ASSEMBLY BILL No. 55

Introduced by Assembly Members Migden and Strom-Martin
(Coauthor: Assembly Member Wayne)

December 7, 1998

An act to amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, to add Sections 1344.5 and 1344.6 to, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.55 (commencing with Section 10145.80) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 55, as introduced, Migden. Health care service plans.

(1) Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations.

Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review.

Existing law requires every health care service plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for

individual enrollees or insureds who have a terminal condition and meet certain specified criteria.

(2) This bill would require health care service plans to provide subscribers and enrollees with written responses to grievances, as specified, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the plan's grievance process for 30 days. The bill would require the department to respond to each grievance in writing within 30 days.

This bill would also, on and after January 1, 2000, require every health care service plan to provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, terminated, or otherwise limited by the plan or by one of its contracting providers. The bill would require the Department of Corporations to establish an independent medical review system whereby requests for reviews are assigned to an independent medical review organization, as specified. An enrollee would in most cases be required to pay to the department a processing fee of $25, which would be refunded if the enrollee prevails in the review, and the remaining costs would be paid by an assessment on health care service plans imposed by the department. The bill would enact other related provisions.

The bill would also provide for a similar but unspecified independent medical review system to be established in the Department of Insurance for review of similar decisions by disability insurers.

It would further require the Commissioner of Corporations to submit a report to the Legislature by March 1, 2001, on the implementation of the independent medical review system.

(3) This bill would require a health care service plan, for services rendered on or after January 1, 1999, to be directly accountable to patients to ensure that physicians, not the health care service plan, are in charge of patient care.

This bill would provide that a health care service plan has the duty to exercise ordinary care when making health care treatment decisions, as defined, and is liable for damages for harm to an enrollee proximately caused by its failure to exercise ordinary care, as well as the health care treatment

decisions made by employers, agents, ostensible agents, or certain representatives of the health care service plan.

The bill would set forth a defense against an action asserted against a health care service plan.

The bill would prohibit a person from maintaining a cause of action against a health care service plan unless the affected enrollee or representative of the affected enrollee has exhausted a prescribed appeals process, except under certain circumstances.

(4) Under existing law, a willful violation of the provisions governing health care service plans is a crime. By changing the definition of the crime applicable to these plans, this 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:

SECTION 1. Section 1344.5 is added to the Health and Safety Code, to read:

1344.5. (a) For services rendered on or after January 1, 1999, a health care service plan shall be directly accountable to patients to ensure that physicians, not the health care service plan, are in charge of patient care.

(b) A health care service plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by its failure to exercise ordinary care.

(c) (1) A health care service plan is also liable for damages for harm to an enrollee proximately caused by the health care treatment decisions made by any of the following:

(A) Employees of the health care service plan.

(B) Agents of the health care service plan.

(C) Ostensible agents of the health care service plan.

(D) Representatives who are acting on behalf of the health care service plan and over whom the plan has the right to exercise influence or control, or has actually exercised influence or control, that results in the failure to exercise ordinary care.

(2) Nothing in this subdivision shall be construed to do any of the following:

(A) Confer enterprise liability on any physician or any other health care provider.

(B) Alter existing law in any way with respect to the liability of a physician or any other health care provider for professional negligence.

(C) Create any new or additional liability on the part of any health care provider who provides services to a health care service plan in connection with the plan's health care treatment decisions.

(D) Create any liability on the part of a health care service plan if its actions only consist of approving a treatment decision recommended by the patient's health care provider and the treatment recommendation is not controlled or influenced by the health care service plan.

(E) Alter existing law in any way with respect to the liability of any health care provider for indemnity or contribution based upon a plaintiff's recovery of damages from others based upon professional negligence by that health care provider.

(d) For purposes of this section, a 'health care treatment decision' means a determination made when a health care service plan arranges for medical services or a decision by the health care service plan that affects the quality of the diagnosis, care, or treatment provided to enrollees of the plan.

(e) It shall be a defense to any action asserted against a health care service plan if both of the following apply:

(1) Neither the health care service plan, nor any employee, agent, ostensible agent, or representative for whose conduct the health care service plan is liable under

subdivision (b), controlled, influenced, delayed, or participated in the health care treatment decision.

