

Introduced by Senator Speier

January 28, 1999

An act to amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, to amend, repeal, and add Section 1370.4 to, and to add and repeal Article 12 (commencing with Section 1399.80) ~~to~~ of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend, repeal, and add Section 10145.3 of, 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 insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 254, as amended, Speier. Health insurance.

~~Under existing law, the Knox-Keene Health Care Service Plan Act of 1975,~~

Existing law provides for regulation of health care service plans—~~are regulated~~ by the Department of Corporations and for regulation of disability insurers by the Department of Insurance.

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.

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.

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 repeal ~~this provision~~ *these provisions* on January 1, 2001, and thereafter instead require every health care service plan *and disability insurer that covers hospital, surgical, or medical benefits* to provide an enrollee *or insured* 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 insurer*, or by one of its contracting providers.

This bill would establish, beginning January 1, 2001, the Independent Review System in the Department of Corporations *and the Department of Insurance*, whereby enrollee *or insured* grievances involving a disputed health care service or other adverse decision may be resolved by independent review organizations. The bill would set forth the duties and responsibilities of the ~~department~~ *departments*, health care service plans, *disability insurers*, and enrollees *and insureds* with respect to the system. It would provide that Medi-Cal and Medicare beneficiaries shall not be excluded from the system, to the extent that their participation is not preempted by federal law.

The bill would require the ~~commissioner~~ *Commissioner of Corporations and the Insurance Commissioner* to contract with a private, nonprofit accrediting organization to accredit the independent review organizations, and would further require the adoption of related regulations.

This bill would require ~~the commissioner~~ *both commissioners*, on or before July 1, 2000, to allocate grant



funding for an independent health care ombudsprogram. It would require the ~~department~~ *departments* to contract with an independent expert ~~entity~~ *entities* to undertake an ~~evaluation~~ *evaluations* of the independent review ~~system~~ *systems* and the independent health care ~~ombudsprogram~~ *ombudsprograms*. The bill would require the ~~evaluator~~ *evaluators* to provide ~~its evaluation~~ *their evaluation* to the ~~department~~ *departments* on or before January 1, 2003, a copy of which ~~shall~~ *would be required to* be made available to the public.

The provisions of the bill relating to independent review would remain in effect only until January 1, 2004, and thereafter currently existing provisions limited to coverage decisions regarding experimental or investigational therapies would again become operative.

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:

1 SECTION 1. The Legislature finds and declares the
 2 following:
 3 (a) The California Managed Health Care
 4 Improvement Task Force has recommended that
 5 California enact an independent system of external
 6 review of health plan decisions. A similar
 7 recommendation was issued by the President’s Advisory
 8 Commission on Consumer Protection and Quality in the
 9 Health Care Industry. Proponents of independent review



1 maintain that this new program will enhance consumer
2 confidence in health plan decisionmaking.

3 (b) More than 15 states have enacted legislation
4 establishing independent review of health care decisions,
5 and in California, one health plan has voluntarily
6 implemented a process for independent review of a
7 broad range of unresolved patient grievances. In
8 addition, Medicare has a system for independent review
9 of unresolved patient grievances. A great diversity of
10 policies and procedures has been applied to these various
11 state and federal independent review systems.

12 (c) Recent studies indicate only modest patient
13 participation in state independent review programs,
14 because many consumers are unaware of their right to
15 access independent review. In addition, the studies
16 indicate that many consumers in need of independent
17 review often are ill or disabled and do not have the ability
18 to pursue an appeal, particularly if the rules are complex
19 and they are not provided with advice and assistance to
20 participate.

21 (d) The Legislature has convened efforts to reach a
22 consensus on legislation to establish an independent
23 review system within California. However, a consensus
24 has not been achieved. In general, consumer,
25 low-income, and senior groups are concerned about
26 impediments to patient access to and participation in an
27 independent review system. They are also concerned
28 that expert reviewers may be biased in favor of health
29 plans. Health plans, insurers, medical groups, and
30 physicians are concerned about the potential for frivolous
31 appeals burdening an independent review system. They
32 are also concerned about the potential for excessive
33 system costs being imposed.

34 (e) It would be in the state's best interest to proceed
35 cautiously with a test of an independent review system
36 that will sunset, with a report back to the Legislature a
37 year prior to the sunset date to help determine whether
38 to extend, modify, or terminate the program. The
39 Legislature also finds that, in light of experience in other
40 states that have implemented independent review



1 systems, which shows only modest success in helping
2 patients, the test in California should err on the side of
3 promoting patient access, participation, and assistance.

4 SEC. 2. This act shall be known as the Patient's
5 Independent Review Act of 1999.

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

8 1368. (a) Every plan shall do all of the following:

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

16 (2) Inform its subscribers and enrollees upon
17 enrollment in the plan and annually thereafter of the
18 procedure for processing and resolving grievances. The
19 information shall include the location and telephone
20 number where grievances may be submitted.

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

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

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

37 (b) (1) (A) After either completing the grievance
38 process described in subdivision (a), or participating in
39 the process for at least 30 days, a subscriber or enrollee
40 may submit the grievance to the department for review.



1 In any case determined by the department to be a case
2 involving an imminent and serious threat to the health of
3 the patient, including, but not limited to, severe pain, the
4 potential loss of life, limb, or major bodily function, or in
5 any other case where the department determines that an
6 earlier review is warranted, a subscriber or enrollee shall
7 not be required to complete the grievance process or
8 participate in the process for at least 30 days before
9 submitting a grievance to the department for review.

10 (B) A grievance may be submitted to the department
11 for review and resolution prior to any arbitration.

12 (C) Notwithstanding subparagraphs (A) and (B), the
13 department may refer any grievance issue that does not
14 pertain to compliance with this chapter to the State
15 Department of Health Services, the Department of
16 Aging, the federal Health Care Financing
17 Administration, or any other appropriate governmental
18 entity for investigation and resolution.

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

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



1 or who are otherwise assisting or advocating on behalf of
2 the subscriber or enrollee. If, after reviewing the record,
3 the department concludes that the grievance is eligible
4 for review under the independent review system
5 established pursuant to Article 12 (commencing with
6 Section 1399.80), the department shall immediately
7 notify the subscriber or enrollee, or agent, of that option
8 and shall, if requested orally or in writing, assist the
9 subscriber or enrollee to apply to participate in the
10 independent medical review system.

11 (4) If, after reviewing the record of a grievance, the
12 department concludes that the grievance was clearly
13 eligible for review under the independent review system
14 established pursuant to Article 12 (commencing with
15 Section 1399.80), but this was not communicated to the
16 enrollee in writing along with a notice of the enrollee's
17 potential right to participate in the independent review
18 system, as required by this chapter, the commissioner
19 shall impose a penalty.

20 (5) The department shall send a written notice of the
21 final disposition of the grievance, and the reasons
22 therefor, to the subscriber or enrollee, the agent, to any
23 provider that has joined with or is otherwise assisting the
24 subscriber or enrollee, and to the plan, within 30 calendar
25 days of receipt of the request for review unless the
26 commissioner, in his or her discretion, determines that
27 additional time is reasonably necessary to fully and fairly
28 evaluate the relevant grievance. In any department
29 response to an enrollee grievance not subject to the
30 independent review system established pursuant to
31 Article 12 (commencing with Section 1399.80), the
32 department's written notice shall include, at a minimum,
33 a brief description of the purpose of the department's
34 review, the department's conclusion relating to the
35 grievance along with a summary of the findings
36 supporting the department's conclusion, the reasons why
37 the department concluded that the plan is or is not in
38 compliance with this chapter, and information about
39 corrective and enforcement actions taken by the
40 department.



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

9 (7) On or before January 1, 2000, the commissioner
10 shall establish and maintain a system of aging of
11 grievances that are pending and unresolved for 30 days
12 or more, that shall include a brief explanation of the
13 reasons each grievance is pending and unresolved for 30
14 days or more.

15 (8) A subscriber or enrollee, or the agent acting on
16 behalf of a subscriber or enrollee, may also request
17 voluntary mediation with the plan prior to exercising the
18 right to submit a grievance to the department. The use of
19 mediation services shall not preclude the right to submit
20 a grievance to the department upon completion of
21 mediation. In order to initiate mediation, the subscriber
22 or enrollee, or the agent acting on behalf of the subscriber
23 or enrollee, and the plan shall voluntarily agree to
24 mediation. Expenses for mediation shall be borne equally
25 by both sides. The department shall have no
26 administrative or enforcement responsibilities in
27 connection with the voluntary mediation process
28 authorized by this paragraph.

29 (c) The plan's grievance system shall include a system
30 of aging of grievances that are pending and unresolved
31 for 30 days or more. On or before January 1, 1997, the plan
32 shall provide a quarterly report to the commissioner of
33 grievances pending and unresolved for 30 or more days
34 with separate categories of grievances for Medicare
35 enrollees and Medi-Cal enrollees. The plan shall include
36 with the report a brief explanation of the reasons each
37 grievance is pending and unresolved for 30 days or more.
38 The plan may include the following statement in the
39 quarterly report that is made available to the public by



1 the commissioner:
2

3 “Under Medicare and Medi-Cal law, Medicare
4 enrollees and Medi-Cal enrollees each have separate
5 avenues of appeal that are not available to other
6 enrollees. Therefore, grievances pending and
7 unresolved may reflect enrollees pursuing their
8 Medicare or Medi-Cal appeal rights.”
9

10 If requested by a plan, the commissioner shall include this
11 statement in a written report made available to the public
12 and prepared by the commissioner that describes or
13 compares grievances that are pending and unresolved
14 with the plan for 30 days or more. Additionally, the
15 commissioner shall, if requested by a plan, append to that
16 written report a brief explanation, provided in writing by
17 the plan, of the reasons why grievances described in that
18 written report are pending and unresolved for 30 days or
19 more. The commissioner shall not be required to include
20 a statement or append a brief explanation to a written
21 report that the commissioner is required to prepare
22 under this chapter, including Sections 1380 and 1397.5.

23 (d) Subject to subparagraph (C) of paragraph (1) of
24 subdivision (b), the grievance or resolution procedures
25 authorized by this section shall be in addition to any other
26 procedures that may be available to any person, and
27 failure to pursue, exhaust, or engage in the procedures
28 described in this section shall not preclude the use of any
29 other remedy provided by law.

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

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

3 1368.01. (a) The grievance system shall require the
4 plan to resolve grievances within 30 days and shall require
5 the plan to provide enrollees and subscribers with a
6 written statement on the disposition or pending status of
7 the grievance within 15 days of the plan's receipt of the
8 grievance.

9 (b) The grievance system shall include a requirement
10 ~~for expedited plan review of grievances for cases for the~~
11 ~~plan to immediately refer the enrollee or subscriber to~~
12 ~~the independent review system established pursuant to~~
13 ~~Article 12 (commencing with Section 1399.80) in cases~~
14 involving an imminent and serious threat to the health of
15 the ~~patient~~ enrollee, including, but not limited to, severe
16 pain, potential loss of life, limb, or major bodily function,
17 ~~or the immediate or serious deterioration of the health of~~
18 ~~the enrollee.~~ When the plan has notice of a case requiring
19 ~~expedited review~~ immediate referral to the independent
20 review system pursuant to Article 12 (commencing with
21 Section 1399.80), the grievance system shall require the
22 plan to immediately inform enrollees and subscribers in
23 writing of their right to ~~notify the department of the~~
24 ~~grievance.~~ The grievance system shall also require the
25 ~~plan to provide enrollees, subscribers, and the~~
26 ~~department with a written statement on the disposition~~
27 ~~or pending status of the grievance no later than three~~
28 ~~days from receipt of the grievance.~~ *apply for an*
29 *independent review, and shall require the plan to*
30 *provide an application for this purpose.*

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

33 1368.03. (a) The department may require enrollees
34 and subscribers to participate in a plan's grievance
35 process for up to 30 days before pursuing a grievance
36 through the department. However, the department may
37 not impose this waiting period for ~~expedited review~~ cases
38 covered by subdivision (b) of Section 1368.01 or in any
39 other case where the department determines that an
40 earlier review is warranted.



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

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

10 1368.04. (a) The commissioner shall investigate and
11 take enforcement action against plans regarding
12 grievances reviewed and found by the department to
13 involve plan noncompliance with the requirements of
14 this chapter, including grievances that have been
15 reviewed pursuant to the independent review system
16 established pursuant to Article 12 (commencing with
17 Section 1399.80). Where harm to an enrollee has occurred
18 as a result of plan noncompliance, the commissioner shall
19 impose penalties. The commissioner shall periodically
20 evaluate grievances to determine if any audit,
21 investigative, or enforcement actions should be
22 undertaken by the department.

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

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

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

37 (c) The administrative penalties available to the
38 commissioner pursuant to this section are not exclusive,
39 and may be sought and employed in any combination
40 with civil, criminal, and other administrative remedies



1 deemed warranted by the commissioner to enforce this
2 chapter.

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

6 SEC. 7. Section 1370.4 of the Health and Safety Code
7 is amended to read:

8 1370.4. (a) Every health care service plan shall
9 provide an external, independent review process to
10 examine the plan's coverage decisions regarding
11 experimental or investigational therapies for individual
12 enrollees who meet all of the following criteria:

13 (1) The enrollee has a terminal condition that,
14 according to the enrollee's physician's current diagnosis,
15 has a high probability of causing death within two years
16 from the date of the request for an independent review;
17 and

18 (2) The enrollee's physician certifies that the enrollee
19 has a condition, as defined in paragraph (1), for which
20 standard therapies have not been effective in improving
21 the condition of the enrollee, or for which standard
22 therapies would not be medically appropriate for the
23 enrollee, or for which there is no more beneficial standard
24 therapy covered by the plan than the therapy proposed
25 pursuant to paragraph (3); and

26 (3) Either (A) the enrollee's physician, who is under
27 contract with or employed by the plan, has
28 recommended a drug, device, procedure or other
29 therapy that the physician certifies in writing is likely to
30 be more beneficial to the enrollee than any available
31 standard therapies, or (B) the enrollee, or the enrollee's
32 physician who is a licensed, board-certified or
33 board-eligible physician qualified to practice in the area
34 of practice appropriate to treat the enrollee's condition,
35 has requested a therapy that, based on two documents
36 from the medical and scientific evidence, as defined in
37 subdivision (d), is likely to be more beneficial for the
38 enrollee than any available standard therapy. The
39 physician certification pursuant to this subdivision shall
40 include a statement of the evidence relied upon by the



1 physician in certifying his or her recommendation.
2 Nothing in this subdivision shall be construed to require
3 the plan to pay for the services of a nonparticipating
4 physician provided pursuant to this subdivision, that are
5 not otherwise covered pursuant to the plan contract; and

6 (4) The enrollee has been denied coverage by the plan
7 for a drug, device, procedure or other therapy
8 recommended or requested pursuant to paragraph (3);
9 and

10 (5) The specific drug, device, procedure or other
11 therapy recommended pursuant to paragraph (3) would
12 be a covered service, except for the plan's determination
13 that the therapy is experimental or investigational; and

14 (6) This section shall not apply to any Medi-Cal
15 beneficiary enrolled in a health care service plan under
16 the plan's contract with the Medi-Cal program.

17 (b) The plan's external, independent review shall
18 meet the following criteria:

19 (1) The plan shall offer all enrollees who meet the
20 criteria in subdivision (a) the opportunity to have the
21 requested therapy reviewed under the external,
22 independent review process. The plan shall notify
23 eligible enrollees in writing of the opportunity to request
24 the external independent review within five business
25 days of the decision to deny coverage.

26 (2) The plan shall contract with one or more impartial,
27 independent entities that are accredited pursuant to
28 subdivision (c). The entity shall arrange for review of the
29 coverage decision by selecting an independent panel of
30 at least three physicians or other providers who are
31 experts in the treatment of the enrollee's medical
32 condition and knowledgeable about the recommended
33 therapy. If the entity is an academic medical center
34 accredited in accordance with subdivision (e), the
35 independent panel may include experts affiliated with or
36 employed by the entity. A panel of two experts may be
37 arranged at the plan's request, provided the enrollee
38 consents in writing. The independent entity may arrange
39 for a panel of one expert only if the independent entity
40 certifies in writing that there is only one expert qualified



1 and able to review the recommended therapy. Neither
2 the plan nor the enrollee shall choose or control the
3 choice of the physician or other provider experts.

4 (3) Neither the expert, nor the independent entity,
5 nor any officer, director, or management employee of the
6 independent entity shall have any material professional,
7 familial, or financial affiliation, as defined in paragraph
8 (4), with any of the following:

9 (A) The plan.

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

12 (C) The physician, the physician's medical group, or
13 the independent practice association (IPA) proposing
14 the therapy.

15 (D) The institution at which the therapy would be
16 provided.

17 (E) The development or manufacture of the principal
18 drug, device, procedure, or other therapy proposed for
19 the enrollee whose treatment is under review.

20 (4) For purposes of this section, the following terms
21 shall have the following meanings:

22 (A) "Material familial affiliation" shall mean any
23 relationship as a spouse, child, parent, sibling, spouse's
24 parent, or child's spouse.

