AMENDED IN SENATE AUGUST 24, 1999

AMENDED IN ASSEMBLY APRIL 27, 1999

AMENDED IN ASSEMBLY APRIL 15, 1999

AMENDED IN ASSEMBLY APRIL 12, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 55

Introduced by Assembly Members Migden ~~and~~, Strom-Martin, *and Thomson*
(Principal coauthor: Senator Speier)
(Coauthor: Assembly Member Wayne)

December 7, 1998

An act to ~~add Title 7 (commencing with Section 3428) to Part 1 of Division 4 of the Civil Code, to~~ amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, 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 amended, Migden. Health care service plans.

~~(1) Under~~

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

~~This bill would require a health care service plan or managed care entity, for services rendered on or after January 1, 2000, to be legally responsible to patients to ensure that health care providers, rather than the plan, shall be in charge of patient care.~~

~~The bill would provide that a health care service plan or managed care entity shall have a duty of ordinary care to provide medically appropriate health care service to its members, subscribers, or enrollees where the health care service is a benefit generally provided under the plan.~~

~~The bill would make a health care service plan or managed care entity liable for any and all harm resulting from the failure to exercise ordinary care in the provision, approval, or denial of health care services.~~

~~The bill would set forth prohibitions regarding health care service plans or managed care entities seeking indemnity from the requirements of this provision and would make any provisions to the contrary in a contract with providers void and unenforceable. The bill would make any waiver of certain provisions in the bill contrary to public policy, unenforceable, and void.~~

~~(2)~~ Existing law provides for the regulation of insurance, administered by the Commissioner of Insurance. ~~Existing law provides that the business of insurance is subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act in the Civil Code and the antitrust and unfair business practices laws in the Business and Professions Code.~~

~~This bill would provide that all persons or entities engaged in the business of insurance, as defined in the bill, in this state shall be held accountable in a civil action for all harm legally caused by the wrongful or unreasonable denial or delay of health care or disability benefits or services.~~

~~This bill would provide that health care service plans and managed care entities shall be subject to the laws of California applicable to any other business or business practice, including those applicable to the business of insurance.~~

~~(3) Existing law provides that for the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by the Civil Code,~~

~~is the amount that will compensate for all the detriment approximately caused thereby, whether it could have been anticipated or not.~~

~~This bill would provide that damages shall be recoverable, including under this provision, for certain violations of the provisions of the bill.~~

~~(4) Existing~~

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.

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.

Under existing law, a health care service plan's grievance system is required to include an expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient.

This bill would require when service is being denied to an enrollee who is an inpatient at a hospital that the service be handled as an expedited plan grievance.

This bill would also, on and after January 1, 2001, 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, significantly delayed, 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. Under this bill, an enrollee would not pay any application or processing fee. The bill would require that the costs of the independent medical review process 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, 2002, on the implementation of the independent medical review system.

~~(5) Under~~

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. Title 7 (commencing with Section 3428) is added to Part 1 of Division 4 of the Civil Code, to read:~~

~~TITLE 7. DUTY OF HEALTH CARE SERVICE PLANS AND MANAGED CARE ENTITIES~~

~~3428. (a) For services rendered on or after January 1, 2000, a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the~~

~~Health and Safety Code or managed care entity, shall be legally responsible to patients to ensure that health care providers, rather than the health care service plan, are in charge of patient care.~~

~~(b) (1) A health care service plan or managed care entity shall have a duty of ordinary care to provide a medically appropriate health care service to its members, subscribers, or enrollees where the health care service is a benefit generally provided under the plan.~~

~~(2) A health care service plan or managed care entity shall be liable for any and all harm resulting from the failure to exercise ordinary care in the provision, approval, or denial of health care services, including but not limited to, where the failure to provide those services resulted from the fact that the health care service plan or managed care entity interfered with, delayed, or otherwise influenced the quality of medical care provided.~~

~~(c) Nothing in this section shall cause a health care service plan or managed care entity to be defined as a health care provider under any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 or 3333.2 of this code, or Sections 340.5, 364, 425.13, 667.7, or 1295 of the Code of Civil Procedure.~~

~~(d) A health care service plan or managed care entity shall not seek indemnity, whether contractual or equitable, from a provider for liability imposed under subdivision (b). Any provision to the contrary in a contract with providers is void and unenforceable.~~

~~(e) 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 or on behalf of self-funded employee benefit plans.~~

~~(f) Any waiver by a member, subscriber, or enrollee of the provisions of this section is contrary to public policy and shall be unenforceable and void.~~

~~(g) This section does not create any new or additional liability on the part of a health care service plan for the~~

~~sole medical negligence of a treating physician. "Sole medical negligence" means that negligent provision of medical care that is based on a decision unrelated to financial or medical coverage issues.~~

~~(h) This section does not abrogate or limit any other theory of liability otherwise available at law.~~

~~(i) If any provision of this section or the application thereof to any person or circumstance is held to be unconstitutional or otherwise invalid or unenforceable, the remainder of the section and the application of those provisions to other persons or circumstances shall not be affected thereby.~~

~~3428.1. (a) All persons or entities engaged in the business of insurance in this state shall be held accountable in a civil action for all harm legally caused by the wrongful or unreasonable denial or delay of health care or disability benefits or services.~~

~~(b) For purposes of this section, "persons or entities engaged in the business of insurance" are the following:~~

~~(1) Any and all entities regulated under the Insurance Code to the extent those entities provide insurance for life, health, medical, or disability risks.~~

~~(2) Any and all entities subject to regulation under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or any subsequent legislation that replaces those provisions.~~

~~(c) Notwithstanding any other law, health care service plans and managed care entities shall be subject to the laws of California applicable to any other business or business practice, including, but not limited to, those specified in Section 1861.03 of the Insurance Code.~~

~~(d) Damages recoverable for violation of this section include, but are not limited to, those set forth in Section 3333.~~

~~(e) Any waiver by a member, subscriber, or enrollee of the provisions of this section is contrary to public policy and shall be unenforceable and void.~~

~~(f) This section does not abrogate or limit any other theory of liability otherwise available at law.~~

~~(g) If any provision of this section or the application thereof to any person or circumstances is held to be unconstitutional or otherwise invalid or unenforceable, the remainder of the section and the application of those provisions to other persons or circumstances shall not be affected thereby.~~

~~SEC. 2.~~

SECTION 1. 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 grievances to be given to subscribers and enrollees who wish to register written 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, significant delay, termination, or 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 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 30 days, a subscriber or enrollee may submit the grievance 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 30 days before submitting a grievance to the department for review.