(2) The health care service plan did not deny or delay payment for any treatment prescribed or recommended by a provider to the enrollee.

(f) The standards set forth in subdivisions (a) and (b) create no obligation on the part of the health care service plan to provide to an enrollee treatment that is not covered by the health care service plan.

(g) This section shall not create any liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees.

(h) Nothing in this section shall cause a health care service plan to be defined as a health care provider under any provision of law.

(i) Nothing in this section abrogates or limits any other theory of liability otherwise available at law.

(j) ‘Health care provider‘ means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2, and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200).

‘Health Care provider‘ includes the legal representatives of a health care provider.

(k) ‘Professional negligence‘ means a negligent act or omission to act by a health care provider in the rendering of professional services, and the act or omission is the proximate cause of a personal injury or wrongful death, provided that these services are within the scope of services for which the provider is licensed and are not within any restriction imposed by the licensing agency or licensed hospital.

SEC. 2. Section 1344.6 is added to the Health and Safety Code, to read:

1344.6. (a) A person may not maintain a cause of action under this chapter against a health care service plan that offers a grievance process unless the affected enrollee or representative of the affected enrollee has exhausted the appeals process offered by the health care service plan pursuant to Section 1368.

(b) An enrollee is not required to comply with subdivision (a) and no abatement or other order for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance both of the following:

(1) Harm to the enrollee has already occurred because of the conduct of the health care service plan or because of an act or omission of an employee, agent, ostensible agent, or representative of the health care service plan for whose conduct the plan is liable, or the requirement of exhausting the process for appeal and review places the health of the enrollee in serious jeopardy.

(2) The review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity, finds after hearing that the pleading was not made in good faith, in which case the court may order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days. The order of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with subdivision (a).

SEC. 3. Section 1368 of the Health and Safety Code is amended to read:

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

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

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The

information shall include the location and telephone number where grievances may be submitted.

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

(4) *Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the denial, termination, or the imposition of other limits on health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity or medical appropriateness.*

(5) Keep in its files all copies of ~~complaints~~ *grievances*, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least ~~60~~ *30* days, a subscriber or enrollee may submit the grievance ~~or complaint~~ to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, *severe pain,* the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or participate in the process for at least ~~60 days~~ *30 days before submitting a grievance to the department for review.*

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

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance ~~or complaint~~ *issue that does not pertain to compliance with this chapter* to the State Department of Health Services, the *California* Department of Aging, the federal Health Care Financing

Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance ~~or complaint~~ to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance ~~or complaint~~ to the department. In addition, following submission of the grievance ~~or complaint~~ to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a ''relative'' includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance ~~or complaint~~, or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. ~~The~~ *If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.*

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been denied, terminated, or otherwise

limited by a plan, or by one of its contracting providers, substantially due to a determination that the service is not medically necessary or medically appropriate for the enrollee's medical condition, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the commissioner shall impose a penalty.

(5) The department shall send a written notice of the final disposition of the grievance ~~or complaint~~, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within ~~60~~ *30* calendar days of receipt of the request for review unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance ~~or complaint. Distribution~~. *In any decision not eligible for the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80), the department's written notice shall include, at a minimum, the following:*

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

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

(C) If the enrollee's grievance is sustained in whole or part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1399.80, that is not eligible for the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80), in which the department finds that the plan has denied, terminated, or otherwise limited health care services that are medically necessary or medically

appropriate, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall either:

(A) Order the plan to promptly offer and provide those health care services to the enrollee, or

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

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

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

(8) On or before January 1, ~~1997~~ *1999*, the commissioner shall establish and maintain a system of aging of ~~complaints~~ *grievances* that are pending and unresolved for ~~60~~ *30* days or more, that shall include a brief explanation of the reasons each ~~complaint~~ *grievance* is pending and unresolved for ~~60~~ *30* days or more.

~~(4)~~

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance ~~or complaint~~ to the department. The use of mediation services shall not preclude the right to submit a grievance ~~or complaint~~ to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The

department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of ~~complaints~~ *grievances* that are pending and unresolved for 30 days or more. On or before January 1, ~~1997~~ *1999*, the plan shall provide a quarterly report to the commissioner of ~~complaints~~ *grievances* pending and unresolved for 30 or more days with separate categories of ~~complaints~~ *grievances* for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each ~~complaint~~ *grievance* is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the commissioner:

> ''Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, ~~complaints~~ *grievances* pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.''