25 (B) "Material professional affiliation" shall mean any
26 physician-patient relationship, any partnership or
27 employment relationship, a shareholder or similar
28 ownership interest in a professional corporation, or any
29 independent contractor arrangement that constitutes a
30 material financial affiliation with any expert or any officer
31 or director of the independent entity. The term "material
32 professional affiliation" shall not include affiliations
33 which are limited to staff privileges at a health facility.

34 (C) "Material financial affiliation" shall mean any
35 financial interest of more than 5 percent of total annual
36 revenue or total annual income of an entity or individual
37 to which this subdivision applies. "Material financial
38 affiliation" shall not include payment by the plan to the
39 independent entity for the services required by this
40 section, nor shall "material financial affiliation" include



1 an expert's participation as a contracting plan provider
2 where the expert is affiliated with an academic medical
3 center or a National Cancer Institute-designated clinical
4 cancer research center.

5 (5) The enrollee shall not be required to pay for the
6 external, independent review. The costs of the review
7 shall be borne by the plan.

8 (6) The plan shall provide to the independent entity
9 arranging for the panel of experts a copy of the following
10 documents within five business days of the plan's receipt
11 of a request by an enrollee or enrollee's physician for an
12 external, independent review:

13 (A) The medical records relevant to the patient's
14 condition for which the proposed therapy has been
15 recommended, provided the documents are within the
16 plan's possession. Any medical records provided to the
17 plan after the initial documents are provided to the
18 independent entity shall be forwarded by the plan to the
19 independent entity within five business days. The
20 confidentiality of the medical records shall be maintained
21 pursuant to Section 56.10 of the Civil Code.

22 (B) A copy of any relevant documents used by the plan
23 in determining whether the proposed therapy should be
24 covered, and any statement by the plan explaining the
25 reasons for the plan's decision not to provide coverage for
26 the proposed therapy. The plan shall provide, upon
27 request, a copy of the documents required by this
28 paragraph, except for the documents described in
29 subparagraphs (A) and (C), to the enrollee and the
30 enrollee's physician.

31 (C) Any information submitted by the enrollee or the
32 enrollee's physician to the plan in support of the
33 enrollee's request for coverage of the proposed drug,
34 device, procedure, or other therapy.

35 (7) The experts on the panel shall render their
36 analyses and recommendations within 30 days of the
37 receipt of the enrollee's request for review. If the
38 enrollee's physician determines that the proposed
39 therapy would be significantly less effective if not
40 promptly initiated, the analyses and recommendations of



1 the experts on the panel shall be rendered within seven
2 days of the request for expedited review. At the request
3 of the expert, the deadline shall be extended by up to
4 three days for a delay in providing the documents
5 required by paragraph (6) of subdivision (b).

6 (8) Each expert's analysis and recommendation shall
7 be in written form and ~~states~~ *state* the reasons the
8 requested therapy is or is not likely to be more beneficial
9 for the enrollee than any available standard therapy, and
10 the reasons that the expert recommends that the therapy
11 should or should not be provided by the plan, citing the
12 enrollee's specific medical condition, the relevant
13 documents provided pursuant to paragraph (6), and the
14 relevant medical and scientific evidence, including, but
15 not limited to, the medical and scientific evidence as
16 defined in subdivision (d), to support the expert's
17 recommendation.

18 (9) The independent entity shall provide the plan and
19 the enrollee's physician with the experts' analyses and
20 recommendations, a description of the qualifications of
21 each expert, and any other information that it chooses to
22 provide to the plan and the enrollee's physician,
23 including, but not limited to, the names of the expert
24 reviewers. The independent entity shall not be required
25 to disclose the names of the expert reviewers to the plan
26 or the enrollee's physician, except pursuant to a properly
27 made request for discovery. If the independent entity
28 chooses to disclose the names of the experts on the panel
29 to the plan, the independent entity must also disclose the
30 names of the experts to the enrollee's physician. The
31 enrollee's physician may provide these documents and
32 information to the enrollee.

33 (10) If the majority of experts on the panel
34 recommend providing the proposed therapy, pursuant to
35 paragraph (8), the recommendation shall be binding on
36 the plan. If the recommendations of the experts on the
37 panel are evenly divided as to whether the therapy
38 should be provided, then the panel's decision shall be
39 deemed to be in favor of coverage. If less than a majority
40 of the experts on the panel recommend providing the



1 therapy, the plan is not required to provide the therapy.
2 Coverage for the services required under this section
3 shall be provided subject to the terms and conditions
4 generally applicable to other benefits under the plan
5 contract.

6 (11) The plan shall have written policies describing
7 the external, independent review process. The plan shall
8 disclose the availability of the external, independent
9 review process and how enrollees may access the review
10 process in the plan's evidence of coverage and disclosure
11 forms.

12 (c) The Commissioner of Corporations, in
13 consultation with the Insurance Commissioner, shall, by
14 January 1, 1998, contract with a private, nonprofit
15 accrediting organization to accredit the independent
16 review entities specified in subdivision (b). The
17 accrediting organization shall have the power to grant
18 and revoke accreditation, and shall develop, apply, and
19 enforce accreditation standards, including those required
20 in subdivision (e), that ensure the independence of the
21 independent review entity, the confidentiality of the
22 medical records, and the qualifications and
23 independence of the health care professionals providing
24 the analyses and recommendations requested of them.
25 The accrediting organization shall demonstrate the
26 ability to objectively evaluate the performance of
27 independent entities and shall demonstrate that it has no
28 conflict of interest, including any material professional,
29 familial, or financial affiliation as defined in paragraph (4)
30 of subdivision (b) with any independent entity or plan,
31 in accrediting entities for the purpose of reviewing
32 medical treatments, treatment recommendations, and
33 coverage decisions by health care service plans.

34 (d) For the purposes of paragraph (3) of subdivision
35 (a), "medical and scientific evidence" means the
36 following sources:

37 (1) Peer-reviewed scientific studies published in or
38 accepted for publication by medical journals that meet
39 nationally recognized requirements for scientific
40 manuscripts and that submit most of their published



1 articles for review by experts who are not part of the
2 editorial staff.

3 (2) Peer-reviewed literature, biomedical compendia,
4 and other medical literature that meet the criteria of the
5 National Institute of Health's National Library of
6 Medicine for indexing in Index Medicus, Excerpta
7 Medicus (EMBASE), Medline, and MEDLARS data base
8 Health Services Technology Assessment Research
9 (HSTAR).

10 (3) Medical journals recognized by the Secretary of
11 Health and Human Services, under Section 1861(t)(2) of
12 the Social Security Act.

13 (4) The following standard reference compendia: The
14 American Hospital Formulary Service-Drug
15 Information, the American Medical Association Drug
16 Evaluation, the American Dental Association Accepted
17 Dental Therapeutics, and the United States
18 Pharmacopoeia-Drug Information.

19 (5) Findings, studies, or research conducted by or
20 under the auspices of federal government agencies and
21 nationally recognized federal research institutes
22 including the Federal Agency for Health Care Policy and
23 Research, National Institutes of Health, National Cancer
24 Institute, National Academy of Sciences, Health Care
25 Financing Administration, Congressional Office of
26 Technology Assessment, and any national board
27 recognized by the National Institutes of Health for the
28 purpose of evaluating the medical value of health
29 services.

30 (6) Peer-reviewed abstracts accepted for presentation
31 at major medical association meetings.

32 (e) In order to receive accreditation for the purposes
33 of this section, an independent entity shall meet all of the
34 following requirements:

35 (1) The independent entity must be an organization
36 that has as its primary function to provide expert reviews
37 and related services and receives a majority of its
38 revenues from these services, except that an academic
39 medical center may qualify as an independent entity for
40 purposes of this act without having as its primary function



1 providing expert reviews and related services and
2 without receiving a majority of its revenues from these
3 services. An independent entity may not be a subsidiary
4 of, nor in any way owned or controlled by, a health plan,
5 a trade association of health plans, or a professional
6 association of health care providers.

7 (2) The independent entity must submit to the
8 accrediting organization and to the Department of
9 Corporations the following information upon initial
10 application for accreditation and annually thereafter
11 upon any change to any of the following information:

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

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

17 (C) The names of all corporations and organizations
18 that the independent entity controls or is affiliated with,
19 and the nature and extent of any ownership or control,
20 including the affiliated organization's type of business.

21 (D) The names and biographical sketches of all
22 directors, officers, and executives of the independent
23 entity, as well as a statement regarding any relationships
24 the directors, officers, and executives may have with any
25 health care service plan, disability insurer, managed care
26 organization, provider group or board or committee.

27 (E) The percentage of revenue the independent
28 entity receives from expert reviews.

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

33 (G) A description of the system the independent
34 entity uses to identify and recruit expert reviewers, the
35 number of expert reviewers credentialed and the types
36 of cases the experts are credentialed to review.

37 (H) Documentation regarding the medical
38 institutions from which the independent entity has
39 selected the experts during the previous 12 months, and



1 the percentage of opinions obtained from each
2 institution.

3 (I) A description of the areas of expertise available
4 from expert reviewers retained by the independent
5 entity.

6 (J) A description of how the independent entity
7 ensures compliance with the conflict-of-interest
8 provisions of this section.

9 (3) The independent entity must demonstrate that it
10 has a quality assurance mechanism in place that does the
11 following:

12 (A) Ensures that the experts retained are
13 appropriately credentialed and privileged.

14 (B) Ensures that the reviews provided by the experts
15 are timely, clear and credible, and that reviews are
16 monitored for quality on an ongoing basis.

17 (C) Ensures that the method of selecting expert
18 reviewers for individual cases achieves a fair and
19 impartial panel of experts who are qualified to render
20 recommendations regarding the clinical conditions and
21 therapies in question.

22 (D) Ensures the confidentiality of medical records
23 and the review materials, consistent with the
24 requirements of this section.

25 (E) Ensures the independence of the experts retained
26 to perform the reviews through conflict-of-interest
27 policies and prohibitions and adequate screening for
28 conflicts of interest, pursuant to paragraph (3) of
29 subdivision (b).

30 (f) (1) The Department of Corporations shall receive
31 the information filed by independent entities pursuant to
32 paragraph (2) of subdivision (e) for the purpose of
33 creating a file of public records. The Department of
34 Corporations shall not be responsible for accrediting
35 independent entities.

36 (2) The accrediting organization shall provide, upon
37 the request of any interested person, a copy of all
38 nonproprietary information filed with it by the
39 independent entity under paragraph (2) of subdivision
40 (e). The accrediting organization may charge a



1 reasonable fee to the interested person for photocopying
2 the requested information.

3 (g) The independent review process established by
4 this section shall be required on and after July 1, 1998.

5 (h) This section shall remain in effect only until
6 January 1, 2001, and as of that date is repealed, unless a
7 later enacted statute, that becomes effective on or before
8 January 1, 2001, deletes or extends that date.

9 SEC. 8. Section 1370.4 is added to the Health and
10 Safety Code, to read:

11 1370.4. (a) Every health care service plan shall
12 provide an external, independent review process to
13 examine the plan's coverage decisions regarding
14 experimental or investigational therapies for individual
15 enrollees who meet all of the following criteria:

16 (1) The enrollee has a terminal condition that,
17 according to the enrollee's physician's current diagnosis,
18 has a high probability of causing death within two years
19 from the date of the request for an independent review;
20 and

21 (2) The enrollee's physician certifies that the enrollee
22 has a condition, as defined in paragraph (1), for which
23 standard therapies have not been effective in improving
24 the condition of the enrollee, or for which standard
25 therapies would not be medically appropriate for the
26 enrollee, or for which there is no more beneficial standard
27 therapy covered by the plan than the therapy proposed
28 pursuant to paragraph (3); and

29 (3) Either (A) the enrollee's physician, who is under
30 contract with or employed by the plan, has
31 recommended a drug, device, procedure or other
32 therapy that the physician certifies in writing is likely to
33 be more beneficial to the enrollee than any available
34 standard therapies, or (B) the enrollee, or the enrollee's
35 physician who is a licensed, board-certified or
36 board-eligible physician qualified to practice in the area
37 of practice appropriate to treat the enrollee's condition,
38 has requested a therapy that, based on two documents
39 from the medical and scientific evidence, as defined in
40 subdivision (d), is likely to be more beneficial for the



1 enrollee than any available standard therapy. The
2 physician certification pursuant to this subdivision shall
3 include a statement of the evidence relied upon by the
4 physician in certifying his or her recommendation.
5 Nothing in this subdivision shall be construed to require
6 the plan to pay for the services of a nonparticipating
7 physician provided pursuant to this subdivision, that are
8 not otherwise covered pursuant to the plan contract; and

9 (4) The enrollee has been denied coverage by the plan
10 for a drug, device, procedure or other therapy
11 recommended or requested pursuant to paragraph (3);
12 and

13 (5) The specific drug, device, procedure or other
14 therapy recommended pursuant to paragraph (3) would
15 be a covered service, except for the plan's determination
16 that the therapy is experimental or investigational; and

17 (6) This section shall not apply to any Medi-Cal
18 beneficiary enrolled in a health care service plan under
19 the plan's contract with the Medi-Cal program.

20 (b) The plan's external, independent review shall
21 meet the following criteria:

22 (1) The plan shall offer all enrollees who meet the
23 criteria in subdivision (a) the opportunity to have the
24 requested therapy reviewed under the external,
25 independent review process. The plan shall notify
26 eligible enrollees in writing of the opportunity to request
27 the external independent review within five business
28 days of the decision to deny coverage.

29 (2) The plan shall contract with one or more impartial,
30 independent entities that are accredited pursuant to
31 subdivision (c). The entity shall arrange for review of the
32 coverage decision by selecting an independent panel of
33 at least three physicians or other providers who are
34 experts in the treatment of the enrollee's medical
35 condition and knowledgeable about the recommended
36 therapy. If the entity is an academic medical center
37 accredited in accordance with subdivision (e), the
38 independent panel may include experts affiliated with or
39 employed by the entity. A panel of two experts may be
40 arranged at the plan's request, provided the enrollee



1 consents in writing. The independent entity may arrange
2 for a panel of one expert only if the independent entity
3 certifies in writing that there is only one expert qualified
4 and able to review the recommended therapy. Neither
5 the plan nor the enrollee shall choose or control the
6 choice of the physician or other provider experts.

7 (3) Neither the expert, nor the independent entity,
8 nor any officer, director, or management employee of the
9 independent entity shall have any material professional,
10 familial, or financial affiliation, as defined in paragraph
11 (4), with any of the following:

12 (A) The plan.

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

15 (C) The physician, the physician's medical group, or
16 the independent practice association (IPA) proposing
17 the therapy.

18 (D) The institution at which the therapy would be
19 provided.

20 (E) The development or manufacture of the principal
21 drug, device, procedure, or other therapy proposed for
22 the enrollee whose treatment is under review.

23 (4) For purposes of this section, the following terms
24 shall have the following meanings:

25 (A) "Material familial affiliation" shall mean any
26 relationship as a spouse, child, parent, sibling, spouse's
27 parent, or child's spouse.

28 (B) "Material professional affiliation" shall mean any
29 physician-patient relationship, any partnership or
30 employment relationship, a shareholder or similar
31 ownership interest in a professional corporation, or any
32 independent contractor arrangement that constitutes a
33 material financial affiliation with any expert or any officer
34 or director of the independent entity. The term "material
35 professional affiliation" shall not include affiliations
36 which are limited to staff privileges at a health facility.

37 (C) "Material financial affiliation" shall mean any
38 financial interest of more than 5 percent of total annual
39 revenue or total annual income of an entity or individual
40 to which this subdivision applies. "Material financial



1 affiliation” shall not include payment by the plan to the
2 independent entity for the services required by this
3 section, nor shall “material financial affiliation” include
4 an expert’s participation as a contracting plan provider
5 where the expert is affiliated with an academic medical
6 center or a National Cancer Institute-designated clinical
7 cancer research center.

8 (5) The enrollee shall not be required to pay for the
9 external, independent review. The costs of the review
10 shall be borne by the plan.

11 (6) The plan shall provide to the independent entity
12 arranging for the panel of experts a copy of the following
13 documents within five business days of the plan’s receipt
14 of a request by an enrollee or enrollee’s physician for an
15 external, independent review:

16 (A) The medical records relevant to the patient’s
17 condition for which the proposed therapy has been
18 recommended, provided the documents are within the
19 plan’s possession. Any medical records provided to the
20 plan after the initial documents are provided to the
21 independent entity shall be forwarded by the plan to the
22 independent entity within five business days. The
23 confidentiality of the medical records shall be maintained
24 pursuant to Section 56.10 of the Civil Code.

25 (B) A copy of any relevant documents used by the plan
26 in determining whether the proposed therapy should be
27 covered, and any statement by the plan explaining the
28 reasons for the plan’s decision not to provide coverage for
29 the proposed therapy. The plan shall provide, upon
30 request, a copy of the documents required by this
31 paragraph, except for the documents described in
32 subparagraphs (A) and (C), to the enrollee and the
33 enrollee’s physician.

34 (C) Any information submitted by the enrollee or the
35 enrollee’s physician to the plan in support of the
36 enrollee’s request for coverage of the proposed drug,
37 device, procedure, or other therapy.

