

AMENDED IN SENATE MAY 18, 1999

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SENATE BILL

No. 254

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) 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.

Existing law provides for regulation of health care service plans 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 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 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 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 both commissioners, on or before July 1, 2000, ~~to allocate grant funding for an independent health care ombudsprogram.~~ It would require the departments to contract with independent expert entities to



undertake evaluations of the independent review systems—and the independent health care ombudsprograms. The bill would require the evaluators to provide their evaluation to the departments on or before January 1, 2003, a copy of which 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
- 10 maintain that this new program will enhance consumer
- 11 confidence in health plan decisionmaking.
- 12 (b) More than 15 states have enacted legislation
- 13 establishing independent review of health care decisions,
- 14 and in California, one health plan has voluntarily
- 15 implemented a process for independent review of a



1 broad range of unresolved patient grievances. In
2 addition, Medicare has a system for independent review
3 of unresolved patient grievances. A great diversity of
4 policies and procedures has been applied to these various
5 state and federal independent review systems.

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

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

28 (e) It would be in the state's best interest to proceed
29 cautiously with a test of an independent review system
30 that will sunset, with a report back to the Legislature a
31 year prior to the sunset date to help determine whether
32 to extend, modify, or terminate the program. The
33 Legislature also finds that, in light of experience in other
34 states that have implemented independent review
35 systems, which shows only modest success in helping
36 patients, the test in California should err on the side of
37 promoting patient access, participation, and assistance.

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



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

3 1368. (a) Every plan shall do all of the following:

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

11 (2) Inform its subscribers and enrollees upon
12 enrollment in the plan and annually thereafter of the
13 procedure for processing and resolving grievances. The
14 information shall include the location and telephone
15 number where grievances may be submitted.

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

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

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

32 (b) (1) (A) After either completing the grievance
33 process described in subdivision (a), or participating in
34 the process for at least 30 days, a subscriber or enrollee
35 may submit the grievance to the department for review.
36 In any case determined by the department to be a case
37 involving an imminent and serious threat to the health of
38 the patient, including, but not limited to, severe pain, the
39 potential loss of life, limb, or major bodily function, or in
40 any other case where the department determines that an



1 earlier review is warranted, a subscriber or enrollee shall
2 not be required to complete the grievance process or
3 participate in the process for at least 30 days before
4 submitting a grievance to the department for review.

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

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

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

29 (3) The department shall review the written
30 documents submitted with the subscriber’s or the
31 enrollee’s request for review, or submitted by the agent
32 on behalf of the subscriber or enrollee. The department
33 may ask for additional information, and may hold an
34 informal meeting with the involved parties, including
35 providers who have joined in submitting the grievance,
36 or who are otherwise assisting or advocating on behalf of
37 the subscriber or enrollee. If, after reviewing the record,
38 the department concludes that the grievance is eligible
39 for review under the independent review system
40 established pursuant to Article 12 (commencing with



1 Section 1399.80), the department shall immediately
2 notify the subscriber or enrollee, or agent, of that option
3 and shall, if requested orally or in writing, assist the
4 subscriber or enrollee to apply to participate in the
5 independent medical review system.

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

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

36 (6) Distribution of the written notice shall not be
37 deemed a waiver of any exemption or privilege under
38 existing law, including, but not limited to, Section 6254.5
39 of the Government Code, for any information in
40 connection with and including the written notice, nor



1 shall any person employed or in any way retained by the
2 department be required to testify as to that information
3 or notice.

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

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

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

36
37 "Under Medicare and Medi-Cal law, Medicare
38 enrollees and Medi-Cal enrollees each have separate
39 avenues of appeal that are not available to other
40 enrollees. Therefore, grievances pending and



1 unresolved may reflect enrollees pursuing their
2 Medicare or Medi-Cal appeal rights.”

3

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

17 (d) Subject to subparagraph (C) of paragraph (1) of
18 subdivision (b), the grievance or resolution procedures
19 authorized by this section shall be in addition to any other
20 procedures that may be available to any person, and
21 failure to pursue, exhaust, or engage in the procedures
22 described in this section shall not preclude the use of any
23 other remedy provided by law.

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

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

36 1368.01. (a) The grievance system shall require the
37 plan to resolve grievances within 30 days and shall require
38 the plan to provide enrollees and subscribers with a
39 written statement on the disposition or pending status of



1 the grievance within 15 days of the plan's receipt of the
2 grievance.