(B) A grievance 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 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 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 to the department. In addition, following submission of the grievance 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 who are otherwise assisting or advocating on behalf of the subscriber or enrollee. 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, *shall* 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, significantly delayed, terminated, or otherwise limited by a plan, or by one of its contracting providers, in whole or in part 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, 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 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. 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, significantly delayed, 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.

(8) On or before January 1, ~~1999~~ *2000*, the commissioner shall establish and maintain a system of

aging of grievances that are pending and unresolved for 30 days or more, that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(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 to the department. The use of mediation services shall not preclude the right to submit a grievance 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 grievances that are pending and unresolved for 30 days or more. On or before January 1, ~~1999~~ *2000*, the plan shall provide a quarterly report to the commissioner of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each 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, 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 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 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 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 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. 3.~~

SEC. 2. 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 and shall require the plan to provide enrollees and subscribers with a written statement on the disposition or pending status of the grievance within 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 a service is being denied to an enrollee who is at that time an inpatient at a hospital, that service shall be handled as an expedited plan grievance. The department shall establish through regulation a process for hospital discharge grievances.* 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 three days from receipt of the grievance.

~~SEC. 4.~~

SEC. 3. 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 30 days before pursuing a grievance through the department. However, the department may not impose this waiting period 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 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. 5.~~

SEC. 4. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The commissioner shall investigate and take enforcement action against plans regarding 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 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 a frequency 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. 6.~~

SEC. 5. 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, 2001, 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, significantly delayed, terminated, or otherwise limited by a decision of the plan, or by one of its contracting providers, in whole or in part 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, substantially based 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) (1) 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.

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

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

(4) It is the intent of the Legislature that Section 1370.4 of this code and Section 10145.3 of the Insurance Code be amended to avoid duplication of the independent medical review process.

(e) No later than January 1, 2001, 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, significantly delayed, 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, 2001, 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. However, the~~ *excluded from participation if the enrollee is not eligible for the independent medical review conducted by Medicare. The* application of this subdivision to a Medicare beneficiary shall not apply in the event, and to the extent, that application is judicially determined to be preempted by federal law.

(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, 2001, every health care service plan shall prominently display in every plan *informational brochure, in every plan* contract, on enrollee and subscriber evidence of coverage forms, on copies of plan procedures for resolving grievances, *on letters of denials issued by either the plan or its contracting physician organization,* 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, significantly

delayed, 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. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an 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, significantly delayed, terminated, or otherwise limited by the plan, or by one of its contracting providers, based in whole or in part on 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, significantly delay, terminate, or otherwise limit health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary or medically appropriate, within ~~60 days~~ *six months* of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond ~~60 days~~ *six months* if the circumstances of a case warrant the extension.

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

(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, significantly delayed, 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)~~

(2) The commissioner finds that the decision to deny, significantly delay, terminate, or otherwise limit disputed health care services was based in whole or in part on 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)~~

(3) 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)~~

(4) 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 notification to the enrollee shall include an annotated list of documents submitted and offer the opportunity for the enrollee to request copies at a reasonable charge.* 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~~ *any state of the United States*, 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~~ *When training and experience with the issue under review are equal among potential reviewing physicians, the independent medical review organization shall utilize a physician licensed in California as the reviewer. When appropriate*, 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, 2001.

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 any of the following:

(1) Generally accepted practice guidelines developed by federal agencies, nationally recognized federal research institutes, or national professional medical specialty societies.

(2) Relevant medical or scientific evidence, if any exists, regarding the clinical value of the disputed health care service.

(3) Generally accepted standards of medical practice.

(4) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(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~~ *professionals. The independent medical review*

organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify pursuant to Section 775 of the Evidence Code and in response to court orders. 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) After removing the names of the parties, including, but not limited to, the enrollee, all medical providers, the plan, and any of the plan's 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.

~~(h) The relationship of the reviewer with the state, including the reviewer's selection and remuneration by the department for purposes of conducting the review, shall not be admissible in any subsequent administrative or civil proceeding.~~

~~(i) In addition to the prohibition specified in subdivision (h), nothing about the independent review process established by this article, including, but not limited to, the analysis, recommendations, and conclusions of the review panel, shall be admissible in any subsequent proceeding.~~

(h) The independent medical review organization, individual reviewer, and the State of California shall be immune from civil liability in any action brought by any person based upon the determinations made pursuant to this article. This subdivision shall not apply to an act or omission of the independent medical review organization or individual reviewer that involves intentional misconduct or gross negligence.

(i) The reviewer may be called to testify as an expert witness for the court pursuant to Section 775 of the Evidence Code, but not as an expert witness for either party in any subsequent legal proceeding.

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~~ *shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any 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~~

(b) 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, 2002, 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. 7.~~

SEC. 6. 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, 2001, there is established in the department the Independent Medical Review System pursuant to the Patient's Independent Medical Review Act of 1998.

~~SEC. 8.~~

SEC. 7. 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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