38 (7) The experts on the panel shall render their
39 analyses and recommendations within 30 days of the
40 receipt of the enrollee’s request for review. If the



1 enrollee’s physician determines that the proposed
2 therapy would be significantly less effective if not
3 promptly initiated, the analyses and recommendations of
4 the experts on the panel shall be rendered within seven
5 days of the request for expedited review. At the request
6 of the expert, the deadline shall be extended by up to
7 three days for a delay in providing the documents
8 required by paragraph (6) of subdivision (b).

9 (8) Each expert’s analysis and recommendation shall
10 be in written form and states the reasons the requested
11 therapy is or is not likely to be more beneficial for the
12 enrollee than any available standard therapy, and the
13 reasons that the expert recommends that the therapy
14 should or should not be provided by the plan, citing the
15 enrollee’s specific medical condition, the relevant
16 documents provided pursuant to paragraph (6), and the
17 relevant medical and scientific evidence, including, but
18 not limited to, the medical and scientific evidence as
19 defined in subdivision (d), to support the expert’s
20 recommendation.

21 (9) The independent entity shall provide the plan and
22 the enrollee’s physician with the experts’ analyses and
23 recommendations, a description of the qualifications of
24 each expert, and any other information that it chooses to
25 provide to the plan and the enrollee’s physician,
26 including, but not limited to, the names of the expert
27 reviewers. The independent entity shall not be required
28 to disclose the names of the expert reviewers to the plan
29 or the enrollee’s physician, except pursuant to a properly
30 made request for discovery. If the independent entity
31 chooses to disclose the names of the experts on the panel
32 to the plan, the independent entity must also disclose the
33 names of the experts to the enrollee’s physician. The
34 enrollee’s physician may provide these documents and
35 information to the enrollee.

36 (10) If the majority of experts on the panel
37 recommend providing the proposed therapy, pursuant to
38 paragraph (8), the recommendation shall be binding on
39 the plan. If the recommendations of the experts on the
40 panel are evenly divided as to whether the therapy



1 should be provided, then the panel’s decision shall be
2 deemed to be in favor of coverage. If less than a majority
3 of the experts on the panel recommend providing the
4 therapy, the plan is not required to provide the therapy.
5 Coverage for the services required under this section
6 shall be provided subject to the terms and conditions
7 generally applicable to other benefits under the plan
8 contract.

9 (11) The plan shall have written policies describing
10 the external, independent review process. The plan shall
11 disclose the availability of the external, independent
12 review process and how enrollees may access the review
13 process in the plan’s evidence of coverage and disclosure
14 forms.

15 (c) The Commissioner of Corporations, in
16 consultation with the Insurance Commissioner, shall
17 contract with a private, nonprofit accrediting
18 organization to accredit the independent review entities
19 specified in subdivision (b). The accrediting organization
20 shall have the power to grant and revoke accreditation,
21 and shall develop, apply, and enforce accreditation
22 standards, including those required in subdivision (e),
23 that ensure the independence of the independent review
24 entity, the confidentiality of the medical records, and the
25 qualifications and independence of the health care
26 professionals providing the analyses and
27 recommendations requested of them. The accrediting
28 organization shall demonstrate the ability to objectively
29 evaluate the performance of independent entities and
30 shall demonstrate that it has no conflict of interest,
31 including any material professional, familial, or financial
32 affiliation as defined in paragraph (4) of subdivision (b)
33 with any independent entity or plan, in accrediting
34 entities for the purpose of reviewing medical treatments,
35 treatment recommendations, and coverage decisions by
36 health care service plans.

37 (d) For the purposes of paragraph (3) of subdivision
38 (a), “medical and scientific evidence” means the
39 following sources:



1 (1) Peer-reviewed scientific studies published in or
2 accepted for publication by medical journals that meet
3 nationally recognized requirements for scientific
4 manuscripts and that submit most of their published
5 articles for review by experts who are not part of the
6 editorial staff.

7 (2) Peer-reviewed literature, biomedical compendia,
8 and other medical literature that meet the criteria of the
9 National Institute of Health's National Library of
10 Medicine for indexing in Index Medicus, Excerpta
11 Medicus (EMBASE), Medline, and MEDLARS data base
12 Health Services Technology Assessment Research
13 (HSTAR).

14 (3) Medical journals recognized by the Secretary of
15 Health and Human Services, under Section 1861(t)(2) of
16 the Social Security Act.

17 (4) The following standard reference compendia: The
18 American Hospital Formulary Service-Drug
19 Information, the American Medical Association Drug
20 Evaluation, the American Dental Association Accepted
21 Dental Therapeutics, and the United States
22 Pharmacopoeia-Drug Information.

23 (5) Findings, studies, or research conducted by or
24 under the auspices of federal government agencies and
25 nationally recognized federal research institutes
26 including the Federal Agency for Health Care Policy and
27 Research, National Institutes of Health, National Cancer
28 Institute, National Academy of Sciences, Health Care
29 Financing Administration, Congressional Office of
30 Technology Assessment, and any national board
31 recognized by the National Institutes of Health for the
32 purpose of evaluating the medical value of health
33 services.

34 (6) Peer-reviewed abstracts accepted for presentation
35 at major medical association meetings.

36 (e) In order to receive accreditation for the purposes
37 of this section, an independent entity shall meet all of the
38 following requirements:

39 (1) The independent entity must be an organization
40 that has as its primary function to provide expert reviews



1 and related services and receives a majority of its
2 revenues from these services, except that an academic
3 medical center may qualify as an independent entity for
4 purposes of this act without having as its primary function
5 providing expert reviews and related services and
6 without receiving a majority of its revenues from these
7 services. An independent entity may not be a subsidiary
8 of, nor in any way owned or controlled by, a health plan,
9 a trade association of health plans, or a professional
10 association of health care providers.

11 (2) The independent entity must submit to the
12 accrediting organization and to the Department of
13 Corporations the following information upon initial
14 application for accreditation and annually thereafter
15 upon any change to any of the following information:

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

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

21 (C) The names of all corporations and organizations
22 that the independent entity controls or is affiliated with,
23 and the nature and extent of any ownership or control,
24 including the affiliated organization's type of business.

25 (D) The names and biographical sketches of all
26 directors, officers, and executives of the independent
27 entity, as well as a statement regarding any relationships
28 the directors, officers, and executives may have with any
29 health care service plan, disability insurer, managed care
30 organization, provider group or board or committee.

31 (E) The percentage of revenue the independent
32 entity receives from expert reviews.

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

36 (G) A description of the system the independent
37 entity uses to identify and recruit expert reviewers, the
38 number of expert reviewers credentialed and the types
39 of cases the experts are credentialed to review.



1 (H) Documentation regarding the medical
2 institutions from which the independent entity has
3 selected the experts during the previous 12 months, and
4 the percentage of opinions obtained from each
5 institution.

6 (I) A description of the areas of expertise available
7 from expert reviewers retained by the independent
8 entity.

9 (J) A description of how the independent entity
10 ensures compliance with the conflict-of-interest
11 provisions of this section.

12 (3) The independent entity must demonstrate that it
13 has a quality assurance mechanism in place that does the
14 following:

15 (A) Ensures that the experts retained are
16 appropriately credentialed and privileged.

17 (B) Ensures that the reviews provided by the experts
18 are timely, clear and credible, and that reviews are
19 monitored for quality on an ongoing basis.

20 (C) Ensures that the method of selecting expert
21 reviewers for individual cases achieves a fair and
22 impartial panel of experts who are qualified to render
23 recommendations regarding the clinical conditions and
24 therapies in question.

25 (D) Ensures the confidentiality of medical records
26 and the review materials, consistent with the
27 requirements of this section.

28 (E) Ensures the independence of the experts retained
29 to perform the reviews through conflict-of-interest
30 policies and prohibitions and adequate screening for
31 conflicts of interest, pursuant to paragraph (3) of
32 subdivision (b).

33 (f) (1) The Department of Corporations shall receive
34 the information filed by independent entities pursuant to
35 paragraph (2) of subdivision (e) for the purpose of
36 creating a file of public records. The Department of
37 Corporations shall not be responsible for accrediting
38 independent entities.

39 (2) The accrediting organization shall provide, upon
40 the request of any interested person, a copy of all



1 nonproprietary information filed with it by the
2 independent entity under paragraph (2) of subdivision
3 (e). The accrediting organization may charge a
4 reasonable fee to the interested person for photocopying
5 the requested information.

6 (g) The independent review process established by
7 this section shall be required on and after January 1, 2004.

8 (h) This section shall become operative on January 1,
9 2004.

10 SEC. 9. Article 12 (commencing with Section
11 1399.80) is added to Chapter 2.2 of Division 2 of the Health
12 and Safety Code, to read:

13

14 Article 12. Appeals Seeking Independent Reviews

15

16 1399.80. (a) Commencing January 1, 2001, there is
17 established in the department the Independent Review
18 System.

19 (b) For the purposes of this ~~chapter~~ *article*, “disputed
20 health care service” means any health care service that
21 would otherwise be a covered benefit under a health care
22 service plan contract that has been denied, significantly
23 delayed, terminated, or otherwise limited by a decision of
24 the plan, or by one of its contracting providers, based, in
25 whole or in part, on a finding that the service is not
26 medically necessary or appropriate for the enrollee’s
27 medical condition.

28 (c) For the purposes of this ~~chapter~~ *article*, “other
29 adverse decision” means the denial, significant delay,
30 termination, or the imposition of other limits on health
31 care services by a plan, or by one of its contracting
32 entities, for reasons other than those in subdivision (b).

33 (d) All enrollee grievances involving a disputed health
34 care service or other adverse decision are eligible for
35 review under the Independent Review System if the
36 requirements of this ~~chapter~~ *article* are met. If the
37 department finds that an enrollee grievance does not
38 meet the requirements of this ~~chapter~~ *article* for review
39 under the Independent Review System, the enrollee
40 request for review shall be treated as a request for the



1 department to review the grievance pursuant to
2 subdivision (b) of Section 1368. All other enrollee
3 grievances remain eligible for review by the department
4 pursuant to subdivision (b) of Section 1368.

5 (e) No later than January 1, 2001, every health care
6 service plan, except a specialized health care service plan,
7 shall provide an enrollee with the opportunity to seek an
8 independent review for unresolved grievances that
9 involve a disputed health care service or other adverse
10 decision. For purposes of this article, “enrollee” shall
11 include a subscriber or designee as described in
12 paragraph (2) of subdivision (b) of Section 1368. The
13 enrollee’s provider may join with or otherwise assist the
14 enrollee to seek an independent medical review, and may
15 advocate on behalf of the enrollee.

16 (f) Every health care service plan contract, except a
17 specialized health care service plan contract, that is
18 issued, amended, renewed, or delivered in this state on or
19 after January 1, 2001, shall authorize enrollee
20 participation in the Independent Review System.

21 (g) Medicare and Medi-Cal beneficiaries enrolled in a
22 health care service plan shall not be excluded from
23 participation in the Independent Review System. The
24 department shall seek to integrate the quality of care and
25 consumer protection provisions, including remedies, of
26 the Independent Review System with related dispute
27 resolution procedures of other health care agency
28 programs, including the Medicare and Medi-Cal
29 programs, in a way that minimizes the potential for
30 duplication, conflict, and added costs. Nothing in this
31 subdivision shall be construed to limit any rights
32 conferred upon enrollees under this chapter. However,
33 the application of this subdivision to a Medicare
34 beneficiary shall not apply in the event, and to the extent,
35 that application is judicially determined to be preempted
36 by federal law.

37 (h) The independent review process authorized by
38 this article is in addition to any other procedures or
39 remedies that may be available. The enrollee’s election to
40 either pursue or not pursue, exhaust, or engage in the



1 procedures described in this article does not preclude the
2 use of any other remedy provided by law and shall not be
3 relevant in any subsequent civil or administrative
4 proceeding.

5 (i) No later than January 1, 2001, every health care
6 service plan shall prominently display in every plan
7 contract, on enrollee and subscriber evidence of
8 coverage forms, on copies of plan procedures for
9 resolving grievances, on the grievance forms required
10 under Section 1368, and on all written notices to enrollees
11 required under the grievance process of the plan,
12 including any written communications to an enrollee that
13 offer the enrollee the opportunity to participate in the
14 grievance process of the plan, and on all written responses
15 to grievances, information concerning the right of an
16 enrollee to request an independent review in cases where
17 the enrollee believes that health care services have been
18 improperly denied, significantly delayed, terminated, or
19 otherwise limited by the plan, or by one of its contracting
20 providers. Enrollees shall be notified of the availability of
21 a standard application form to request an independent
22 review.

23 (j) The department shall develop a standard
24 application form for independent review that shall be
25 used by each plan. An enrollee may apply for an
26 independent review when all of the following conditions
27 are met:

28 (1) The grievance involves a disputed health care
29 service or other adverse decision and the enrollee first
30 sought the health care service that is the subject of the
31 grievance from an in-plan participating provider, except
32 that the requirement to have first sought care from an
33 in-plan provider shall not apply in cases involving
34 emergency services or out-of-network urgent care.

35 (2) The health care service was denied, significantly
36 delayed, terminated, or otherwise limited by the plan, or
37 by one of its contracting providers, or in cases involving
38 emergency services or urgent out-of-network care where
39 the enrollee did not first seek care from a participating



1 plan provider, the plan has denied reimbursement for the
2 reasonable costs of securing ~~such~~ that care.

3 (3) The enrollee has filed a grievance with the plan or
4 its contracting provider pursuant to Section 1368, and the
5 disputed decision is upheld or the grievance remains
6 unresolved after 30 days. The enrollee shall not be
7 required to participate in the plan's grievance process for
8 more than 30 days. In the case of a grievance that requires
9 ~~expedited review~~ *immediate referral to the Independent*
10 *Review System* pursuant to Section 1368.01, the enrollee
11 shall not be required to participate in the plan's grievance
12 process ~~for more than three days~~.

13 (k) An enrollee may apply for an independent review
14 within 60 days of any of the qualifying periods or events
15 under subdivision (j), in a manner determined by the
16 commissioner. The commissioner may extend the
17 application deadline beyond 60 days if the circumstances
18 of a case warrant the extension. Each plan shall notify its
19 enrollees of the commissioner's authority to extend the
20 application deadline.

21 (l) As part of an appeal for an independent review, the
22 enrollee shall provide all of the following:

23 (1) A brief description of the enrollee's medical
24 condition for which health care services were denied,
25 significantly delayed, terminated, or otherwise limited, or
26 for which reimbursement for reasonable costs was
27 denied.

28 (2) If the grievance involves a disputed health care
29 service, an explanation of the reasons why the enrollee
30 believes that the disputed health care service is or was
31 medically necessary or appropriate for the enrollee's
32 medical condition. If the grievance involves one or more
33 other adverse decisions, an explanation of the reasons
34 why the enrollee believes the plan's decision was
35 incorrect.

36 The enrollee shall be encouraged to also provide other
37 information supporting the enrollee's position as well as
38 a copy of all information provided to the enrollee by the
39 plan or any of its contracting providers, still in the
40 possession of the enrollee, concerning a plan or provider



1 decision regarding disputed health care services and
2 services related to other adverse decisions, and a copy of
3 any materials the enrollee submitted to the plan, still in
4 the possession of the enrollee, in support of the grievance,
5 as well as any additional material that the enrollee
6 believes is relevant.

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

11 (m) (1) Upon receipt of an enrollee appeal for an
12 independent review, the plan or its contracting providers
13 shall provide the independent review organization a
14 copy of all of the following documents within three
15 business days of the plan's receipt of the request by an
16 enrollee for an independent review:

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

20 (i) The enrollee's medical condition that is the subject
21 of the independent review.

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

24 (iii) The health care services requested by the
25 enrollee for the condition.

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

37 (B) A copy of all information provided to the enrollee
38 by the plan and any of its contracting providers
39 concerning plan and provider decisions in response to the
40 grievance, and a copy of any materials the enrollee or the



1 enrollee's provider submitted to the plan and to the plan's
2 contracting providers in support of the enrollee's
3 grievance. This documentation shall include the written
4 response to the enrollee's grievance, required by
5 paragraph (4) of subdivision (a) of Section 1368, which
6 requires, in part, a description of the criteria used and the
7 clinical reasons for the decision, including all criteria and
8 clinical reasons related to medical necessity or
9 appropriateness. The confidentiality of ~~any enrollee~~
10 ~~medical~~ *all medical record* information shall be
11 maintained pursuant to applicable state and federal laws.

12 (C) A copy of any other relevant documents or
13 information used by the plan or its contracting providers
14 in determining whether disputed health care services or
15 services subject to one or more other adverse decisions
16 should have been provided, and any statements by the
17 plan and its contracting providers explaining the reasons
18 for the decision not to provide the services on the basis of
19 medical necessity or appropriateness, or for any other
20 reason. The plan shall concurrently provide a copy of
21 documents required by this subparagraph, except for any
22 information found by the commissioner to be legally
23 privileged information, to the enrollee and the enrollee's
24 provider. The department and the independent review
25 organization shall maintain the confidentiality of any
26 information found by the commissioner to be the
27 proprietary information of the plan.