3 (b) The grievance system shall include a requirement
4 for the plan to immediately refer the enrollee or
5 subscriber to the independent review system established
6 pursuant to Article 12 (commencing with Section
7 1399.80) in cases involving an imminent and serious
8 threat to the health of the enrollee, including, but not
9 limited to, severe pain, potential loss of life, limb, or major
10 bodily function, or the immediate or serious deterioration
11 of the health of the enrollee. When the plan has notice of
12 a case requiring immediate referral to the independent
13 review system pursuant to Article 12 (commencing with
14 Section 1399.80), the grievance system shall require the
15 plan to immediately inform enrollees and subscribers in
16 writing of their right to apply for an independent review,
17 and shall require the plan to provide an application for
18 this purpose.

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

21 1368.03. (a) The department may require enrollees
22 and subscribers to participate in a plan's grievance
23 process for up to 30 days before pursuing a grievance
24 through the department. However, the department may
25 not impose this waiting period for cases covered by
26 subdivision (b) of Section 1368.01 or in any other case
27 where the department determines that an earlier review
28 is warranted.

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

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

38 1368.04. (a) The commissioner shall investigate and
39 take enforcement action against plans regarding
40 grievances reviewed and found by the department to



1 involve plan noncompliance with the requirements of
2 this chapter, including grievances that have been
3 reviewed pursuant to the independent review system
4 established pursuant to Article 12 (commencing with
5 Section 1399.80). Where harm to an enrollee has occurred
6 as a result of plan noncompliance, the commissioner shall
7 impose penalties. The commissioner shall periodically
8 evaluate grievances to determine if any audit,
9 investigative, or enforcement actions should be
10 undertaken by the department.

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

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

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

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

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

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

36 1370.4. (a) Every health care service plan shall
37 provide an external, independent review process to
38 examine the plan's coverage decisions regarding
39 experimental or investigational therapies for individual
40 enrollees who meet all of the following criteria:



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

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

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

34 (4) The enrollee has been denied coverage by the plan
35 for a drug, device, procedure or other therapy
36 recommended or requested pursuant to paragraph (3);
37 and

38 (5) 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 investigational; and

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

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

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

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

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

38 (A) The plan.

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



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

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

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

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

11 (A) “Material familial affiliation” shall mean any
12 relationship as a spouse, child, parent, sibling, spouse’s
13 parent, or child’s spouse.

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

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

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

37 (6) The plan shall provide to the independent entity
38 arranging for the panel of experts a copy of the following
39 documents within five business days of the plan’s receipt



1 of a request by an enrollee or enrollee’s physician for an
2 external, independent review:

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

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

21 (C) Any information submitted by the enrollee or the
22 enrollee’s physician to the plan in support of the
23 enrollee’s request for coverage of the proposed drug,
24 device, procedure, or other therapy.

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

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



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

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

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

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



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

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

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 to provide expert reviews
28 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 having as its primary function
32 providing expert reviews and related services and
33 without receiving a majority of its revenues from these
34 services. An independent entity may not be a subsidiary
35 of, nor in any way owned or controlled by, a health plan,
36 a trade association of health plans, or a professional
37 association of health care providers.

38 (2) The independent entity must submit to the
39 accrediting organization and to the Department of
40 Corporations the following information upon initial



1 application for accreditation and annually thereafter
2 upon any change to any of the following information:

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

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

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

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

18 (E) The percentage of revenue the independent
19 entity receives from expert reviews.

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

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

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

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

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

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

1 (A) Ensures that the experts retained are
2 appropriately credentialed and privileged.

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

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

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

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

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

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

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

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

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



1 1370.4. (a) Every health care service plan shall
2 provide an external, independent review process to
3 examine the plan's coverage decisions regarding
4 experimental or investigational therapies for individual
5 enrollees who meet all of the following criteria:

6 (1) The enrollee has a terminal condition that,
7 according to the enrollee's physician's current diagnosis,
8 has a high probability of causing death within two years
9 from the date of the request for an independent review;
10 and

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

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

39 (4) The enrollee has been denied coverage by the plan
40 for a drug, device, procedure or other therapy



1 recommended or requested pursuant to paragraph (3);
2 and

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

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

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

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

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

37 (3) Neither the expert, nor the independent entity,
38 nor any officer, director, or management employee of the
39 independent entity shall have any material professional,



1 familial, or financial affiliation, as defined in paragraph
2 (4), with any of the following:

3 (A) The plan.