If requested by a plan, the commissioner shall include this statement in a written report made available to the public and prepared by the commissioner that describes or compares ~~complaints~~ *grievances* that are pending and unresolved with the plan for 30 days or more. Additionally, the commissioner shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why ~~complaints~~ *grievances* described in that written report are pending and unresolved for 30 days or more. The commissioner shall not be required to include a statement or append a brief explanation to a written report that the commissioner is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance~~, complaint,~~ or resolution

procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

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

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

1368.01. (a) The grievance system shall require the plan to resolve grievances within 30 days ~~whenever possible~~ and shall require the plan to provide enrollees and subscribers with a written statement on the disposition or pending status of the grievance within ~~30~~ *15* days of the plan's receipt of the grievance.

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, *severe pain,* potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than ~~five~~ *three* days from receipt of the grievance.

SEC. 5. Section 1368.03 of the Health and Safety Code is amended to read:

1368.03. (a) The department may require enrollees and subscribers to participate in a plan's grievance process for up to ~~60~~ *30* days before pursuing a ~~complaint~~ *grievance* through the department. However, the department may not impose this waiting period ~~in~~ *for expedited review* cases covered by subdivision (b) of Section 1368.01 or in any other case where the department determines that an earlier review is warranted.

(b) Notwithstanding subdivision (a), the department may refer any grievance ~~or complaint~~ *issue that does not pertain to compliance with this chapter* to the State Department of Health Services, the Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

SEC. 6. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The commissioner shall~~, as appropriate,~~ investigate and take enforcement action against plans regarding ~~complaints by enrollees and subscribers~~ *grievances reviewed and found by the department to involve plan noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80). Where harm to an enrollee has occurred as a result of plan noncompliance, the commissioner shall impose penalties*. The commissioner shall periodically evaluate ~~complaints~~ *grievances* to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The commissioner may, after appropriate notice and opportunity for hearing, levy an administrative penalty, by order, in an amount not to exceed two hundred fifty thousand dollars ($250,000) if the commissioner determines that a health care service plan has knowingly committed, or has performed with~~ such~~ *a* frequency~~ as to indicate~~ *that indicates* a general business practice, any of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the commissioner to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the State Corporations Fund.

SEC. 7. Article 12 (commencing with Section 1399.80) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Appeals Seeking Independent Medical Reviews

1399.80. (a) Commencing January 1, 2000, there is established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, ‘disputed health care service‘ means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, terminated, or otherwise limited by a decision of the plan, or by one of its contracting providers, substantially due to a finding that the service is not medically necessary or medically appropriate for the enrollee’s medical condition. A decision regarding a ‘disputed health care service‘ relates to the practice of medicine and is not a ‘coverage decision.‘

(c) For the purposes of this chapter, ‘coverage decision‘ means the approval or denial of health care services by a plan, or by one of its contracting entities, based, in whole or in part, on a finding that the provision

of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A ‘coverage decision‘ does not encompass a plan or contracting provider decision regarding a ‘disputed health care service.‘

(d) All enrollee grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this chapter are met. If the department finds that an enrollee grievance involving a disputed health care service does not meet the requirements of this chapter for review under the Independent Medical Review System, the enrollee request for review shall be treated as a request for the department to review the grievance pursuant to subdivision (b) of Section 1368. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the department pursuant to subdivision (b) of Section 1368.

(e) No later than January 1, 2000, every health care service plan shall provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, terminated, or otherwise limited by the plan, or by one of its contracting providers, if the decision was based, in whole or in part, on a finding that the proposed health care services are not medically necessary or medically appropriate. For purposes of this article, ‘enrollee‘ shall include a subscriber or designee as described in paragraph (2) of subdivision (b) of Section 1368, and an enrollee’s provider with the consent of the enrollee or the designee. The provider may join with or otherwise assist the enrollee to seek an independent medical review, and may advocate on behalf of the enrollee.

