

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:

- 1 SECTION 1. Section 1367.241 of the Health and Safety Code
- 2 is amended to read:
- 3 1367.241. (a) Notwithstanding any other ~~provision of~~ law, on
- 4 and after January 1, 2013, a health care service plan that provides
- 5 prescription drug benefits shall accept only the prior authorization
- 6 form developed pursuant to subdivision (c), or an electronic prior
- 7 authorization process described in subdivision (e), when requiring
- 8 prior authorization for prescription drug benefits. This section does
- 9 not apply in the event that a physician or physician group has been

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

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

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

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

- 33 (1) The form shall not exceed two pages.
- 34 (2) The form shall be made electronically available by the
35 department and the health care service plan.
- 36 (3) The completed form may also be electronically submitted
37 from the prescribing provider to the health care service plan.
- 38 (4) The department and the Department of Insurance shall
39 develop the form with input from interested parties from at least
40 one public meeting.

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

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

7 (B) National standards pertaining to electronic prior
8 authorization.

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

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

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

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

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

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

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

33 10123.191. (a) Notwithstanding any other ~~provision of~~ law,
34 on and after January 1, 2013, a health insurer that provides
35 prescription drug benefits shall utilize and accept only the prior
36 authorization form developed pursuant to subdivision (c), or an
37 electronic prior authorization process described in subdivision (e),
38 when requiring prior authorization for prescription drug benefits.

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

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

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

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

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

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

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

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

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

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

39 (B) National standards pertaining to electronic prior
40 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 is consistent with~~
 5 ~~the standardized form described in subdivision (c) and~~ that meets
 6 the National Council for Prescription Drug Programs’ SCRIPT
 7 standard for electronic prior authorization transactions.

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

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

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

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

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

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