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

6 (C) The physician, the physician’s medical group, or
7 the independent practice association (IPA) proposing
8 the therapy.

9 (D) The institution at which the therapy would be
10 provided.

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

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

16 (A) “Material familial affiliation” shall mean any
17 relationship as a spouse, child, parent, sibling, spouse’s
18 parent, or child’s spouse.

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

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



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

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

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

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

27 (C) Any information submitted by the enrollee or the
28 enrollee's physician to the plan in support of the
29 enrollee's request for coverage of the proposed drug,
30 device, procedure, or other therapy.

31 (7) The experts on the panel shall render their
32 analyses and recommendations within 30 days of the
33 receipt of the enrollee's request for review. If the
34 enrollee's physician determines that the proposed
35 therapy would be significantly less effective if not
36 promptly initiated, the analyses and recommendations of
37 the experts on the panel shall be rendered within seven
38 days of the request for expedited review. At the request
39 of the expert, the deadline shall be extended by up to



1 three days for a delay in providing the documents
2 required by paragraph (6) of subdivision (b).

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

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

30 (10) If the majority of experts on the panel
31 recommend providing the proposed therapy, pursuant to
32 paragraph (8), the recommendation shall be binding on
33 the plan. If the recommendations of the experts on the
34 panel are evenly divided as to whether the therapy
35 should be provided, then the panel's decision shall be
36 deemed to be in favor of coverage. If less than a majority
37 of the experts on the panel recommend providing the
38 therapy, the plan is not required to provide the therapy.
39 Coverage for the services required under this section
40 shall be provided subject to the terms and conditions



1 generally applicable to other benefits under the plan
2 contract.

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

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

31 (d) For the purposes of paragraph (3) of subdivision
32 (a), "medical and scientific evidence" means the
33 following sources:

34 (1) Peer-reviewed scientific studies published in or
35 accepted for publication by medical journals that meet
36 nationally recognized requirements for scientific
37 manuscripts and that submit most of their published
38 articles for review by experts who are not part of the
39 editorial staff.



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

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

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

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

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

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

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



1 services. An independent entity may not be a subsidiary
2 of, nor in any way owned or controlled by, a health plan,
3 a trade association of health plans, or a professional
4 association of health care providers.

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

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

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

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

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

25 (E) The percentage of revenue the independent
26 entity receives from expert reviews.

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

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

34 (H) Documentation regarding the medical
35 institutions from which the independent entity has
36 selected the experts during the previous 12 months, and
37 the percentage of opinions obtained from each
38 institution.



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

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

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

10 (A) Ensures that the experts retained are
11 appropriately credentialed and privileged.

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

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

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

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

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

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



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

3 (h) This section shall become operative on January 1,
4 2004.

5 SEC. 9. Article 12 (commencing with Section
6 1399.80) is added to Chapter 2.2 of Division 2 of the Health
7 and Safety Code, to read:

8

9 Article 12. Appeals Seeking Independent Reviews

10

11 1399.80. (a) Commencing January 1, 2001, there is
12 established in the department the Independent Review
13 System.

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

23 (c) For the purposes of this article, “other adverse
24 decision” means the denial, significant delay,
25 termination, or the imposition of other limits on health
26 care services by a plan, or by one of its contracting
27 entities, for reasons other than those in subdivision (b).

28 (d) All enrollee grievances involving a disputed health
29 care service or other adverse decision are eligible for
30 review under the Independent Review System if the
31 requirements of this article are met. If the department
32 finds that an enrollee grievance does not meet the
33 requirements of this article for review under the
34 Independent Review System, the enrollee request for
35 review shall be treated as a request for the department to
36 review the grievance pursuant to subdivision (b) of
37 Section 1368. All other enrollee grievances remain
38 eligible for review by the department pursuant to
39 subdivision (b) of Section 1368.



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

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

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

33 (h) The independent review process authorized by
34 this article is in addition to any other procedures or
35 remedies that may be available. The enrollee’s election to
36 either pursue or not pursue, exhaust, or engage in the
37 procedures described in this article does not preclude the
38 use of any other remedy provided by law and shall not be
39 relevant in any subsequent civil or administrative
40 proceeding.