(f) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall authorize enrollee participation in the Independent Medical Review System. Medi-Cal beneficiaries enrolled in a health care service plan shall not be excluded from participation. Medicare beneficiaries shall not be excluded unless the

federal Health Care Financing Administration issues a finding that federal law preempts their participation.

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

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available. The enrollee's election to either pursue or not pursue, exhaust, or engage in the procedures described in this article does not preclude the use of any other remedy provided by law.

(i) No later than January 1, 2000, every health care service plan shall prominently display in every plan contract, on enrollee and subscriber evidence of coverage forms, on copies of plan procedures for resolving grievances, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, terminated, or otherwise limited by the plan, or by one of its contracting providers.

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

(1) (A) The enrollee's provider has recommended a health care service as medically necessary or medically appropriate for the enrollee's medical conditions, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary or medically appropriate for the enrollee's medical condition, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided in subdivision (b) of Section 1399.84.

(2) The disputed health care service has been denied, terminated, or otherwise limited by the plan, or by one of its contracting providers, substantially due to a decision that the health care service is not medically necessary or medically appropriate.

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

(k) An enrollee may apply to the department for an independent medical review of a decision to deny, terminate, or otherwise limit health care services, substantially due to a finding that the disputed health care services are not medically necessary or medically appropriate, within 60 days of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond 60 days if the circumstances of a case warrant the extension.

(*l*) The enrollee shall pay to the department an application processing fee of twenty-five dollars ($25), which shall be refunded if the enrollee prevails, in whole or in part, in the review. Medi-Cal beneficiaries shall be exempt from the fee. The commissioner shall reduce or

waive the fee in other cases involving low-income individuals, according to a schedule established by the commissioner. The remaining costs of the Independent Medical Review System shall be borne by the plans as provided in Section 1399.85.

(m) As part of the application for an independent medical review, the enrollee shall provide the department with all of the following:

(1) A brief description of the enrollee's medical condition for which health care services were denied, terminated, or otherwise limited.

(2) Documentation showing any of the following:

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

(B) The enrollee has received the disputed health care service, on an urgent care or emergency basis, from a provider who determined it was medically necessary or medically appropriate for the enrollee's medical condition.

(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary or medically appropriate for the enrollee's medical condition.

The enrollee shall be encouraged to also provide a copy of all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

(3) A written consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter.

(n) Upon notice from the department that the health care service plan's enrollee has applied for an

independent medical review, the plan or its contracting providers shall provide to the department, or to the independent medical review organization if requested by the department, a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review:

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

(A) The enrollee's medical condition.

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

(C) The disputed health care services requested by the enrollee for the condition.

Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the department shall be forwarded immediately to the department, or to the independent medical review organization if requested by the department. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

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

(3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision not to provide disputed health care services on the basis of medical necessity or medical appropriateness. The plan shall concurrently provide a copy of documents required by this subparagraph, except for any information found by the commissioner to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent review organization shall maintain the confidentiality of any information found by the commissioner to be the proprietary information of the plan.

1399.81. (a) Upon receipt of an enrollee's request for an independent medical review, the commissioner shall assign the request in whole or in part to an independent medical review organization as described in Section 1399.82 when all of the following conditions are satisfied:

(1) The enrollee has provided an executed release to obtain necessary medical records.

(2) The enrollee has submitted payment for the application fee, unless the fee is reduced or waived.

(3) The commissioner finds that the decision to deny, terminate, or otherwise limit disputed health care services was substantially due to a determination that the proposed health care services are not medically necessary or medically appropriate. The commissioner shall consider the entire record submitted by the enrollee, the plan, and providers when making this finding.

(4) The enrollee has followed the plan's grievance process pursuant to Section 1368. However, the commissioner may waive this requirement in extraordinary and compelling cases, where the commissioner finds that the enrollee has acted reasonably.

(5) The enrollee has submitted documentation satisfying the requirements of paragraph (1) of subdivision (j) of Section 1399.80.

(b) The department shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The department shall issue a notification to the enrollee no later than two business days after receiving all of the material required under subdivision (a). The department shall approve in one business day enrollee requests whenever the enrollee's plan has agreed that the case is eligible for an independent medical review. The department shall not certify coverage decisions for independent review. To the extent an enrollee request for independent review is not approved by the department, the enrollee request shall be treated as an immediate request for the department to review the grievance pursuant to subdivision (b) of Section 1368.