28 (2) The provisions of paragraph (1) requiring the
29 referral of a grievance and related documents to an
30 independent review organization shall not apply in cases
31 where the plan files a written objection with the
32 department and the enrollee, within three days of
33 receiving a request for independent review, stating its
34 belief that the requested appeal:

35 (A) Does not meet the eligibility requirements for
36 independent review.

37 (B) Is frivolous and without merit.

38 (C) Is deficient due to both subparagraphs (A) and
39 (B).



1 The written objection to the department shall be
2 accompanied by a copy of the entire grievance record.
3 The department shall establish an expedited process,
4 which shall not exceed three days from receipt of an
5 objection unless an extension is requested by the enrollee,
6 for reviewing these cases and notifying the enrollee of its
7 decision. If there is an imminent and serious threat to the
8 health of the enrollee, as defined in subdivision ~~(e)~~ (d) of
9 Section 1399.83, the department shall accelerate its
10 review of the objection. If the department disagrees with
11 the plan's objection, the grievance shall be referred
12 immediately to an independent review organization. If
13 the department agrees with the plan, the grievance shall
14 immediately be treated as a request for the department
15 to review the grievance pursuant to subdivision (b) of
16 Section 1368. The department shall consider the entire
17 grievance record, as well as any material submitted by the
18 enrollee and the enrollee's providers, when making its
19 decision regarding an objection.

20 1399.81. (a) Except in cases involving a plan
21 objection submitted to the department, upon receipt of
22 an enrollee's request for an independent review, the plan
23 shall assign the request to an independent review
24 organization as described in Section 1399.82 in
25 accordance with any regulations or orders of the
26 commissioner when the enrollee has complied with the
27 requirements of subdivisions (j), (k), and (l) of Section
28 1399.80.

29 (b) The independent review organization, which shall
30 be selected by the department based on selection criteria
31 developed by the department, shall conduct the review
32 in accordance with Section 1399.83 and any regulations or
33 orders of the commissioner adopted pursuant thereto.

34 1399.82. (a) By January 1, 2001, the commissioner
35 shall make every effort to contract with one or more
36 independent review organizations in the state to conduct
37 reviews for purposes of this article. The independent
38 review organizations shall be accredited pursuant to this
39 article and shall be independent of any health care
40 service ~~plans~~ plan doing business in this state. Prior to July



1 1, 2000, the commissioner, after public notice, hearings,
2 and comment, shall adopt regulations to ensure the
3 independence of these organizations. The regulations
4 shall include conflict-of-interest standards, consistent
5 with the purposes of this article, that an organization shall
6 be required to meet in order to qualify for participation
7 in the Independent Review System.

8 (b) (1) The independent review organization, any
9 experts it designates to conduct a review, or any officer,
10 director, or employee of the independent entity shall
11 have no material professional, familial, or financial
12 affiliation, as determined by the commissioner, with any
13 of the following:

14 (A) The plan.

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

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

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

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

26 (c) The commissioner shall, by July 1, 2000, contract
27 with a private, nonprofit accrediting organization to
28 accredit the independent review organizations described
29 in subdivision (a). The accrediting organization may
30 grant and revoke accreditation, and shall develop, apply,
31 and enforce accreditation standards that ensure the
32 independence of the independent review organization,
33 the confidentiality of the medical records, and the
34 qualifications and independence of the health care
35 professionals and other experts providing the analyses
36 and recommendations requested of them. The
37 accrediting organization shall demonstrate the ability to
38 objectively evaluate the performance of independent
39 review organizations and shall demonstrate that it has no
40 conflict of interest, including any material professional,



1 familial, or financial affiliation, as provided in subdivision
2 (b), with any independent review organization or plan,
3 in accrediting those organizations for the purpose of
4 reviewing disputed health care decisions and other
5 adverse decisions made by health care service plans.

6 (d) Prior to July 1, 2000, the commissioner, after public
7 notice, hearings, and comment, shall adopt regulations
8 related to the accreditation of independent review
9 organizations. In developing the regulations required by
10 this subdivision, the department shall consider adopting
11 the following, but may accept, reject, or modify the
12 following based on information received as a result of the
13 rulemaking process. If the department rejects or modifies
14 any of the following, it shall discuss its reasons for doing
15 so in the final rulemaking document. In order to receive
16 accreditation for the purposes of this section, an
17 independent review organization shall meet all of the
18 following requirements:

19 (1) An independent review organization shall not be
20 an affiliate or a subsidiary of, nor in any way be owned or
21 controlled by, a health plan, or a trade association of
22 health plans. A board member, director, officer, or
23 employee of the independent review organization shall
24 not serve as a board member, director, or employee of a
25 health care service plan. A board member, director, or
26 officer of a health plan or a trade association of health
27 plans shall not serve as a board member, director, officer,
28 or employee of an independent review organization.

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

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

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



1 (C) The names of all corporations and organizations
2 that the independent review organization controls or is
3 affiliated with, and the nature and extent of any
4 ownership or control, including the affiliated
5 organization's type of business.

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

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

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

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

28 (G) A description of the system the independent
29 review organization uses to identify and recruit medical
30 professionals and other experts to review disputed health
31 care decisions and other adverse decisions made by
32 health care service plans, the number of medical
33 professionals credentialed, and the types of cases and
34 areas of expertise which the medical professionals are
35 credentialed to review, and the number of other experts,
36 the types of cases and areas of expertise which those other
37 experts are licensed or credentialed to review.

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



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

4 (A) Ensures that the medical professionals retained
5 are appropriately credentialed and privileged and that
6 the other experts retained are appropriately qualified,
7 licensed, and credentialed.

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

12 (C) Ensures that the method of selecting medical
13 professionals and other experts for individual cases
14 achieves a fair and impartial panel of medical
15 professionals and other experts who are qualified to
16 render recommendations regarding disputed health care
17 decisions and other adverse decisions made by health
18 care service plans.

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

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

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

33 (A) The medical professional shall be a clinician
34 knowledgeable in the treatment of the enrollee's medical
35 condition, knowledgeable about the proposed treatment,
36 and familiar with guidelines, protocols, and the criteria
37 set forth in subdivision (b) of Section 1399.83 in the area
38 of treatment under review.

39 (B) The medical professional shall hold a
40 nonrestricted license in the State of California, and for



1 physicians, a current certification by a recognized
2 American medical specialty board in the area or areas
3 appropriate to the condition or treatment under review.
4 For good cause shown, such as the unavailability of
5 licensed qualified medical professionals in California or
6 the availability of uniquely qualified clinics outside of
7 California, the independent review organization may
8 utilize a medical professional who holds a nonrestricted
9 license in any state of the United States, provided that the
10 out-of-state medical professional is knowledgeable about
11 the treatment standards required in California and
12 applies those standards.

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

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

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

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

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

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

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

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

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



1 (A) “Material familial affiliation” means any
2 relationship as a spouse, child, parent, sibling, spouse’s
3 parent, or child’s spouse.

4 (B) “Material professional affiliation” means any
5 physician-patient relationship, any partnership or
6 employment relationship, a shareholder or similar
7 ownership interest in a professional corporation, or any
8 independent contractor arrangement that constitutes a
9 material financial affiliation with any expert or any officer
10 or director of the independent review organization.
11 “Material professional affiliation” does not include
12 affiliations that are limited to staff privileges at a health
13 facility.

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

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

34 (f) The independent review process established by
35 this article shall not commence until one or more
36 independent review organizations have been accredited
37 and have executed a contract with the department
38 pursuant to this section.

39 1399.83. (a) Upon receipt of information and
40 documents related to a case pursuant to subdivision (c)



1 of Section 1399.81, the expert reviewer or reviewers
2 selected to conduct the review by the independent
3 review organization shall promptly review all pertinent
4 medical records of the enrollee, *and* provider reports, as
5 well as any other information submitted to the
6 organization as authorized by the department or
7 requested from any of the parties to the dispute by the
8 reviewers. If reviewers request information from any of
9 the parties, a copy of the request and the response shall
10 be provided to all of the parties.

11 (b) (1) Following its review of a grievance involving
12 a disputed health care service, the medical expert
13 reviewer or reviewers shall determine and state whether
14 the disputed health care service is or was medically
15 necessary or appropriate based on:

16 (A) Generally accepted practice guidelines
17 developed by federal agencies, nationally recognized
18 federal research institutes, or national professional
19 medical specialty societies.

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

23 (C) Generally accepted standards of medical practice.

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

27 (2) Medically necessary or appropriate health care
28 services shall include those related to treatment or
29 therapy to maximize functional capacity. This subdivision
30 is to be construed in the best interests of the enrollee.

31 (c) Following its review of a grievance involving one
32 or more other adverse decisions, the expert reviewer or
33 reviewers shall determine and state whether the decision
34 to deny, significantly delay, terminate, or otherwise
35 impose limits on health care services was reasonable
36 taking into consideration, among other relevant
37 information, all of the provisions of the enrollee's health
38 care service plan contract.

39 (d) The independent review organization shall
40 require its expert reviewers to complete a review and



1 make a determination in writing, and in layperson's terms
2 to the maximum extent practicable, within 30 days of the
3 receipt by the independent review organization of the
4 application for review and supporting documentation, or
5 within less time as prescribed by the commissioner. If a
6 requested health care service that is the subject of the
7 grievance has not been provided and the enrollee's
8 provider or the department certifies in writing that an
9 imminent and serious threat to the health of the enrollee
10 may exist, including, but not limited to, ~~serious~~ *severe*
11 pain, the potential loss of life, limb, or major bodily
12 function, or the immediate and serious deterioration of
13 the health of the enrollee, the analyses and
14 determinations of the reviewers shall be expedited and
15 rendered within three days of the certification notice.
16 Subject to the approval of the department, the deadlines
17 for analyses and determinations involving both regular
18 and expedited reviews may be extended by up to three
19 days following reviewer receipt of delayed
20 documentation required by this chapter.

21 (e) Each analysis shall cite the enrollee's medical
22 condition and the relevant documents in the record to
23 support the determination.

24 (f) In cases involving disputed health care services,
25 each analysis shall cite relevant findings associated with
26 the provisions of subdivision (b). If more than one
27 medical expert reviews the case, the recommendation of
28 the majority shall prevail. If the medical experts
29 reviewing the case are evenly split as to whether the
30 disputed health care service is or was medically necessary
31 or appropriate, the decision shall be in favor of the
32 enrollee.

33 (g) In cases related to a grievance involving one or
34 more other adverse decisions, if more than one expert
35 reviews the case, the recommendation of the majority
36 shall prevail. If the experts reviewing the case are evenly
37 split as to whether it was reasonable to deny, significantly
38 delay, terminate, or otherwise impose limits on health
39 care services, the decision shall be in favor of the enrollee.



1 (h) The independent review organization shall
2 provide the commissioner with the analyses and
3 determinations of the experts reviewing the case, a
4 description of the qualifications of the experts, and the
5 names of the reviewers. If more than one expert reviewed
6 the case and the result was differing determinations, the
7 independent review organization shall provide the
8 commissioner with each of the separate reviewer
9 analyses and determinations.

10 (i) The commissioner, except in cases subject to
11 expedited reconsideration under subdivision (j), shall
12 immediately adopt the determination of the
13 independent review organization, and shall promptly
14 issue a written decision to the parties, which decision shall
15 be binding on the plan as an order.

16 (j) The commissioner may request the independent
17 review organization, on an expedited basis, to reconsider
18 any determination involving one or more other adverse
19 decisions when the commissioner finds that the
20 determination is clearly contrary to the legal
21 requirements of this chapter or other laws. If after
22 reconsideration, the independent review organization
23 renders a determination that the commissioner finds
24 remains clearly contrary to the legal requirements of this
25 chapter or other law, the commissioner shall forward the
26 determination to the parties, along with the
27 commissioner's finding, and the disputed portion of the
28 determination involving one or more other adverse
29 decisions shall not be binding. In these cases, the
30 department shall immediately treat that portion of the
31 grievance related to the disputed determination
32 pursuant to subdivision (b) of Section 1368.

33 (k) Nothing about the independent review process
34 established by this article, including, but not limited to,
35 the analysis, recommendations, and conclusions of the
36 review panel, shall be admissible in any subsequent
37 proceeding.

38 (l) After removing the names of the parties, including,
39 but not limited to, the enrollee, all medical providers, the
40 plan, and any of its employees or contractors,



1 commissioner orders adopting a determination of an
2 independent review organization shall be made available
3 by the department to the public upon request, at the
4 department's cost.

5 1399.84. (a) Upon receiving the order adopted by the
6 commissioner pursuant to subdivision (i) or (j) of Section
7 1399.83, the plan shall immediately contact the enrollee
8 and offer to promptly implement the order.

9 (b) In any case where an enrollee secured urgent care
10 or emergency services outside of the plan provider
11 network, and these services are later found by the
12 independent review organization to have been a covered
13 benefit under the terms and conditions of the health care
14 service plan contract and were medically necessary or
15 appropriate, the commissioner shall require the plan to
16 promptly reimburse the enrollee for any reasonable costs
17 associated with those services when the commissioner
18 finds that the enrollee's decision to secure the services
19 outside of the plan provider network prior to seeking an
20 independent review was reasonable under the
21 circumstances.

22 (c) In addition to requiring plan compliance
23 regarding subdivisions (a) and (b), the commissioner
24 shall review individual cases submitted for independent
25 review to determine whether any enforcement actions,
26 including penalties, may be appropriate. In particular,
27 where harm to an enrollee has already occurred because
28 of the decision of a plan, or one of its contracting
29 providers, to deny, significantly delay, terminate, or
30 otherwise limit covered health care services that an
31 independent review determines to be medically
32 necessary or appropriate, the commissioner shall impose
33 penalties.

34 (d) Pursuant to Section 1368.04, the commissioner
35 shall periodically evaluate independent review cases to
36 determine if any audit, investigative, or enforcement
37 actions should be undertaken by the department,
38 particularly if a plan repeatedly fails to act promptly and
39 reasonably to resolve grievances associated with a denial,
40 significant delay, termination, or the imposition of other



1 limits on medically necessary or appropriate health care
2 services when the obligation of the plan to provide those
3 health care services to enrollees or subscribers is
4 reasonably clear.

5 1399.85. (a) After considering the results of a
6 competitive bidding process and any other relevant
7 information on program costs, the commissioner shall
8 establish a reasonable, per-case reimbursement schedule
9 to pay the costs of independent review organization
10 reviews, which may vary depending on the type of
11 medical condition under review and on other relevant
12 factors.

13 (b) As a condition ~~for~~ of receiving payments for
14 reviews, independent review organizations shall agree to
15 provide reasonable data required for an evaluation of the
16 independent review system.

17 1399.86. (a) On or before July 1, 2000, the
18 commissioner shall allocate grant funding for an
19 independent health care ombudsprogram. At a
20 minimum, the commissioner shall approve project grants
21 for at least one new or existing independent assistance
22 project in southern, central, and northern California if
23 qualified applicants apply from each of those three
24 regions. The number of projects approved shall
25 eventually be sufficient to provide independent
26 assistance to all California enrollees. However, in order to
27 facilitate the startup and effective implementation of this
28 section, the commissioner may take until July 1, 2002, if
29 necessary, to fund a sufficient number of projects to serve
30 all California enrollees.

31 (b) Project activities shall include, but are not limited
32 to, providing counseling, advising, assisting, and
33 advocating for enrollees at every stage of:

34 (A) The health plan grievance process.

35 (B) The department's grievance review process
36 under subdivision (b) of Section 1368.

37 (C) Applying for and participating in the
38 Independent Review System.

39 (c) All of the projects shall, as necessary and
40 appropriate, directly assist enrollees in their dealings with



1 plans, provider groups, providers, and government
2 agencies, including advocating on behalf of enrollees in
3 any informal or formal proceeding.

4 (d) The commissioner shall use a competitive bidding
5 process to select projects. The projects shall be selected
6 based on, but not limited to, all of the following selection
7 criteria:

8 (1) The applicant's experience providing enrollees
9 with education, counseling, and advocacy services.

10 (2) The number of enrollees covered by health plans
11 served by the project and the size of the geographic
12 region to be served by the project.

13 (3) Evidence of an understanding of the range and
14 complexity of health care concerns likely to be raised by
15 enrollees, including vulnerable populations served by
16 various health plans.

17 (4) The number and quality of staff with formal
18 training and experience in health care, counseling, and
19 consumer advocacy.

20 (5) The ability to complement, and not duplicate,
21 existing consumer services provided by health plans,
22 other independent assistance programs, and regulatory
23 assistance programs, which shall include a commitment
24 to refer enrollees, as appropriate, to the Health Insurance
25 Counseling and Advocacy Program (HICAP) in cases
26 eligible for HICAP assistance.

27 (6) The commitment to collect and analyze data on
28 enrollee experiences in health plan grievance systems, in
29 the department's grievance review process, and in the
30 Independent Review System.

31 (7) The ability and commitment to provide significant
32 matching contributions to support the program in the
33 form of private or public financial support or in-kind
34 contributions, or a combination of the two.