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

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

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

31 (2) The health care service was denied, significantly
32 delayed, terminated, or otherwise limited by the plan, or
33 by one of its contracting providers, or in cases involving
34 emergency services or urgent out-of-network care where
35 the enrollee did not first seek care from a participating
36 plan provider, the plan has denied reimbursement for the
37 reasonable costs of securing that care.

38 (3) The enrollee has filed a grievance with the plan or
39 its contracting provider pursuant to Section 1368, and the
40 disputed decision is upheld or the grievance remains



1 unresolved after 30 days. The enrollee shall not be
2 required to participate in the plan's grievance process for
3 more than 30 days. In the case of a grievance that requires
4 immediate referral to the Independent Review System
5 pursuant to Section 1368.01, the enrollee shall not be
6 required to participate in the plan's grievance process.

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

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

17 (1) A brief description of the enrollee's medical
18 condition for which health care services were denied,
19 significantly delayed, terminated, or otherwise limited, or
20 for which reimbursement for reasonable costs was
21 denied.

22 (2) If the grievance involves a disputed health care
23 service, an explanation of the reasons why the enrollee
24 believes that the disputed health care service is or was
25 medically necessary or appropriate for the enrollee's
26 medical condition. If the grievance involves one or more
27 other adverse decisions, an explanation of the reasons
28 why the enrollee believes the plan's decision was
29 incorrect.

30 The enrollee shall be encouraged to also provide other
31 information supporting the enrollee's position as well as
32 a copy of all information provided to the enrollee by the
33 plan or any of its contracting providers, still in the
34 possession of the enrollee, concerning a plan or provider
35 decision regarding disputed health care services and
36 services related to other adverse decisions, and a copy of
37 any materials the enrollee submitted to the plan, still in
38 the possession of the enrollee, in support of the grievance,
39 as well as any additional material that the enrollee
40 believes is relevant.



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

5 (m) (1) Upon receipt of an enrollee appeal for an
6 independent review, the plan or its contracting providers
7 shall provide the independent review organization a
8 copy of all of the following documents within three
9 business days of the plan's receipt of the request by an
10 enrollee for an independent review:

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

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

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

18 (iii) The health care services requested by the
19 enrollee for the condition.

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

31 (B) A copy of all information provided to the enrollee
32 by the plan and any of its contracting providers
33 concerning plan and provider decisions in response to the
34 grievance, and a copy of any materials the enrollee or the
35 enrollee's provider submitted to the plan and to the plan's
36 contracting providers in support of the enrollee's
37 grievance. This documentation shall include the written
38 response to the enrollee's grievance, required by
39 paragraph (4) of subdivision (a) of Section 1368, which
40 requires, in part, a description of the criteria used and the



1 clinical reasons for the decision, including all criteria and
2 clinical reasons related to medical necessity or
3 appropriateness. The confidentiality of all medical record
4 information shall be maintained pursuant to applicable
5 state and federal laws.

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

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

29 (A) Does not meet the eligibility requirements for
30 independent review.

31 (B) Is frivolous and without merit.

32 (C) Is deficient due to both subparagraphs (A) and
33 (B).

34 The written objection to the department shall be
35 accompanied by a copy of the entire grievance record.
36 The department shall establish an expedited process,
37 which shall not exceed three days from receipt of an
38 objection unless an extension is requested by the enrollee,
39 for reviewing these cases and notifying the enrollee of its
40 decision. If there is an imminent and serious threat to the



1 health of the enrollee, as defined in subdivision (d) of
2 Section 1399.83, the department shall accelerate its
3 review of the objection. If the department disagrees with
4 the plan's objection, the grievance shall be referred
5 immediately to an independent review organization. If
6 the department agrees with the plan, the grievance shall
7 immediately be treated as a request for the department
8 to review the grievance pursuant to subdivision (b) of
9 Section 1368. The department shall consider the entire
10 grievance record, as well as any material submitted by the
11 enrollee and the enrollee's providers, when making its
12 decision regarding an objection.

13 1399.81. (a) Except in cases involving a plan
14 objection submitted to the department, upon receipt of
15 an enrollee's request for an independent review, the plan
16 shall assign the request to an independent review
17 organization as described in Section 1399.82 in
18 accordance with any regulations or orders of the
19 commissioner when the enrollee has complied with the
20 requirements of subdivisions (j), (k), and (l) of Section
21 1399.80.