(c) If the request for review is approved, the department shall immediately arrange for delivery by the plan, and its contracting providers or directly provide the independent medical review organization with all necessary information and documents related to the case submitted by the enrollee, the enrollee's provider, the health care service plan, and its contracting providers. If there is an imminent and serious threat to the health of the enrollee, as defined in subdivision (c) of Section 1399.83, all necessary information and documents shall be delivered within 24 hours of approval of the request. In other cases, information and documents shall be provided to the independent medical review organization no later than two business days after approval of the request.

(d) The organization shall conduct the review in accordance with Section 1399.83 and any regulations or orders of the commissioner adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity or appropriateness of the disputed health care services and shall not include

any consideration of coverage decisions or other contractual issues.

1399.82. (a) By January 1, 2000, the commissioner shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any health care service plans doing business in this state. The commissioner may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System.

(b) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the commissioner, with any of the following:

(1) The plan.

(2) Any officer, director, or employee of the plan.

(3) A physician, the physician's medical group, or the independent practice association either denying or proposing the health care service in dispute.

(4) The institution at which either the proposed health care service, or the alternative service, if any, recommended by the plan, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the enrollee whose treatment is under review, or the alternative therapy, if any, recommended by the plan.

(c) The commissioner shall, by July 1, 1999, contract with a private, nonprofit accrediting organization to accredit the independent medical review organizations described in subdivision (a). The accrediting organization may grant and revoke accreditation, and shall develop, apply, and enforce accreditation standards that ensure the independence of the independent medical review organization, the confidentiality of the

medical records, and the qualifications and independence of the health care professionals providing the analyses and recommendations requested of them. The accrediting organization shall demonstrate the ability to objectively evaluate the performance of independent medical review organizations and shall demonstrate that it has no conflict of interest, including any material professional, familial, or financial affiliation, as provided in subdivision (b), with any independent medical review organization or plan, in accrediting those organizations for the purpose of reviewing medical treatment and treatment recommendation decisions made by health care service plans.

(d) In order to receive accreditation for the purposes of this section, an independent medical review organization shall meet all of the following requirements:

(1) An independent medical review organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health plan or a trade association of health plans. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health plan or a trade association of health plans shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The independent medical review organization shall submit to the accrediting organization and to the department the following information upon initial application for accreditation and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review organization

controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of a plan, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent medical review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any health care service plan or provider group for which the independent medical review organization provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise which the medical professionals are credentialed to review.

(H) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The independent medical review organization shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts-of-interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) The medical professional shall hold a nonrestricted license in the State of California, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. For good cause shown, such as the unavailability of licensed qualified medical professionals in California or the availability of uniquely qualified clinics outside of California, the independent medical review organization may utilize a medical professional who holds a

nonrestricted license in any state of the United States, provided that the out-of-state medical professional is knowledgeable about the treatment standards in California and applies those standards.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The plan or a provider group of the plan, except that an academic medical center under contract to the plan to provide services to enrollees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the plan.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the enrollee whose condition is under review.

(F) The enrollee or the enrollee's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) 'Material familial affiliation' means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) 'Material professional affiliation' means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any

independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent medical review organization. ‘Material professional affiliation‘ does not include affiliations that are limited to staff privileges at a health facility.

(C) ‘Material financial affiliation‘ means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent medical review organization or individual to which this subdivision applies. ‘Material financial affiliation‘ does not include payment by the plan to the independent medical review organization for the services required by this section, nor does ‘material financial affiliation‘ include an expert’s participation as a contracting plan provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The accrediting organization shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with it by an independent medical review organization seeking accreditation under this article. The accrediting organization may charge a nominal fee to the interested person for photocopying the requested information.

(f) The independent review process established by this section shall be required on and after January 1, 2000.

1399.83. (a) Upon receipt of information and documents related to a case pursuant to subdivision (c) of Section 1399.81, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties.

The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary or medically appropriate based on generally accepted practice guidelines developed by federal agencies, nationally recognized federal research institutes, national professional medical specialty societies, or relevant medical or scientific evidence or generally accepted standards of medical practice.