35 (8) The commitment to provide project services to
36 enrollees free of charge.

37 (9) The degree of consumer representation on the
38 applicant's governing advisory board, if such a board
39 exists.



1 (e) The evaluation of bids submitted pursuant to
2 subdivision (d) shall be conducted by the commissioner
3 in consultation with a panel of at least three individuals
4 screened and appointed by the commissioner who have
5 no conflicts of interest including, but not limited to, a
6 financial interest in the outcome of the bidding process,
7 or employment or contractual arrangements with plans,
8 their contracting medical groups or contracting
9 providers, and who have significant experience with, and
10 knowledge about, managed health care issues, health
11 care dispute resolution mechanisms, and consumer
12 advocacy.

13 (f) Funding for the projects shall commence no earlier
14 than July 1, 2000, and may continue for a period extending
15 no later than December 31, 2003.

16 (g) As a condition ~~for~~ *of* receiving funding, each of the
17 projects shall agree to provide reasonable data required
18 for an evaluation of the independent health care
19 ombudsprogram.

20 1399.87. (a) The costs of the independent review
21 system and independent health care ombudsprogram
22 shall be borne by health care service plans pursuant to an
23 assessment fee system established by the commissioner.
24 Every health care service plan shall pay annually to the
25 department, on the date or dates set by the department,
26 its prorated share of fees, as determined by the
27 commissioner, to pay for the estimated annual costs
28 associated with carrying out, overseeing, and evaluating
29 the independent review system and independent health
30 care ombudsprogram. In determining the amount to be
31 assessed, the commissioner shall consider all existing
32 assessments and appropriations available for the support
33 of this chapter including any offsetting funds that can be
34 made available as a result of enrollee grievances being
35 diverted from the department and reviewed instead by
36 independent review organizations with enrollees assisted
37 by the independent health care ombudsprogram instead
38 of by department staff. The commissioner may adjust fees
39 upward or downward, on a schedule set by the
40 department, to address shortages or overpayments.



1 (b) The portion of the assessment fee imposed by
2 subdivision (a) to pay for the independent health care
3 ombudsprogram shall not apply to any health care service
4 plan that is funding and has in place by July 1, 2000, or
5 thereafter, an independent, external health care
6 ombudsprogram certified by the commissioner as
7 substantially complying with the selection criteria for
8 eligibility utilized under this chapter, and provided that
9 the health plan ombudsprogram agrees to collect and
10 provide reasonable data to the department and its
11 evaluator in accordance with subdivisions (a) and (b) of
12 Section 1399.88. The commissioner's certification review
13 shall be done in consultation with the panel established
14 pursuant to subdivision (e) of Section 1399.86.

15 (c) These funds shall be used for all costs reasonably
16 incurred in the administration of this article, including,
17 but not limited to, startup costs, overhead, department
18 administration, contracting with an accrediting
19 organization, contracts with independent review
20 organizations, payments to expert reviewers, grants for
21 ombudsprogram projects and program evaluation.

22 1399.88. (a) The department shall contract with an
23 independent expert entity to undertake an evaluation of
24 the independent review system and the independent
25 health care ombudsprogram.

26 (b) The independent evaluation shall include, but not
27 be limited to, an assessment of the effectiveness and value
28 of the independent review system and the
29 ombudsprogram. The evaluation shall include a
30 description of assessments imposed on plans to
31 implement these programs, changes in department
32 staffing attributable to these new programs, any increase,
33 reduction, or redirection of existing department staff as
34 a result of these new programs, and any changes in
35 department workload attributed to enrollee use of the
36 ombudsprogram and the referral of grievances to the
37 independent review system.

38 (c) The evaluation shall assess the long-term efficacy
39 of these programs as a means of providing timely and
40 effective resolution of enrollee grievances with plans, and



1 for improving access to and the quality of health care
2 services, and as a catalyst for systemic improvements in
3 the delivery of health care services. In addition to
4 reviewing data generated by these new California
5 programs, the evaluator shall survey and report on similar
6 programs underway in other states.

7 (d) The evaluator shall provide its evaluation to the
8 department on or before January 1, 2003. The department
9 shall make a single copy of the evaluation available at no
10 cost to members of the public upon request. The
11 department may recover the cost of additional copies that
12 are requested. After holding a series of public hearings on
13 the evaluation, the department shall submit a report,
14 along with its own recommendations for continuing,
15 modifying, or terminating the independent review
16 system and the independent health care
17 ombudsprogram, to the Legislature by March 1, 2003. The
18 department shall make a single copy of its report
19 available at no cost to members of the public upon
20 request. The department may recover the cost of
21 additional copies that are requested.

22 1399.89. A plan's coverage decision regarding
23 experimental or investigational therapies for individual
24 enrollees shall be subject to this article.

25 1399.90. This article shall remain in effect only until
26 January 1, 2004, and as of that date is repealed, unless a
27 later enacted statute, that is enacted before January 1,
28 2004, deletes or extends that date.

29 SEC. 10. *Section 10145.3 of the Insurance Code is*
30 *amended to read:*

31 10145.3. (a) Every disability insurer that covers
32 hospital, medical, or surgical benefits shall provide an
33 external, independent review process to examine the
34 insurer's coverage decisions regarding experimental or
35 investigational therapies for individual insureds who
36 meet all of the following criteria:

37 (1) The insured has a terminal condition that,
38 according to the insured's physician's current diagnosis,
39 has a high probability of causing death within two years



1 from the date of the request for an independent medical
2 review.

3 (2) The insured's physician certifies that the insured
4 has a condition, as defined in paragraph (1), for which
5 standard therapies have not been effective in improving
6 the condition of the insured, or for which standard
7 therapies would not be medically appropriate for the
8 insured, or for which there is no more beneficial standard
9 therapy covered by the insurer than the therapy
10 proposed pursuant to paragraph (3).

11 (3) Either (A) the insured's contracting physician has
12 recommended a drug, device, procedure, or other
13 therapy that the physician certifies in writing is likely to
14 be more beneficial to the insured than any available
15 standard therapies, or (B) the insured, or the insured's
16 physician who is a licensed, board-certified or
17 board-eligible physician qualified to practice in the area
18 of practice appropriate to treat the insured's condition,
19 has requested a therapy that, based on two documents
20 from the medical and scientific evidence, as defined in
21 subdivision (d), is likely to be more beneficial for the
22 insured than any available standard therapy. The
23 physician certification pursuant to this subdivision shall
24 include a statement of the evidence relied upon by the
25 physician in certifying his or her recommendation.
26 Nothing in this subdivision shall be construed to require
27 the insurer to pay for the services of a noncontracting
28 physician, provided pursuant to this subdivision, that are
29 not otherwise covered pursuant to the contract.

30 (4) The insured has been denied coverage by the
31 insurer for a drug, device, procedure, or other therapy
32 recommended or requested pursuant to paragraph (3),
33 unless coverage for the specific therapy has been
34 excluded by the plan contract.

35 (5) This section does not apply to any Medi-Cal
36 beneficiary enrolled with an insurer under the insurer's
37 contract with the Medi-Cal program.

38 (6) The specific drug, device, procedure, or other
39 therapy recommended pursuant to paragraph (3) would



1 be a covered service except for the plan's determination
2 that the therapy is experimental or under investigation.

3 (b) The insurer's external, independent review shall
4 meet the following criteria:

5 (1) The insurer shall offer all insureds who meet the
6 criteria in subdivision (a) the opportunity to have the
7 requested therapy reviewed under the external,
8 independent review process. The insurer shall notify
9 eligible insureds in writing of the opportunity to request
10 the external independent review within five business
11 days of the decision to deny coverage.

12 (2) The insurer shall contract with one or more
13 impartial, independent entities that are accredited
14 pursuant to subdivision (c). The entity shall arrange for
15 review of the coverage decision by selecting an
16 independent panel of at least three physicians or other
17 providers who are experts in the treatment of the
18 insured's medical condition and knowledgeable about
19 the recommended therapy. If the entity is an academic
20 medical center accredited in accordance with subdivision
21 (e), the independent panel may include experts affiliated
22 with or employed by the entity. A panel of two experts
23 may be arranged at the insurer's request, provided the
24 insured consents in writing. The independent entity may
25 arrange for a panel of one expert only if the independent
26 entity certifies in writing that there is only one expert
27 qualified and able to review the recommended therapy.
28 Neither the insurer nor the insured shall choose or control
29 the choice of the physician or other provider experts.

30 (3) Neither the expert, nor the independent entity,
31 nor any officer, director, or management employee of the
32 independent entity may have any material professional,
33 familial, or financial affiliation, as defined in paragraph
34 (4), with any of the following:

35 (A) The insurer.

36 (B) Any officer, director, or management employee of
37 the insurer.

38 (C) The physician, the physician's medical group, or
39 the independent practice association (IPA) proposing
40 the therapy.



1 (D) The institution at which the therapy would be
2 provided.

3 (E) The development or manufacture of the principal
4 drug, device, procedure, or other therapy proposed for
5 the insured whose treatment is under review.

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

8 (A) “Material familial affiliation” means any
9 relationship as a spouse, child, parent, sibling, spouse’s
10 parent, or child’s spouse.

11 (B) “Material professional affiliation” means any
12 physician-patient relationship, any partnership or
13 employment relationship, a shareholder or similar
14 ownership interest in a professional corporation, or any
15 independent contractor arrangement that constitutes a
16 material financial affiliation with any expert or any officer
17 or director of the independent entity. The term “material
18 professional affiliation” does not include affiliations that
19 are limited to staff privileges at a health facility.

20 (C) “Material financial affiliation” means any financial
21 interest of more than 5 percent of total annual revenue
22 or total annual income of an entity or individual to which
23 this subdivision applies. “Material financial affiliation”
24 does not include payment by the insurer to the
25 independent entity for the services required by this
26 section, nor does “material financial affiliation” include
27 an expert’s participation as a contracting provider for the
28 insurer where the expert is affiliated with an academic
29 medical center or a National Cancer Institute-designated
30 clinical cancer research center.

31 (5) The insured shall not be required to pay for the
32 external independent review. The costs of the review
33 shall be borne by the insurer.

34 (6) The insurer shall provide to the independent
35 entity arranging for the panel of experts a copy of the
36 following documents within five business days of the
37 insurer’s receipt of a request by an insured or insured’s
38 physician for an external independent review.

39 (A) The medical records relevant to the patient’s
40 condition for which the proposed therapy has been



1 recommended, provided the documents are within the
2 insurer's possession. Any medical records provided to the
3 insurer after the initial documents are provided to the
4 independent entity shall be forwarded by the insurer to
5 the independent entity within five business days. The
6 confidentiality of the medical records shall be maintained
7 pursuant to Section 56.10 of the Civil Code.

8 (B) A copy of any relevant documents used by the
9 insurer in determining whether the proposed therapy
10 should be covered, and any statement by the insurer
11 explaining the reasons for the insurer's decision not to
12 provide coverage for the proposed therapy. The insurer
13 shall provide, upon request, a copy of the documents
14 required by this paragraph, except for the documents
15 described in paragraphs (A) and (C), to the insured and
16 the insured's physician.

17 (C) Any information submitted by the insured or the
18 insured's physician to the insurer in support of the
19 insured's request for coverage of the proposed drug,
20 device, procedure, or other therapy.

21 (7) The experts on the panel shall render their
22 analyses and recommendations within 30 days of the
23 receipt of the insured's request for review. If the insured's
24 physician determines that the proposed therapy would
25 be significantly less effective if not promptly initiated, the
26 analyses and recommendations of the experts on the
27 panel shall be rendered within seven days of the request
28 for expedited review. At the request of the expert, the
29 deadline shall be extended by up to three days for a delay
30 in providing the documents required by paragraph (6) of
31 subdivision (b).

32 (8) Each expert's analysis and recommendation shall
33 be in written form and state the reasons the requested
34 therapy is or is not likely to be more beneficial for the
35 insured than any available standard therapy, and the
36 reasons that the expert recommends that the therapy
37 should or should not be covered by the insurer, citing the
38 insured's specific medical condition, the relevant
39 documents provided pursuant to paragraph (6), and the
40 relevant medical and scientific evidence, including, but



1 not limited to, the medical and scientific evidence as
2 defined in subdivision (d), to support the expert's
3 recommendation.

4 (9) The independent entity shall provide the insurer
5 and the insured's physician with the expert's analyses and
6 recommendations, a description of the qualifications of
7 each expert, and any other information that it chooses to
8 provide to the insurer and the insured's physician,
9 including, but not limited to, the names of the expert
10 reviewers. The independent entity shall not be required
11 to disclose the names of the expert reviewers to the
12 insurer or to the insured's physician, except pursuant to
13 a properly made request for discovery. If the
14 independent entity chooses to disclose the names of the
15 experts on the panel to the insurer, the independent
16 entity must also disclose the names of the experts to the
17 insured's physician. The insured's physician may provide
18 these documents and information to the enrollee.

19 (10) If the majority of experts on the panel
20 recommend providing the proposed therapy, pursuant to
21 paragraph (8), the recommendation shall be binding on
22 the insurer. If the recommendations of the experts on the
23 panel are evenly divided as to whether the therapy
24 should be provided, then the panel's decision shall be
25 deemed to be in favor of coverage. If less than a majority
26 of the experts on the panel recommend providing the
27 therapy, the insurer is not required to provide the
28 therapy. Coverage for the services required under this
29 section shall be provided subject to the terms and
30 conditions generally applicable to other benefits under
31 the contract.

32 (11) The insurer shall have written policies describing
33 the external, independent review process. The insurer
34 shall disclose the availability of the external, independent
35 review process and how insureds may access the review
36 process in the insurer's evidence of coverage and
37 disclosure forms.

38 (c) The Commissioner of Corporations, in
39 consultation with the Insurance Commissioner, shall, by
40 January 1, 1998, contract with a private, nonprofit



1 accrediting organization to accredit the independent
2 review entities specified in subdivision (b). The
3 accrediting organization shall have the power to grant
4 and revoke accreditation, and shall develop, apply, and
5 enforce accreditation standards, including those required
6 in subdivision (e), that ensure the independence of the
7 independent review entity, the confidentiality of the
8 medical records, and the qualifications and
9 independence of the health care professionals providing
10 the analyses and recommendations requested of them.
11 The accrediting organization shall demonstrate the
12 ability to objectively evaluate the performance of
13 independent entities and shall demonstrate that it has no
14 conflict of interest, including any material professional,
15 familial, or financial affiliation as defined in paragraph (4)
16 of subdivision (b) with any independent entity or
17 disability insurer, in accrediting entities for the purpose
18 of reviewing medical treatments, treatment
19 recommendations, and coverage decisions by disability
20 insurers.

21 (d) For the purposes of paragraph (3) of subdivision
22 (a), “medical and scientific evidence” means the
23 following sources:

24 (1) Peer-reviewed scientific studies published in or
25 accepted for publication by medical journals that meet
26 nationally recognized requirements for scientific
27 manuscripts and that submit most of their published
28 articles for review by experts who are not part of the
29 editorial staff.

30 (2) Peer-reviewed literature, biomedical compendia
31 and other medical literature that meet the criteria of the
32 National Institute of Health’s National Library of
33 Medicine for indexing in Index Medicus, Excerpta
34 Medicus (EMBASE), Medline and MEDLARS data base
35 Health Services Technology Assessment Research
36 (HSTAR).

37 (3) Medical journals recognized by the Secretary of
38 Health and Human Services, under Section 1861(t)(2) of
39 the Social Security Act.

1 (4) The following standard reference compendia: The
2 American Hospital Formulary Service-Drug
3 Information, the American Medical Association Drug
4 Evaluation, the American Dental Association Accepted
5 Dental Therapeutics and The United States
6 Pharmacopoeia-Drug Information.

7 (5) Findings, studies, or research conducted by or
8 under the auspices of federal government agencies and
9 nationally recognized federal research institutes,
10 including the Federal Agency for Health Care Policy and
11 Research, National Institutes of Health, National Cancer
12 Institute, National Academy of Sciences, Health Care
13 Financing Administration, Congressional Office of
14 Technology Assessment, and any national board
15 recognized by the National Institutes of Health for the
16 purpose of evaluating the medical value of health
17 services.

18 (6) Peer-reviewed abstracts accepted for presentation
19 at major medical association meetings.

20 (e) In order to receive accreditation for the purposes
21 of this section, an independent entity shall meet all of the
22 following requirements:

23 (1) The independent entity must be an organization
24 that has as its primary function the provision of expert
25 reviews and related services and receives a majority of its
26 revenues from these services, except that an academic
27 medical center may qualify as an independent entity for
28 purposes of this act without meeting either of these
29 criteria. An independent entity may not be a subsidiary
30 of, nor in any way owned or controlled by, a health plan,
31 a trade association of health plans, or a professional
32 association of health care providers.

33 (2) The independent entity must submit to the
34 accrediting organization and to the Department of
35 Corporations the following information upon initial
36 application for accreditation and annually thereafter
37 upon any change to any of the following information:

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



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

3 (C) The names of all corporations and organizations
4 that the independent entity controls or is affiliated with,
5 and the nature and extent of any ownership or control,
6 including the affiliated organization's type of business.