22 (b) The independent review organization, which shall
23 be selected by the department based on selection criteria
24 developed by the department, shall conduct the review
25 in accordance with Section 1399.83 and any regulations or
26 orders of the commissioner adopted pursuant thereto.

27 1399.82. (a) By January 1, 2001, the commissioner
28 shall make every effort to contract with one or more
29 independent review organizations in the state to conduct
30 reviews for purposes of this article. The independent
31 review organizations shall be accredited pursuant to this
32 article and shall be independent of any health care
33 service plan doing business in this state. Prior to July 1,
34 2000, the commissioner, after public notice, hearings, and
35 comment, shall adopt regulations to ensure the
36 independence of these organizations. The regulations
37 shall include conflict-of-interest standards, consistent
38 with the purposes of this article, that an organization shall
39 be required to meet in order to qualify for participation
40 in the Independent Review System.



1 (b) (1) The independent review organization, any
2 experts it designates to conduct a review, or any officer,
3 director, or employee of the independent entity shall
4 have no material professional, familial, or financial
5 affiliation, as determined by the commissioner, with any
6 of the following:

7 (A) The plan.

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

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

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

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

19 (c) The commissioner shall, by July 1, 2000, contract
20 with a private, nonprofit accrediting organization to
21 accredit the independent review organizations described
22 in subdivision (a). The accrediting organization may
23 grant and revoke accreditation, and shall develop, apply,
24 and enforce accreditation standards that ensure the
25 independence of the independent review organization,
26 the confidentiality of the medical records, and the
27 qualifications and independence of the health care
28 professionals and other experts providing the analyses
29 and recommendations requested of them. The
30 accrediting organization shall demonstrate the ability to
31 objectively evaluate the performance of independent
32 review organizations and shall demonstrate that it has no
33 conflict of interest, including any material professional,
34 familial, or financial affiliation, as provided in subdivision
35 (b), with any independent review organization or plan,
36 in accrediting those organizations for the purpose of
37 reviewing disputed health care decisions and other
38 adverse decisions made by health care service plans.

39 (d) Prior to July 1, 2000, the commissioner, after public
40 notice, hearings, and comment, shall adopt regulations



1 related to the accreditation of independent review
2 organizations. In developing the regulations required by
3 this subdivision, the department shall consider adopting
4 the following, but may accept, reject, or modify the
5 following based on information received as a result of the
6 rulemaking process. If the department rejects or modifies
7 any of the following, it shall discuss its reasons for doing
8 so in the final rulemaking document. In order to receive
9 accreditation for the purposes of this section, an
10 independent review organization shall meet all of the
11 following requirements:

12 (1) An independent review organization shall not be
13 an affiliate or a subsidiary of, nor in any way be owned or
14 controlled by, a health plan, or a trade association of
15 health plans. A board member, director, officer, or
16 employee of the independent review organization shall
17 not serve as a board member, director, or employee of a
18 health care service plan. A board member, director, or
19 officer of a health plan or a trade association of health
20 plans shall not serve as a board member, director, officer,
21 or employee of an independent review organization.

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

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

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

33 (C) The names of all corporations and organizations
34 that the independent review organization controls or is
35 affiliated with, and the nature and extent of any
36 ownership or control, including the affiliated
37 organization's type of business.

38 (D) The names and biographical sketches of all
39 directors, officers, and executives of the independent
40 review organization, as well as a statement regarding any



1 past or present relationships the directors, officers, and
2 executives may have with any health care service plan,
3 disability insurer, managed care organization, provider
4 group, or board or committee of a plan, managed care
5 organization, or provider group.

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

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

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

20 (G) A description of the system the independent
21 review organization uses to identify and recruit medical
22 professionals and other experts to review disputed health
23 care decisions and other adverse decisions made by
24 health care service plans, the number of medical
25 professionals credentialed, and the types of cases and
26 areas of expertise which the medical professionals are
27 credentialed to review, and the number of other experts,
28 the types of cases and areas of expertise which those other
29 experts are licensed or credentialed to review.

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

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

36 (A) Ensures that the medical professionals retained
37 are appropriately credentialed and privileged and that
38 the other experts retained are appropriately qualified,
39 licensed, and credentialed.



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

5 (C) Ensures that the method of selecting medical
6 professionals and other experts for individual cases
7 achieves a fair and impartial panel of medical
8 professionals and other experts who are qualified to
9 render recommendations regarding disputed health care
10 decisions and other adverse decisions made by health
11 care service plans.