(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the commissioner. If the disputed health care service has not been provided and the enrollee's provider or the department certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the certification notice. Subject to the approval of the department, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by up to three days following reviewer receipt of delayed documentation required by this chapter.

(d) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary or medically appropriate. Each analysis shall cite the enrollee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the

medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(e) The independent medical review organization shall provide the commissioner, the plan, the enrollee, and the enrollee's provider with the analyses and determinations of the medical professionals reviewing the case, a description of the qualifications of the medical professionals, and the names of the reviewers. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(f) The commissioner shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties, which decision shall be binding on the plan.

(g) (1) Subject to provisions of the Evidence Code, the opinion of a medical professional reviewer on whether the disputed health care service was medically necessary or medically appropriate may be offered for admissibility solely on that issue by a party to the medical review who calls the medical professional as his or her expert witness in any subsequent administrative or civil proceeding. Any opinion evidence of the medical professional reviewer that is admitted shall be considered only as the testimony of the party's expert witness, and not as the testimony of the medical professional conducting the medical review. Any opinion evidence of the medical professional reviewer that is admitted shall be accorded the same weight as other expert opinion evidence and shall be subject to the same rules, including cross-examination.

(2) A medical professional reviewer opinion of medical necessity or medical appropriateness shall not be based in whole or in part on a determination that the disputed health care service is excluded from or covered under the terms and conditions of the health care service

plan contract, and that coverage determination shall be inadmissible.

(h) After removing the names of the parties, including, but not limited to, the enrollee, all medical providers, the plan, and any of its employees or contractors, commissioner decisions adopting a determination of an independent medical review organization shall be made available by the department to the public upon request, at the department's cost.

1399.84. (a) Upon receiving the decision adopted by the commissioner pursuant to Section 1399.83 that a disputed health care service is medically necessary or medically appropriate, the plan shall immediately contact the enrollee and offer to promptly implement the decision.

(b) In any case where an enrollee secured urgent care, emergency services, or other extraordinary and compelling health care services outside of the plan provider network, which services are later found by the independent medical review organization to have been medically necessary or medically appropriate, the commissioner shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the commissioner finds that the enrollee's decision to secure the services outside of the plan provider network prior to completing the plan grievance process or seeking an independent medical review was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract.

(c) In addition to requiring plan compliance regarding subdivisions (a) and (b), the commissioner shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where harm to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to deny, terminate, or otherwise limit covered health care services that an independent

medical review determines to be medically necessary or medically appropriate, the commissioner shall impose penalties.

(d) Pursuant to Section 1368.04, the commissioner shall periodically evaluate independent medical review cases to determine if any audit, investigative, or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a denial, termination, or the imposition of other limits on medically necessary or medically appropriate health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

1399.85. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) Aside from the application fee of twenty-five dollars ($25), the costs of the independent medical review system for enrollees shall be borne by health care service plans pursuant to an assessment fee system established by the commissioner. Every health care service plan shall pay annually to the department, on the date or dates set by the department, its prorated share of fees, as determined by the commissioner, to pay for the estimated annual costs associated with carrying out, overseeing, and evaluating the independent medical review system. In determining the amount to be assessed, the commissioner shall consider all appropriations available for the support of this chapter. The commissioner may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments.

(c) These funds shall be used for all costs reasonably incurred in the administration of this chapter, including,

but not limited to, startup costs, overhead, department administration, contracting with an accrediting organization, contracts with independent medical review organizations, payments to medical professional reviewers, and program evaluation.

(d) The commissioner shall submit to the Legislature by March 1, 2001, a report on the initial implementation of this article. The report shall include a description of assessments imposed on plans to implement this article, increased staffing and other resources attributable to these new responsibilities, and any redirection of existing staff and resources to carry out these responsibilities. A single copy of the report shall be made available at no cost to members of the public upon request. The department may recover the cost of additional copies that are requested.

SEC. 8. Article 2.55 (commencing with Section 10145.80) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 2.55. Appeals Seeking Independent Medical Review

10145.80. Commencing January 1, 2000, there is established in the department the Independent Medical Review System pursuant to the Patient's Independent Medical Review Act of 1998.

SEC. 9. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act

shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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