7 (D) The names and biographical sketches of all
8 directors, officers, and executives of the independent
9 entity, as well as a statement regarding any relationships
10 the directors, officers, and executives may have with any
11 health care service plan, disability insurer, managed care
12 organization, provider group or board or committee.

13 (E) The percentage of revenue the independent
14 entity receives from expert reviews.

15 (F) A description of the review process, including, but
16 *not* limited—~~not~~ to, the method of selecting expert
17 reviewers and matching the expert reviewers to specific
18 cases.

19 (G) A description of the system the independent
20 entity uses to identify and recruit expert reviewers, the
21 number of expert reviewers credentialed, and the types
22 of cases the experts are credentialed to review.

23 (H) Documentation regarding the medical
24 institutions from which the independent entity has
25 selected the experts during the previous 12 months, and
26 the percentage of opinions obtained from each
27 institution.

28 (I) A description of the areas of expertise available
29 from expert reviewers retained by the independent
30 entity.

31 (J) A description of how the independent entity
32 ensures compliance with the conflict-of-interest
33 provisions of this section.

34 (3) The independent entity must demonstrate that it
35 has a quality assurance mechanism in place that does the
36 following:

37 (A) Ensures that the experts retained are
38 appropriately credentialed and privileged.



1 (B) Ensures that the reviews provided by the experts
2 are timely, clear and credible, and that reviews are
3 monitored for quality on an ongoing basis.

4 (C) Ensures that the method of selecting expert
5 reviewers for individual cases achieves a fair and
6 impartial panel of experts who are qualified to render
7 recommendations regarding the clinical conditions and
8 therapies in question.

9 (D) Ensures the confidentiality of medical records
10 and the review materials, consistent with the
11 requirements of this section.

12 (E) Ensures the independence of the experts retained
13 to perform the reviews through conflict-of-interest
14 policies and prohibitions and adequate screening for
15 conflicts of interest, pursuant to paragraph (3) of
16 subdivision (b).

17 (f) (1) The Department of Corporations shall receive
18 the information filed by independent entities pursuant to
19 paragraph (2) of subdivision (e) for the purpose of
20 creating a file of public records. The Department of
21 Corporations shall not be responsible for accrediting
22 independent entities.

23 (2) The accrediting organization shall provide, upon
24 the request of any interested person, a copy of all
25 nonproprietary information filed with it by the
26 independent entity under paragraph (2) of subdivision
27 (e). The accrediting organization may charge a
28 reasonable fee to the interested person for photocopying
29 the requested information.

30 (g) The independent review process established by
31 this section shall be required on and after July 1, 1998.

32 (h) *This section shall remain in effect only until*
33 *January 1, 2001, and as of that date is repealed, unless a*
34 *later enacted statute, that is enacted before January 1,*
35 *2001, deletes or extends that date.*

36 *SEC. 11. Section 10145.3 is added to the Insurance*
37 *Code, to read:*

38 *10145.3. (a) Every disability insurer that covers*
39 *hospital, medical, or surgical benefits shall provide an*
40 *external, independent review process to examine the*



1 insurer's coverage decisions regarding experimental or
2 investigational therapies for individual insureds who
3 meet all of the following criteria:

4 (1) The insured has a terminal condition that,
5 according to the insured's physician's current diagnosis,
6 has a high probability of causing death within two years
7 from the date of the request for an independent medical
8 review.

9 (2) The insured's physician certifies that the insured
10 has a condition, as defined in paragraph (1), for which
11 standard therapies have not been effective in improving
12 the condition of the insured, or for which standard
13 therapies would not be medically appropriate for the
14 insured, or for which there is no more beneficial standard
15 therapy covered by the insurer than the therapy
16 proposed pursuant to paragraph (3).

17 (3) Either (A) the insured's contracting physician has
18 recommended a drug, device, procedure, or other
19 therapy that the physician certifies in writing is likely to
20 be more beneficial to the insured than any available
21 standard therapies, or (B) the insured, or the insured's
22 physician who is a licensed, board-certified or
23 board-eligible physician qualified to practice in the area
24 of practice appropriate to treat the insured's condition,
25 has requested a therapy that, based on two documents
26 from the medical and scientific evidence, as defined in
27 subdivision (d), is likely to be more beneficial for the
28 insured than any available standard therapy. The
29 physician certification pursuant to this subdivision shall
30 include a statement of the evidence relied upon by the
31 physician in certifying his or her recommendation.
32 Nothing in this subdivision shall be construed to require
33 the insurer to pay for the services of a noncontracting
34 physician, provided pursuant to this subdivision, that are
35 not otherwise covered pursuant to the contract.

36 (4) The insured has been denied coverage by the
37 insurer for a drug, device, procedure, or other therapy
38 recommended or requested pursuant to paragraph (3),
39 unless coverage for the specific therapy has been
40 excluded by the plan contract.



1 (5) This section does not apply to any Medi-Cal
2 beneficiary enrolled with an insurer under the insurer's
3 contract with the Medi-Cal program.

4 (6) The specific drug, device, procedure, or other
5 therapy recommended pursuant to paragraph (3) would
6 be a covered service except for the plan's determination
7 that the therapy is experimental or under investigation.

8 (b) The insurer's external, independent review shall
9 meet the following criteria:

10 (1) The insurer shall offer all insureds who meet the
11 criteria in subdivision (a) the opportunity to have the
12 requested therapy reviewed under the external,
13 independent review process. The insurer shall notify
14 eligible insureds in writing of the opportunity to request
15 the external independent review within five business
16 days of the decision to deny coverage.

17 (2) The insurer shall contract with one or more
18 impartial, independent entities that are accredited
19 pursuant to subdivision (c). The entity shall arrange for
20 review of the coverage decision by selecting an
21 independent panel of at least three physicians or other
22 providers who are experts in the treatment of the
23 insured's medical condition and knowledgeable about
24 the recommended therapy. If the entity is an academic
25 medical center accredited in accordance with subdivision
26 (e), the independent panel may include experts affiliated
27 with or employed by the entity. A panel of two experts
28 may be arranged at the insurer's request, provided the
29 insured consents in writing. The independent entity may
30 arrange for a panel of one expert only if the independent
31 entity certifies in writing that there is only one expert
32 qualified and able to review the recommended therapy.
33 Neither the insurer nor the insured shall choose or control
34 the choice of the physician or other provider experts.

35 (3) Neither the expert, nor the independent entity,
36 nor any officer, director, or management employee of the
37 independent entity may have any material professional,
38 familial, or financial affiliation, as defined in paragraph
39 (4), with any of the following:

40 (A) The insurer.



1 (B) Any officer, director, or management employee of
2 the insurer.

3 (C) The physician, the physician's medical group, or
4 the independent practice association (IPA) proposing
5 the therapy.

6 (D) The institution at which the therapy would be
7 provided.

8 (E) The development or manufacture of the principal
9 drug, device, procedure, or other therapy proposed for
10 the insured whose treatment is under review.

11 (4) For purposes of this section, the following terms
12 have the following meanings:

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

16 (B) "Material professional affiliation" means any
17 physician-patient relationship, any partnership or
18 employment relationship, a shareholder or similar
19 ownership interest in a professional corporation, or any
20 independent contractor arrangement that constitutes a
21 material financial affiliation with any expert or any officer
22 or director of the independent entity. The term "material
23 professional affiliation" does not include affiliations that
24 are limited to staff privileges at a health facility.

25 (C) "Material financial affiliation" means any financial
26 interest of more than 5 percent of total annual revenue
27 or total annual income of an entity or individual to which
28 this subdivision applies. "Material financial affiliation"
29 does not include payment by the insurer to the
30 independent entity for the services required by this
31 section, nor does "material financial affiliation" include
32 an expert's participation as a contracting provider for the
33 insurer where the expert is affiliated with an academic
34 medical center or a National Cancer Institute-designated
35 clinical cancer research center.

36 (5) The insured shall not be required to pay for the
37 external independent review. The costs of the review
38 shall be borne by the insurer.

39 (6) The insurer shall provide to the independent
40 entity arranging for the panel of experts a copy of the



1 following documents within five business days of the
2 insurer's receipt of a request by an insured or insured's
3 physician for an external independent review.

4 (A) The medical records relevant to the patient's
5 condition for which the proposed therapy has been
6 recommended, provided the documents are within the
7 insurer's possession. Any medical records provided to the
8 insurer after the initial documents are provided to the
9 independent entity shall be forwarded by the insurer to
10 the independent entity within five business days. The
11 confidentiality of the medical records shall be maintained
12 pursuant to Section 56.10 of the Civil Code.

13 (B) A copy of any relevant documents used by the
14 insurer in determining whether the proposed therapy
15 should be covered, and any statement by the insurer
16 explaining the reasons for the insurer's decision not to
17 provide coverage for the proposed therapy. The insurer
18 shall provide, upon request, a copy of the documents
19 required by this paragraph, except for the documents
20 described in paragraphs (A) and (C), to the insured and
21 the insured's physician.

22 (C) Any information submitted by the insured or the
23 insured's physician to the insurer in support of the
24 insured's request for coverage of the proposed drug,
25 device, procedure, or other therapy.

26 (7) The experts on the panel shall render their
27 analyses and recommendations within 30 days of the
28 receipt of the insured's request for review. If the insured's
29 physician determines that the proposed therapy would
30 be significantly less effective if not promptly initiated, the
31 analyses and recommendations of the experts on the
32 panel shall be rendered within seven days of the request
33 for expedited review. At the request of the expert, the
34 deadline shall be extended by up to three days for a delay
35 in providing the documents required by paragraph (6) of
36 subdivision (b).

37 (8) Each expert's analysis and recommendation shall
38 be in written form and state the reasons the requested
39 therapy is or is not likely to be more beneficial for the
40 insured than any available standard therapy, and the



1 reasons that the expert recommends that the therapy
2 should or should not be covered by the insurer, citing the
3 insured's specific medical condition, the relevant
4 documents provided pursuant to paragraph (6), and the
5 relevant medical and scientific evidence, including, but
6 not limited to, the medical and scientific evidence as
7 defined in subdivision (d), to support the expert's
8 recommendation.

9 (9) The independent entity shall provide the insurer
10 and the insured's physician with the expert's analyses and
11 recommendations, a description of the qualifications of
12 each expert, and any other information that it chooses to
13 provide to the insurer and the insured's physician,
14 including, but not limited to, the names of the expert
15 reviewers. The independent entity shall not be required
16 to disclose the names of the expert reviewers to the
17 insurer or to the insured's physician, except pursuant to
18 a properly made request for discovery. If the
19 independent entity chooses to disclose the names of the
20 experts on the panel to the insurer, the independent
21 entity must also disclose the names of the experts to the
22 insured's physician. The insured's physician may provide
23 these documents and information to the enrollee.

24 (10) If the majority of experts on the panel
25 recommend providing the proposed therapy, pursuant to
26 paragraph (8), the recommendation shall be binding on
27 the insurer. If the recommendations of the experts on the
28 panel are evenly divided as to whether the therapy
29 should be provided, then the panel's decision shall be
30 deemed to be in favor of coverage. If less than a majority
31 of the experts on the panel recommend providing the
32 therapy, the insurer is not required to provide the
33 therapy. Coverage for the services required under this
34 section shall be provided subject to the terms and
35 conditions generally applicable to other benefits under
36 the contract.

37 (11) The insurer shall have written policies describing
38 the external, independent review process. The insurer
39 shall disclose the availability of the external, independent
40 review process and how insureds may access the review



1 process in the insurer's evidence of coverage and
2 disclosure forms.

3 (c) The Commissioner of Corporations, in
4 consultation with the Insurance Commissioner, shall
5 contract with a private, nonprofit accrediting
6 organization to accredit the independent review entities
7 specified in subdivision (b). The accrediting organization
8 shall have the power to grant and revoke accreditation,
9 and shall develop, apply, and enforce accreditation
10 standards, including those required in subdivision (e),
11 that ensure the independence of the independent review
12 entity, the confidentiality of the medical records, and the
13 qualifications and independence of the health care
14 professionals providing the analyses and
15 recommendations requested of them. The accrediting
16 organization shall demonstrate the ability to objectively
17 evaluate the performance of independent entities and
18 shall demonstrate that it has no conflict of interest,
19 including any material professional, familial, or financial
20 affiliation as defined in paragraph (4) of subdivision (b)
21 with any independent entity or disability insurer, in
22 accrediting entities for the purpose of reviewing medical
23 treatments, treatment recommendations, and coverage
24 decisions by disability insurers.

25 (d) For the purposes of paragraph (3) of subdivision
26 (a), "medical and scientific evidence" means the
27 following sources:

28 (1) Peer-reviewed scientific studies published in or
29 accepted for publication by medical journals that meet
30 nationally recognized requirements for scientific
31 manuscripts and that submit most of their published
32 articles for review by experts who are not part of the
33 editorial staff.

34 (2) Peer-reviewed literature, biomedical compendia,
35 and other medical literature that meet the criteria of the
36 National Institute of Health's National Library of
37 Medicine for indexing in Index Medicus, Excerpta
38 Medicus (EMBASE), Medline and MEDLARS data base
39 Health Services Technology Assessment Research
40 (HSTAR).



1 (3) *Medical journals recognized by the Secretary of*
2 *Health and Human Services, under Section 1861(t)(2) of*
3 *the Social Security Act.*

4 (4) *The following standard reference compendia: The*
5 *American Hospital Formulary Service-Drug*
6 *Information, the American Medical Association Drug*
7 *Evaluation, the American Dental Association Accepted*
8 *Dental Therapeutics, and the United States*
9 *Pharmacopoeia-Drug Information.*

10 (5) *Findings, studies, or research conducted by or*
11 *under the auspices of federal government agencies and*
12 *nationally recognized federal research institutes,*
13 *including the Federal Agency for Health Care Policy and*
14 *Research, National Institutes of Health, National Cancer*
15 *Institute, National Academy of Sciences, Health Care*
16 *Financing Administration, Congressional Office of*
17 *Technology Assessment, and any national board*
18 *recognized by the National Institutes of Health for the*
19 *purpose of evaluating the medical value of health*
20 *services.*

21 (6) *Peer-reviewed abstracts accepted for presentation*
22 *at major medical association meetings.*

23 (e) *In order to receive accreditation for the purposes*
24 *of this section, an independent entity shall meet all of the*
25 *following requirements:*

26 (1) *The independent entity must be an organization*
27 *that has as its primary function the provision of expert*
28 *reviews and related services and receives a majority of its*
29 *revenues from these services, except that an academic*
30 *medical center may qualify as an independent entity for*
31 *purposes of this act without meeting either of these*
32 *criteria. An independent entity may not be a subsidiary*
33 *of, nor in any way owned or controlled by, a health plan,*
34 *a trade association of health plans, or a professional*
35 *association of health care providers.*

36 (2) *The independent entity must submit to the*
37 *accrediting organization and to the Department of*
38 *Corporations the following information upon initial*
39 *application for accreditation and annually thereafter*
40 *upon any change to any of the following information:*

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

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

6 (C) The names of all corporations and organizations
7 that the independent entity controls or is affiliated with,
8 and the nature and extent of any ownership or control,
9 including the affiliated organization's type of business.

10 (D) The names and biographical sketches of all
11 directors, officers, and executives of the independent
12 entity, as well as a statement regarding any relationships
13 the directors, officers, and executives may have with any
14 health care service plan, disability insurer, managed care
15 organization, provider group, or board, or committee.

16 (E) The percentage of revenue the independent
17 entity receives from expert reviews.

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

21 (G) A description of the system the independent
22 entity uses to identify and recruit expert reviewers, the
23 number of expert reviewers credentialed, and the types
24 of cases the experts are credentialed to review.

25 (H) Documentation regarding the medical
26 institutions from which the independent entity has
27 selected the experts during the previous 12 months, and
28 the percentage of opinions obtained from each
29 institution.

30 (I) A description of the areas of expertise available
31 from expert reviewers retained by the independent
32 entity.

33 (J) A description of how the independent entity
34 ensures compliance with the conflict-of-interest
35 provisions of this section.

36 (3) The independent entity must demonstrate that it
37 has a quality assurance mechanism in place that does the
38 following:

39 (A) Ensures that the experts retained are
40 appropriately credentialed and privileged.



1 (B) Ensures that the reviews provided by the experts
2 are timely, clear and credible, and that reviews are
3 monitored for quality on an ongoing basis.

4 (C) Ensures that the method of selecting expert
5 reviewers for individual cases achieves a fair and
6 impartial panel of experts who are qualified to render
7 recommendations regarding the clinical conditions and
8 therapies in question.

9 (D) Ensures the confidentiality of medical records
10 and the review materials, consistent with the
11 requirements of this section.

12 (E) Ensures the independence of the experts retained
13 to perform the reviews through conflict-of-interest
14 policies and prohibitions and adequate screening for
15 conflicts of interest, pursuant to paragraph (3) of
16 subdivision (b).

17 (f) (1) The Department of Corporations shall receive
18 the information filed by independent entities pursuant to
19 paragraph (2) of subdivision (e) for the purpose of
20 creating a file of public records. The Department of
21 Corporations shall not be responsible for accrediting
22 independent entities.