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

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

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

26 (A) The medical professional shall be a clinician
27 knowledgeable in the treatment of the enrollee's medical
28 condition, knowledgeable about the proposed treatment,
29 and familiar with guidelines, protocols, and the criteria
30 set forth in subdivision (b) of Section 1399.83 in the area
31 of treatment under review.

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



1 utilize a medical professional who holds a nonrestricted
2 license in any state of the United States, provided that the
3 out-of-state medical professional is knowledgeable about
4 the treatment standards required in California and
5 applies those standards.

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

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

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

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

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

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

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

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

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

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

37 (B) "Material professional affiliation" means any
38 physician-patient relationship, any partnership or
39 employment relationship, a shareholder or similar
40 ownership interest in a professional corporation, or any



1 independent contractor arrangement that constitutes a
2 material financial affiliation with any expert or any officer
3 or director of the independent review organization.
4 “Material professional affiliation” does not include
5 affiliations that are limited to staff privileges at a health
6 facility.

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

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

27 (f) The independent review process established by
28 this article shall not commence until one or more
29 independent review organizations have been accredited
30 and have executed a contract with the department
31 pursuant to this section.

32 1399.83. (a) Upon receipt of information and
33 documents related to a case pursuant to subdivision (c)
34 of Section 1399.81, the expert reviewer or reviewers
35 selected to conduct the review by the independent
36 review organization shall promptly review all pertinent
37 medical records of the enrollee and provider reports, as
38 well as any other information submitted to the
39 organization as authorized by the department or
40 requested from any of the parties to the dispute by the



1 reviewers. If reviewers request information from any of
2 the parties, a copy of the request and the response shall
3 be provided to all of the parties.

4 (b) (1) Following its review of a grievance involving
5 a disputed health care service, the medical expert
6 reviewer or reviewers shall determine and state whether
7 the disputed health care service is or was medically
8 necessary or appropriate based on:

9 (A) Generally accepted practice guidelines
10 developed by federal agencies, nationally recognized
11 federal research institutes, or national professional
12 medical specialty societies.

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

16 (C) Generally accepted standards of medical practice.

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

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

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

32 (d) The independent review organization shall
33 require its expert reviewers to complete a review and
34 make a determination in writing, and in layperson's terms
35 to the maximum extent practicable, within 30 days of the
36 receipt by the independent review organization of the
37 application for review and supporting documentation, or
38 within less time as prescribed by the commissioner. If a
39 requested health care service that is the subject of the
40 grievance has not been provided and the enrollee's



1 provider or the department certifies in writing that an
2 imminent and serious threat to the health of the enrollee
3 may exist, including, but not limited to, severe pain, the
4 potential loss of life, limb, or major bodily function, or the
5 immediate and serious deterioration of the health of the
6 enrollee, the analyses and determinations of the
7 reviewers shall be expedited and rendered within three
8 days of the certification notice. Subject to the approval of
9 the department, the deadlines for analyses and
10 determinations involving both regular and expedited
11 reviews may be extended by up to three days following
12 reviewer receipt of delayed documentation required by
13 this chapter.

14 (e) Each analysis shall cite the enrollee's medical
15 condition and the relevant documents in the record to
16 support the determination.

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

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

33 (h) The independent review organization shall
34 provide the commissioner with the analyses and
35 determinations of the experts reviewing the case, a
36 description of the qualifications of the experts, and the
37 names of the reviewers. If more than one expert reviewed
38 the case and the result was differing determinations, the
39 independent review organization shall provide the



1 commissioner with each of the separate reviewer
2 analyses and determinations.

3 (i) The commissioner, except in cases subject to
4 expedited reconsideration under subdivision (j), shall
5 immediately adopt the determination of the
6 independent review organization, and shall promptly
7 issue a written decision to the parties, which decision shall
8 be binding on the plan as an order.

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

26 (k) Nothing about the independent review process
27 established by this article, including, but not limited to,
28 the analysis, recommendations, and conclusions of the
29 review panel, shall be admissible in any subsequent
30 proceeding.

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

38 1399.84. (a) Upon receiving the order adopted by the
39 commissioner pursuant to subdivision (i) or (j) of Section



1 1399.83, the plan shall immediately contact the enrollee
2 and offer to promptly implement the order.

