription drug benefits shall accept only the prior authorization form developed pursuant to subdivision (c), or an electronic prior authorization process described in subdivision (e), when requiring prior authorization for prescription drug benefits. This section does not apply in the event that a physician or physician group has been

delegated the financial risk for prescription drugs by a health care service plan and does not use a prior authorization process. This section does not apply to a health care service plan, or to its affiliated providers, if the health care service plan owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

(b) If a health care service plan fails to utilize or accept the prior authorization form, or fails to respond within two business days upon receipt of a completed prior authorization request from a prescribing provider, pursuant to the submission of the prior authorization form developed as described in subdivision (c), or an electronic prior authorization process described in subdivision (e), the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7 of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(c) On or before July 1, 2012, the department and the Department of Insurance shall jointly develop a uniform prior authorization form. Notwithstanding any other provision of law, on and after January 1, 2013, or six months after the form is developed, whichever is later, every prescribing provider shall use that uniform prior authorization form, or an electronic prior authorization process described in subdivision (e), to request prior authorization for coverage of prescription drug benefits and every health care service plan shall accept that form as sufficient to request prior authorization for prescription drug benefits.

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

(1) The form shall not exceed two pages.

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

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

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

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

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

(B) National standards pertaining to electronic prior authorization.

(e) A prescribing provider may use an electronic prior authorization system utilizing the standardized form described in subdivision (c) or an electronic process developed specifically for transmitting prior authorization information ~~that is consistent with the standardized form described in subdivision (c) and~~ that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.

(f) This section does not apply if any of the following occurs:

(1) A contracted network physician group is delegated the financial risk for the pharmacy or medical drug benefit by a health care service plan.

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

(3) A contracted network physician group is delegated a utilization management function by the health care service plan concerning any pharmacy or medical drug benefit, regardless of the delegation of financial risk.

(g) For purposes of this section, a "prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

SEC. 2. Section 10123.191 of the Insurance Code is amended to read:

10123.191. (a) Notwithstanding any other ~~provision of~~ law, on and after January 1, 2013, a health insurer that provides prescription drug benefits shall utilize and accept only the prior authorization form developed pursuant to subdivision (c), or an electronic prior authorization process described in subdivision (e), when requiring prior authorization for prescription drug benefits.

(b) If a health insurer fails to utilize or accept the prior authorization form, or fails to respond within two business days

upon receipt of a completed prior authorization request from a prescribing provider, pursuant to the submission of the prior authorization form developed as described in subdivision (c), or an electronic prior authorization process described in subdivision (e), the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7 of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(c) On or before July 1, 2012, the department and the Department of Managed Health Care shall jointly develop a uniform prior authorization form. Notwithstanding any other provision of law, on and after January 1, 2013, or six months after the form is developed, whichever is later, every prescribing provider shall use that uniform prior authorization form, or an electronic prior authorization process described in subdivision (e), to request prior authorization for coverage of prescription drug benefits and every health insurer shall accept that form as sufficient to request prior authorization for prescription drug benefits.

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

(1) The form shall not exceed two pages.

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

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

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

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

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

(B) National standards pertaining to electronic prior authorization.

(e) A prescribing provider may use an electronic prior authorization system utilizing the standardized form described in subdivision (c) or an electronic process developed specifically for transmitting prior authorization information ~~that is consistent with the standardized form described in subdivision (c) and~~ that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.

(f) This section does not apply if any of the following occurs:

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

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

(3) A contracted network physician group is delegated a utilization management function by the health insurer concerning any pharmacy or medical drug benefit, regardless of the delegation of financial risk.

(g) For purposes of this section, a "prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an insured.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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