23 (2) The accrediting organization shall provide, upon
24 the request of any interested person, a copy of all
25 nonproprietary information filed with it by the
26 independent entity under paragraph (2) of subdivision
27 (e). The accrediting organization may charge a
28 reasonable fee to the interested person for photocopying
29 the requested information.

30 (g) The independent review process established by
31 this section shall be required on and after July 1, 2004.

32 (h) This section shall become operative on January 1,
33 2004.

34 SEC. 12. Article 2.55 (commencing with Section
35 10145.80) is added to Chapter 1 of Part 2 of Division 2 of
36 the Insurance Code, to read:
37



1 Article 2.55. Appeals Seeking Independent Review

2

3 10145.80. (a) Commencing January 1, 2001, there is
4 established in the department the Independent Review
5 System.

6 (b) For the purposes of this article, “disputed health
7 care service” means any health care service that would
8 otherwise be a covered benefit under a disability
9 insurance policy that has been denied, significantly
10 delayed, terminated, or otherwise limited by a decision of
11 the insurer, or by one of its contracting providers, based,
12 in whole or in part, on a finding that the service is not
13 medically necessary or appropriate for the enrollee’s
14 medical condition.

15 (c) For the purposes of this article, “other adverse
16 decision” means the denial, significant delay,
17 termination, or the imposition of other limits on health
18 care services by an insurer, or by one of its contracting
19 entities, for reasons other than those in subdivision (b).

20 (d) All insured grievances involving a disputed health
21 care service or other adverse decision are eligible for
22 review under the Independent Review System if the
23 requirements of this article are met.

24 (e) No later than January 1, 2001, every disability
25 insurer that covers hospital, medical, or surgical benefits
26 shall provide an insured with the opportunity to seek an
27 independent review for unresolved grievances that
28 involve a disputed health care service or other adverse
29 decision. The insured’s provider may join with or
30 otherwise assist the insured to seek an independent
31 medical review, and may advocate on behalf of the
32 insured.

33 (f) Every disability insurance policy that is issued,
34 amended, renewed, or delivered in this state on or after
35 January 1, 2001, shall authorize insured participation in
36 the Independent Review System.

37 (g) Medicare and Medi-Cal beneficiaries covered by a
38 disability insurance policy shall not be excluded from
39 participation in the Independent Review System. The
40 department shall seek to integrate the quality of care and



1 consumer protection provisions, including remedies, of
2 the Independent Review System with related dispute
3 resolution procedures of other health care agency
4 programs, including the Medicare and Medi-Cal
5 programs, in a way that minimizes the potential for
6 duplication, conflict, and added costs. Nothing in this
7 subdivision shall be construed to limit any rights
8 conferred upon insureds under this article. However, the
9 application of this subdivision to a Medicare beneficiary
10 shall not apply in the event, and to the extent, that
11 application is judicially determined to be preempted by
12 federal law.

13 (h) The independent review process authorized by
14 this article is in addition to any other procedures or
15 remedies that may be available. The insured's election to
16 either pursue or not pursue, exhaust, or engage in the
17 procedures described in this article does not preclude the
18 use of any other remedy provided by law and shall not be
19 relevant in any subsequent civil or administrative
20 proceeding.

21 (i) No later than January 1, 2001, every disability
22 insurer that covers hospital, medical, or surgical benefits
23 shall prominently display in every insurer contract, on
24 insured and subscriber evidence of coverage forms, on
25 grievance forms, and on all written notices to insureds
26 required under any grievance process of the insurer,
27 including any written communications to an insured that
28 offer the insured the opportunity to participate in any
29 grievance process of the insurer, and on all written
30 responses to grievances, information concerning the
31 right of an insured to request an independent review in
32 cases where the insured believes that health care services
33 have been improperly denied, significantly delayed,
34 terminated, or otherwise limited by the insurer, or by one
35 of its contracting providers. Insureds shall be notified of
36 the availability of a standard application form to request
37 an independent review.

38 (j) The department shall develop a standard
39 application form for independent review that shall be
40 used by each insurer. An insured may apply for an

1 independent review when all of the following conditions
2 are met:

3 (1) The grievance involves a disputed health care
4 service or other adverse decision and the insured first
5 sought the health care service that is the subject of the
6 grievance from a participating provider, except that the
7 requirement to have first sought care from a participating
8 provider shall not apply in cases involving emergency
9 services or out-of-network urgent care.

10 (2) The health care service was denied, significantly
11 delayed, terminated, or otherwise limited by the insurer,
12 or by one of its contracting providers, or in cases involving
13 emergency services or urgent out-of-network care where
14 the insurer did not first seek care from a participating
15 provider, the plan has denied reimbursement for the
16 reasonable costs of securing that care.

17 (3) The insured has filed a grievance with the insurer
18 or its contracting provider, and the disputed decision is
19 upheld or the grievance remains unresolved after 30 days,
20 if the insurer has a grievance process. The insured shall
21 not be required to participate in the insurer's grievance
22 process for more than 30 days. In the case of a grievance
23 that requires immediate referral to the Independent
24 Review System, the insured shall not be required to
25 participate in the insurer's grievance process.

26 (k) An insured may apply for an independent review
27 within 60 days of any of the qualifying periods or events
28 under subdivision (j), in a manner determined by the
29 commissioner. The commissioner may extend the
30 application deadline beyond 60 days if the circumstances
31 of a case warrant the extension. Each insurer shall notify
32 its insureds of the commissioner's authority to extend the
33 application deadline.

34 (l) As part of an appeal for an independent review, the
35 insured shall provide all of the following:

36 (1) A brief description of the insured's medical
37 condition for which health care services were denied,
38 significantly delayed, terminated, or otherwise limited, or
39 for which reimbursement for reasonable costs was
40 denied.



1 (2) If the grievance involves a disputed health care
2 service, an explanation of the reasons why the insured
3 believes that the disputed health care service is or was
4 medically necessary or appropriate for the insured's
5 medical condition. If the grievance involves one or more
6 other adverse decisions, an explanation of the reasons
7 why the insured believes the insurer's decision was
8 incorrect.

9 The insured shall be encouraged to also provide other
10 information supporting the insured's position as well as a
11 copy of all information provided to the insured by the
12 insurer or any of its contracting providers, still in the
13 possession of the insured, concerning an insurer or
14 provider decision regarding disputed health care services
15 and services related to other adverse decisions, and a copy
16 of any materials the insured submitted to the insurer, still
17 in the possession of the insured, in support of the
18 grievance, as well as any additional material that the
19 insured believes is relevant.

20 (3) A written consent to obtain any necessary medical
21 records from the insurer, any of its contracting providers,
22 and any out-of-network provider the insured may have
23 consulted on the matter.

24 (m) (1) Upon receipt of an insured appeal for an
25 independent review, the insurer or its contracting
26 providers shall provide the independent review
27 organization a copy of all of the following documents
28 within three business days of the insurer's receipt of the
29 request by an insured for an independent review:

30 (A) A copy of all of the insured's medical records in the
31 possession of the insurer or its contracting providers
32 relevant to each of the following:

33 (i) The insured's medical condition that is the subject
34 of the independent review.

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

37 (iii) The health care services requested by the insurer
38 for the condition.

39 Any newly developed or discovered relevant medical
40 records in the possession of the insurer or its contracting



1 providers after the initial documents are provided shall
2 be forwarded immediately to the independent review
3 organization. The insurer shall concurrently provide a
4 copy of medical records required by this subparagraph to
5 the insured or the insured's provider unless the offer of
6 medical records is declined or otherwise prohibited by
7 law. The confidentiality of all medical record information
8 shall be maintained pursuant to applicable state and
9 federal laws.

10 (B) A copy of all information provided to the insured
11 by the insurer and any of its contracting providers
12 concerning insurer and provider decisions in response to
13 the grievance, and a copy of any materials the insured or
14 the insured's provider submitted to the insurer and to the
15 insurer's contracting providers in support of the insured's
16 grievance. This documentation shall include a written
17 response to the insured's grievance including a
18 description of the criteria used and the clinical reasons for
19 the decision, including all criteria and clinical reasons
20 related to medical necessity or appropriateness. The
21 confidentiality of all medical record information shall be
22 maintained pursuant to applicable state and federal laws.

23 (C) A copy of any other relevant documents or
24 information used by the insurer or its contracting
25 providers in determining whether disputed health care
26 services or services subject to one or more other adverse
27 decisions should have been provided, and any statements
28 by the insurer and its contracting providers explaining
29 the reasons for the decision not to provide the services on
30 the basis of medical necessity or appropriateness, or for
31 any other reason. The insurer shall concurrently provide
32 a copy of documents required by this subparagraph,
33 except for any information found by the commissioner to
34 be legally privileged information, to the insured and the
35 insured's provider. The department and the independent
36 review organization shall maintain the confidentiality of
37 any information found by the commissioner to be the
38 proprietary information of the insurer.

39 (2) The provisions of paragraph (1) requiring the
40 referral of a grievance and related documents to an



1 independent review organization shall not apply in cases
2 where the insurer files a written objection with the
3 department and the insured, within three days of
4 receiving a request for independent review, stating its
5 belief that the requested appeal:

6 (A) Does not meet the eligibility requirements for
7 independent review.

8 (B) Is frivolous and without merit.

9 (C) Is deficient due to both subparagraphs (A) and
10 (B).

11 The written objection to the department shall be
12 accompanied by a copy of the entire grievance record.
13 The department shall establish an expedited process,
14 which shall not exceed three days from receipt of an
15 objection unless an extension is requested by the insured,
16 for reviewing these cases and notifying the insured of its
17 decision. If there is an imminent and serious threat to the
18 health of the insured, as defined in subdivision (d) of
19 Section 10145.83, the department shall accelerate its
20 review of the objection. If the department disagrees with
21 the insurer's objection, the grievance shall be referred
22 immediately to an independent review organization. If
23 the department agrees with the insurer, the grievance
24 shall immediately be treated as a request for the
25 department to review the grievance. The department
26 shall consider the entire grievance record, as well as any
27 material submitted by the insured and the insured's
28 providers, when making its decision regarding an
29 objection.

30 10145.81. (a) Except in cases involving an insurer
31 objection submitted to the department, upon receipt of
32 an insured's request for an independent review, the
33 insurer shall assign the request to an independent review
34 organization as described in Section 10145.82 in
35 accordance with any regulations or orders of the
36 commissioner when the insured has complied with the
37 requirements of subdivisions (j), (k), and (l) of Section
38 10145.80.

39 (b) The independent review organization, which shall
40 be selected by the department based on selection criteria



1 developed by the department, shall conduct the review
2 in accordance with Section 10145.83 and any regulations
3 or orders of the commissioner adopted pursuant thereto.

4 10145.82. (a) By January 1, 2001, the commissioner
5 shall make every effort to contract with one or more
6 independent review organizations in the state to conduct
7 reviews for purposes of this article. The independent
8 review organizations shall be accredited pursuant to this
9 article and shall be independent of any disability insurer
10 doing business in this state. Prior to July 1, 2000, the
11 commissioner, after public notice, hearings, and
12 comment, shall adopt regulations to ensure the
13 independence of these organizations. The regulations
14 shall include conflict-of-interest standards, consistent
15 with the purposes of this article, that an organization shall
16 be required to meet in order to qualify for participation
17 in the Independent Review System.

18 (b) (1) The independent review organization, any
19 experts it designates to conduct a review, or any officer,
20 director, or employee of the independent entity shall
21 have no material professional, familial, or financial
22 affiliation, as determined by the commissioner, with any
23 of the following:

24 (A) The insurer.

25 (B) Any officer, director, or employee of the insurer.

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

29 (D) The institution at which either the proposed
30 health care service, or the alternative service, if any,
31 recommended by the insurer, would be provided.

32 (E) The development or manufacture of the principal
33 drug, device, procedure, or other therapy proposed by
34 the insured whose treatment is under review, or the
35 alternative therapy, if any, recommended by the insurer.

36 (c) The commissioner shall, by July 1, 2000, contract
37 with a private, nonprofit accrediting organization to
38 accredit the independent review organizations described
39 in subdivision (a). The accrediting organization may
40 grant and revoke accreditation, and shall develop, apply,



1 and enforce accreditation standards that ensure the
2 independence of the independent review organization,
3 the confidentiality of the medical records, and the
4 qualifications and independence of the health care
5 professionals and other experts providing the analyses
6 and recommendations requested of them. The
7 accrediting organization shall demonstrate the ability to
8 objectively evaluate the performance of independent
9 review organizations and shall demonstrate that it has no
10 conflict of interest, including any material professional,
11 familial, or financial affiliation, as provided in subdivision
12 (b), with any independent review organization or
13 insurer, in accrediting those organizations for the
14 purpose of reviewing disputed health care decisions and
15 other adverse decisions made by disability insureds.

16 (d) Prior to July 1, 2000, the commissioner, after public
17 notice, hearings, and comment, shall adopt regulations
18 related to the accreditation of independent review
19 organizations. In developing the regulations required by
20 this subdivision, the department shall consider adopting
21 the following, but may accept, reject, or modify the
22 following based on information received as a result of the
23 rulemaking process. If the department rejects or modifies
24 any of the following, it shall discuss its reasons for doing
25 so in the final rulemaking document. In order to receive
26 accreditation for the purposes of this section, an
27 independent review organization shall meet all of the
28 following requirements:

29 (1) An independent review organization shall not be
30 an affiliate or a subsidiary of, nor in any way be owned or
31 controlled by, a disability insurer, or a trade association of
32 disability insurers. A board member, director, officer, or
33 employee of the independent review organization shall
34 not serve as a board member, director, or employee of a
35 disability insurer. A board member, director, or officer of
36 a disability insurer, or a trade association of disability
37 insurers, shall not serve as a board member, director,
38 officer, or employee of an independent review
39 organization.



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

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

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

12 (C) *The names of all corporations and organizations*
13 *that the independent review organization controls or is*
14 *affiliated with, and the nature and extent of any*
15 *ownership or control, including the affiliated*
16 *organization's type of business.*

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

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

29 (ii) *The names of any disability insurer or provider*
30 *group for which the independent review organization*
31 *provides review services, including, but not limited to,*
32 *utilization review, quality assurance review, and external*
33 *medical review. Any change in this information shall be*
34 *reported to the department within five business days of*
35 *the change.*

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

39 (G) *A description of the system the independent*
40 *review organization uses to identify and recruit medical*



1 *professionals and other experts to review disputed health*
2 *care decisions and other adverse decisions made by*
3 *disability insurers, the number of medical professionals*
4 *credentialed, and the types of cases and areas of expertise*
5 *which the medical professionals are credentialed to*
6 *review, and the number of other experts, the types of*
7 *cases and areas of expertise which those other experts are*
8 *licensed or credentialed to review.*

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

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

15 *(A) Ensures that the medical professionals retained*
16 *are appropriately credentialed and privileged and that*
17 *the other experts retained are appropriately qualified,*
18 *licensed, and credentialed.*

19 *(B) Ensures that the reviews provided by the medical*
20 *professionals and other experts are timely, clear, and*
21 *credible, and that reviews are monitored for quality on an*
22 *ongoing basis.*

23 *(C) Ensures that the method of selecting medical*
24 *professionals and other experts for individual cases*
25 *achieves a fair and impartial panel of medical*
26 *professionals and other experts who are qualified to*
27 *render recommendations regarding disputed health care*
28 *decisions and other adverse decisions made by disability*
29 *insurers.*

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

34 *(E) Ensures the independence of the medical*
35 *professionals and other experts retained to perform the*
36 *reviews through conflict-of-interest policies and*
37 *prohibitions, and ensures adequate screening for conflicts*
38 *of interest, pursuant to paragraph (5).*

39 *(4) Medical professionals selected by independent*
40 *review organizations to review medical treatment*



1 *decisions shall be physicians or other appropriate*
2 *providers who meet the following minimum*
3 *requirements:*

4 *(A) The medical professional shall be a clinician*
5 *knowledgeable in the treatment of the insured's medical*
6 *condition, knowledgeable about the proposed treatment,*
7 *and familiar with guidelines, protocols, and the criteria*
8 *set forth in subdivision (b) of Section 10145.83 in the area*
9 *of treatment under review.*

10 *(B) The medical professional shall hold a*
11 *nonrestricted license in the State of California, and for*
12 *physicians, a current certification by a recognized*
13 *American medical specialty board in the area or areas*
14 *appropriate to the condition or treatment under review.*
15 *For good cause shown, such as the unavailability of*
16 *licensed qualified medical professionals in California or*
17 *the availability of uniquely qualified clinics outside of*
18 *California, the independent review organization may*
19 *utilize a medical professional who holds a nonrestricted*
20 *license in any state of the United States, provided that the*
21 *out-of-state medical professional is knowledgeable about*
22 *the treatment standards required in California and*
23 *applies those standards.*

24 *(C) The medical professional and other experts shall*
25 *have no history of disciplinary action or sanctions,*
26 *including, but not limited to, loss of staff privileges or*
27 *participation restrictions, taken or pending by any*
28 *hospital, government, or regulatory body.*

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

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

39 *(B) Any officer, director, or management employee of*
40 *the insurer.*



1 (C) *The physician, the physician’s medical group, or*
2 *the independent practice association (IPA) proposing*
3 *the treatment.*

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

6 (E) *The development or manufacture of the*
7 *treatment proposed for the insured whose condition is*
8 *under review.*

9 (F) *The insured or the insured’s immediate family.*

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

12 (A) *“Material familial affiliation” means any*
13 *relationship as a spouse, child, parent, sibling, spouse’s*
14 *parent, or child’s spouse.*

15 (B) *“Material professional affiliation” means any*
16 *physician-patient relationship, any partnership or*
17 *employment relationship, a shareholder or similar*
18 *ownership interest in a professional corporation, or any*
19 *independent contractor arrangement that constitutes a*
20 *material financial affiliation with any expert or any officer*
21 *or director of the independent review organization.*
22 *“Material professional affiliation” does not include*
23 *affiliations that are limited to staff privileges at a health*
24 *facility.*

25 (C) *“Material financial affiliation” means any financial*
26 *interest of more than 5 percent of total annual revenue*
27 *or total annual income of an independent review*
28 *organization or individual to which this subdivision*
29 *applies. “Material financial affiliation” does not include*
30 *payment by the insurer to the independent review*
31 *organization for the services required by this section, nor*
32 *does “material financial affiliation” include an expert’s*
33 *participation as a contracting insurer provider where the*
34 *expert is affiliated with an academic medical center or a*
35 *National Cancer Institute-designated clinical cancer*
36 *research center.*

37 (e) *The accrediting organization shall provide, upon*
38 *the request of any interested person, a copy of all*
39 *nonproprietary information, as determined by the*
40 *commissioner, filed with it by an independent review*



1 organization seeking accreditation under this article. The
2 accrediting organization may charge a nominal fee to the
3 interested person for photocopying the requested
4 information.

5 (f) The independent review process established by
6 this article shall not commence until one or more
7 independent review organizations have been accredited
8 and have executed a contract with the department
9 pursuant to this section.

10 10145.83. (a) Upon receipt of information and
11 documents related to a case pursuant to subdivision (c)
12 of Section 10145.81, the expert reviewer or reviewers
13 selected to conduct the review by the independent
14 review organization shall promptly review all pertinent
15 medical records of the insured and provider reports, as
16 well as any other information submitted to the
17 organization as authorized by the department or
18 requested from any of the parties to the dispute by the
19 reviewers. If reviewers request information from any of
20 the parties, a copy of the request and the response shall
21 be provided to all of the parties.

22 (b) (1) Following its review of a grievance involving
23 a disputed health care service, the medical expert
24 reviewer or reviewers shall determine and state whether
25 the disputed health care service is or was medically
26 necessary or appropriate based on:

27 (A) Generally accepted practice guidelines
28 developed by federal agencies, nationally recognized
29 federal research institutes, or national professional
30 medical specialty societies.

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

34 (C) Generally accepted standards of medical practice.

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

38 (2) Medically necessary or appropriate health care
39 services shall include those related to treatment or



1 *therapy to maximize functional capacity. This subdivision*
2 *is to be construed in the best interests of the insured.*

3 *(c) Following its review of a grievance involving one*
4 *or more other adverse decisions, the expert reviewer or*
5 *reviewers shall determine and state whether the decision*
6 *to deny, significantly delay, terminate, or otherwise*
7 *impose limits on health care services was reasonable*
8 *taking into consideration, among other relevant*
9 *information, all of the provisions of the insured's policy.*

10 *(d) The independent review organization shall*
11 *require its expert reviewers to complete a review and*
12 *make a determination in writing, and in layperson's terms*
13 *to the maximum extent practicable, within 30 days of the*
14 *receipt by the independent review organization of the*
15 *application for review and supporting documentation, or*
16 *within less time as prescribed by the commissioner. If a*
17 *requested health care service that is the subject of the*
18 *grievance has not been provided and the insured's*
19 *provider or the department certifies in writing that an*
20 *imminent and serious threat to the health of the insured*
21 *may exist, including, but not limited to, severe pain, the*
22 *potential loss of life, limb, or major bodily function, or the*
23 *immediate and serious deterioration of the health of the*
24 *insured, the analyses and determinations of the reviewers*
25 *shall be expedited and rendered within three days of the*
26 *certification notice. Subject to the approval of the*
27 *department, the deadlines for analyses and*
28 *determinations involving both regular and expedited*
29 *reviews may be extended by up to three days following*
30 *reviewer receipt of delayed documentation required by*
31 *this article.*

32 *(e) Each analysis shall cite the insured's medical*
33 *condition and the relevant documents in the record to*
34 *support the determination.*

35 *(f) In cases involving disputed health care services,*
36 *each analysis shall cite relevant findings associated with*
37 *the provisions of subdivision (b). If more than one*
38 *medical expert reviews the case, the recommendation of*
39 *the majority shall prevail. If the medical experts*
40 *reviewing the case are evenly split as to whether the*



1 *disputed health care service is or was medically necessary*
2 *or appropriate, the decision shall be in favor of the*
3 *insured.*

4 (g) *In cases related to a grievance involving one or*
5 *more other adverse decisions, if more than one expert*
6 *reviews the case, the recommendation of the majority*
7 *shall prevail. If the experts reviewing the case are evenly*
8 *split as to whether it was reasonable to deny, significantly*
9 *delay, terminate, or otherwise impose limits on health*
10 *care services, the decision shall be in favor of the insured.*

11 (h) *The independent review organization shall*
12 *provide the commissioner with the analyses and*
13 *determinations of the experts reviewing the case, a*
14 *description of the qualifications of the experts, and the*
15 *names of the reviewers. If more than one expert reviewed*
16 *the case and the result was differing determinations, the*
17 *independent review organization shall provide the*
18 *commissioner with each of the separate reviewer*
19 *analyses and determinations.*

20 (i) *The commissioner, except in cases subject to*
21 *expedited reconsideration under subdivision (j), shall*
22 *immediately adopt the determination of the*
23 *independent review organization, and shall promptly*
24 *issue a written decision to the parties, which decision shall*
25 *be binding on the plan as an order.*

26 (j) *The commissioner may request the independent*
27 *review organization, on an expedited basis, to reconsider*
28 *any determination involving one or more other adverse*
29 *decisions when the commissioner finds that the*
30 *determination is clearly contrary to the legal*
31 *requirements of this article or other laws. If after*
32 *reconsideration, the independent review organization*
33 *renders a determination that the commissioner finds*
34 *remains clearly contrary to the legal requirements of this*
35 *article or other law, the commissioner shall forward the*
36 *determination to the parties, along with the*
37 *commissioner's finding, and the disputed portion of the*
38 *determination involving one or more other adverse*
39 *decisions shall not be binding.*



1 (k) Nothing about the independent review process
2 established by this article, including, but not limited to,
3 the analysis, recommendations, and conclusions of the
4 review panel, shall be admissible in any subsequent
5 proceeding.

6 (l) After removing the names of the parties, including,
7 but not limited to, the insured, all medical providers, the
8 insurer, and any of its employees or contractors,
9 commissioner orders adopting a determination of an
10 independent review organization shall be made available
11 by the department to the public upon request, at the
12 department's cost.

13 10145.84. (a) Upon receiving the order adopted by
14 the commissioner pursuant to subdivision (i) or (j) of
15 Section 10145.83, the insurer shall immediately contact
16 the insured and offer to promptly implement the order.

17 (b) In any case where an insured secured urgent care
18 or emergency services outside of the insurer provider
19 network, and these services are later found by the
20 independent review organization to have been a covered
21 benefit under the terms and conditions of the disability
22 insurance policy and were medically necessary or
23 appropriate, the commissioner shall require the insurer
24 to promptly reimburse the insured for any reasonable
25 costs associated with those services when the
26 commissioner finds that the insured's decision to secure
27 the services outside of the insurer network prior to
28 seeking an independent review was reasonable under the
29 circumstances.

30 (c) In addition to requiring insurer compliance
31 regarding subdivisions (a) and (b), the commissioner
32 shall review individual cases submitted for independent
33 review to determine whether any enforcement actions,
34 including penalties, may be appropriate. In particular,
35 where harm to an insured has already occurred because
36 of the decision of an insurer, or one of its contracting
37 providers, to deny, significantly delay, terminate, or
38 otherwise limit covered health care services that an
39 independent review determines to be medically



1 *necessary or appropriate, the commissioner shall impose*
2 *penalties.*

3 *(d) The commissioner shall periodically evaluate*
4 *independent review cases to determine if any audit,*
5 *investigative, or enforcement actions should be*
6 *undertaken by the department, particularly if an insurer*
7 *repeatedly fails to act promptly and reasonably to resolve*
8 *grievances associated with a denial, significant delay,*
9 *termination, or the imposition of other limits on*
10 *medically necessary or appropriate health care services*
11 *when the obligation of the insurer to provide those health*
12 *care services to insureds is reasonably clear.*

13 *10145.85. (a) After considering the results of a*
14 *competitive bidding process and any other relevant*
15 *information on program costs, the commissioner shall*
16 *establish a reasonable, per-case reimbursement schedule*
17 *to pay the costs of independent review organization*
18 *reviews, which may vary depending on the type of*
19 *medical condition under review and on other relevant*
20 *factors.*

21 *(b) As a condition of receiving payments for reviews,*
22 *independent review organizations shall agree to provide*
23 *reasonable data required for an evaluation of the*
24 *independent review system.*

25 *10145.86. (a) On or before July 1, 2000, the*
26 *commissioner shall allocate grant funding for an*
27 *independent health care ombudsprogram. At a*
28 *minimum, the commissioner shall approve project grants*
29 *for at least one new or existing independent assistance*
30 *project in southern, central, and northern California if*
31 *qualified applicants apply from each of those three*
32 *regions. The number of projects approved shall*
33 *eventually be sufficient to provide independent*
34 *assistance to all California disability insurance insureds.*
35 *However, in order to facilitate the start-up and effective*
36 *implementation of this section, the commissioner may*
37 *take until July 1, 2002, if necessary, to fund a sufficient*
38 *number of projects to serve all California disability*
39 *insurance insureds.*



1 (b) Project activities shall include, but are not limited
2 to, providing counseling, advising, assisting, and
3 advocating for insureds at every stage of:

4 (A) The insurer grievance process.

5 (B) Applying for and participating in the Independent
6 Review System.

7 (c) All of the projects shall, as necessary and
8 appropriate, directly assist insureds in their dealings with
9 insurers, provider groups, providers, and government
10 agencies, including advocating on behalf of insureds in
11 any informal or formal proceeding.

12 (d) The commissioner shall use a competitive bidding
13 process to select projects. The projects shall be selected
14 based on, but not limited to, all of the following selection
15 criteria:

16 (1) The applicant's experience providing insureds
17 with education, counseling, and advocacy services.

18 (2) The number of insureds covered by health plans
19 served by the project and the size of the geographic
20 region to be served by the project.

21 (3) Evidence of an understanding of the range and
22 complexity of health care concerns likely to be raised by
23 insureds, including vulnerable populations served by
24 various insurers.

25 (4) The number and quality of staff with formal
26 training and experience in health care, counseling, and
27 consumer advocacy.

28 (5) The ability to complement, and not duplicate,
29 existing consumer services provided by insurers, other
30 independent assistance programs, and regulatory
31 assistance programs, which shall include a commitment
32 to refer insureds, as appropriate, to the Health Insurance
33 Counseling and Advocacy Program (HICAP) in cases
34 eligible for HICAP assistance.

35 (6) The commitment to collect and analyze data on
36 insured experiences in insurer grievance systems and in
37 the Independent Review System.

38 (7) The ability and commitment to provide significant
39 matching contributions to support the program in the



1 form of private or public financial support or in-kind
2 contributions, or a combination of the two.

3 (8) The commitment to provide project services to
4 insureds free of charge.

5 (9) The degree of consumer representation on the
6 applicant's governing advisory board, if a board exists.

7 (e) The evaluation of bids submitted pursuant to
8 subdivision (d) shall be conducted by the commissioner
9 in consultation with a panel of at least three individuals
10 screened and appointed by the commissioner who have
11 no conflicts of interest including, but not limited to, a
12 financial interest in the outcome of the bidding process,
13 or employment or contractual arrangements with
14 insurers, their contracting medical groups or contracting
15 providers, and who have significant experience with, and
16 knowledge about, managed health care issues, health
17 care dispute resolution mechanisms, and consumer
18 advocacy.

19 (f) Funding for the projects shall commence no earlier
20 than July 1, 2000, and may continue for a period extending
21 no later than December 31, 2003.

22 (g) As a condition of receiving funding, each of the
23 projects shall agree to provide reasonable data required
24 for an evaluation of the independent health care
25 ombudsprogram.

26 10145.87. (a) The costs of the independent review
27 system and independent health care ombudsprogram
28 shall be borne by disability insurers that cover hospital,
29 medical, or surgical benefits pursuant to an assessment
30 fee system established by the commissioner. Every
31 insurer subject to this article shall pay annually to the
32 department, on the date or dates set by the department,
33 its prorated share of fees, as determined by the
34 commissioner, to pay for the estimated annual costs
35 associated with carrying out, overseeing, and evaluating
36 the independent review system and independent health
37 care ombudsprogram. In determining the amount to be
38 assessed, the commissioner shall consider all existing
39 assessments and appropriations available for the support
40 of this chapter. The commissioner may adjust fees



1 upward or downward, on a schedule set by the
2 department, to address shortages or overpayments.

3 (b) The portion of the assessment fee imposed by
4 subdivision (a) to pay for the independent health care
5 ombudsprogram shall not apply to any insurer that is
6 funding and has in place by July 1, 2000, or thereafter, an
7 independent, external health care ombudsprogram
8 certified by the commissioner as substantially complying
9 with the selection criteria for eligibility utilized under
10 this chapter, and provided that the insurer
11 ombudsprogram agrees to collect and provide reasonable
12 data to the department and its evaluator in accordance
13 with subdivisions (a) and (b) of Section 10145.88. The
14 commissioner's certification review shall be done in
15 consultation with the panel established pursuant to
16 subdivision (e) of Section 10145.86.

17 (c) These funds shall be used for all costs reasonably
18 incurred in the administration of this article, including,
19 but not limited to, startup costs, overhead, department
20 administration, contracting with an accrediting
21 organization, contracts with independent review
22 organizations, payments to expert reviewers, grants for
23 ombudsprogram projects, and program evaluation.

24 10145.88. (a) The department shall contract with an
25 independent expert entity to undertake an evaluation of
26 the independent review system and the independent
27 health care ombudsprogram.

28 (b) The independent evaluation shall include, but not
29 be limited to, an assessment of the effectiveness and value
30 of the independent review system and the
31 ombudsprogram. The evaluation shall include a
32 description of assessments imposed on insurers to
33 implement these programs, changes in department
34 staffing attributable to these new programs, any increase,
35 reduction, or redirection of existing department staff as
36 a result of these new programs, and any changes in
37 department workload attributed to insured use of the
38 ombudsprogram and the referral of grievances to the
39 independent review system.

1 (c) The evaluation shall assess the long-term efficacy
2 of these programs as a means of providing timely and
3 effective resolution of insured grievances with insurers,
4 and for improving access to and the quality of health care
5 services, and as a catalyst for systemic improvements in
6 the delivery of health care services. In addition to
7 reviewing data generated by these new California
8 programs, the evaluator shall survey and report on similar
9 programs underway in other states.

10 (d) The evaluator shall provide its evaluation to the
11 department on or before January 1, 2003. The department
12 shall make a single copy of the evaluation available at no
13 cost to members of the public upon request. The
14 department may recover the cost of additional copies that
15 are requested. After holding a series of public hearings on
16 the evaluation, the department shall submit a report,
17 along with its own recommendations for continuing,
18 modifying, or terminating the independent review
19 system and the independent health care
20 ombudsprogram, to the Legislature by March 1, 2003. The
21 department shall make a single copy of its report
22 available at no cost to members of the public upon
23 request. The department may recover the cost of
24 additional copies that are requested.

25 10145.89. An insurer's coverage decision regarding
26 experimental or investigational therapies for individual
27 insureds shall be subject to this article.

28 10145.90. This article shall remain in effect only until
29 January 1, 2004, and as of that date is repealed, unless a
30 later enacted statute, that is enacted before January 1,
31 2004, deletes or extends that date.

32 SEC. 13. No reimbursement is required by this act
33 pursuant to Section 6 of Article XIII B of the California
34 Constitution because the only costs that may be incurred
35 by a local agency or school district will be incurred
36 because this act creates a new crime or infraction,
37 eliminates a crime or infraction, or changes the penalty
38 for a crime or infraction, within the meaning of Section
39 17556 of the Government Code, or changes the definition



1 of a crime within the meaning of Section 6 of Article
2 XIII B of the California Constitution.
3 ~~Notwithstanding Section 17580 of the Government~~
4 ~~Code, unless otherwise specified, the provisions of this act~~
5 ~~shall become operative on the same date that the act~~
6 ~~takes effect pursuant to the California Constitution.~~

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