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

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

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

39 1399.85. (a) After considering the results of a
40 competitive bidding process and any other relevant



1 information on program costs, the commissioner shall
2 establish a reasonable, per-case reimbursement schedule
3 to pay the costs of independent review organization
4 reviews, which may vary depending on the type of
5 medical condition under review and on other relevant
6 factors.

7 (b) As a condition of receiving payments for reviews,
8 independent review organizations shall agree to provide
9 reasonable data required for an evaluation of the
10 independent review system.

11 ~~1399.86. (a) On or before July 1, 2000, the~~
12 ~~commissioner shall allocate grant funding for an~~
13 ~~independent health care ombudsprogram. At a~~
14 ~~minimum, the commissioner shall approve project grants~~
15 ~~for at least one new or existing independent assistance~~
16 ~~project in southern, central, and northern California if~~
17 ~~qualified applicants apply from each of those three~~
18 ~~regions. The number of projects approved shall~~
19 ~~eventually be sufficient to provide independent~~
20 ~~assistance to all California enrollees. However, in order to~~
21 ~~facilitate the startup and effective implementation of this~~
22 ~~section, the commissioner may take until July 1, 2002, if~~
23 ~~necessary, to fund a sufficient number of projects to serve~~
24 ~~all California enrollees.~~

25 ~~(b) Project activities shall include, but are not limited~~
26 ~~to, providing counseling, advising, assisting, and~~
27 ~~advocating for enrollees at every stage of:~~

28 ~~(A) The health plan grievance process.~~

29 ~~(B) The department's grievance review process~~
30 ~~under subdivision (b) of Section 1368.~~

31 ~~(C) Applying for and participating in the~~
32 ~~Independent Review System.~~

33 ~~(e) All of the projects shall, as necessary and~~
34 ~~appropriate, directly assist enrollees in their dealings with~~
35 ~~plans, provider groups, providers, and government~~
36 ~~agencies, including advocating on behalf of enrollees in~~
37 ~~any informal or formal proceeding.~~

38 ~~(d) The commissioner shall use a competitive bidding~~
39 ~~process to select projects. The projects shall be selected~~



1 based on, but not limited to, all of the following selection
2 criteria:

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

5 (2) The number of enrollees covered by health plans
6 served by the project and the size of the geographic
7 region to be served by the project.

8 (3) Evidence of an understanding of the range and
9 complexity of health care concerns likely to be raised by
10 enrollees, including vulnerable populations served by
11 various health plans.

12 (4) The number and quality of staff with formal
13 training and experience in health care, counseling, and
14 consumer advocacy.

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

22 (6) The commitment to collect and analyze data on
23 enrollee experiences in health plan grievance systems, in
24 the department's grievance review process, and in the
25 Independent Review System.

26 (7) The ability and commitment to provide significant
27 matching contributions to support the program in the
28 form of private or public financial support or in-kind
29 contributions, or a combination of the two.

30 (8) The commitment to provide project services to
31 enrollees free of charge.

32 (9) The degree of consumer representation on the
33 applicant's governing advisory board, if such a board
34 exists.

35 (e) The evaluation of bids submitted pursuant to
36 subdivision (d) shall be conducted by the commissioner
37 in consultation with a panel of at least three individuals
38 screened and appointed by the commissioner who have
39 no conflicts of interest including, but not limited to, a
40 financial interest in the outcome of the bidding process;



1 ~~or employment or contractual arrangements with plans,~~
2 ~~their contracting medical groups or contracting~~
3 ~~providers, and who have significant experience with, and~~
4 ~~knowledge about, managed health care issues, health~~
5 ~~care dispute resolution mechanisms, and consumer~~
6 ~~advocacy.~~

7 ~~(f) Funding for the projects shall commence no earlier~~
8 ~~than July 1, 2000, and may continue for a period extending~~
9 ~~no later than December 31, 2003.~~

10 ~~(g) As a condition of receiving funding, each of the~~
11 ~~projects shall agree to provide reasonable data required~~
12 ~~for an evaluation of the independent health care~~
13 ~~ombudsprogram.~~

14 ~~1399.87.~~

15 *1399.86.* ~~(a) The costs of the independent review~~
16 ~~system and independent health care ombudsprogram~~
17 ~~shall be borne by health care service plans pursuant to an~~
18 ~~assessment fee system established by the commissioner.~~
19 ~~Every health care service plan shall pay annually to the~~
20 ~~department, on the date or dates set by the department,~~
21 ~~its prorated share of fees, as determined by the~~
22 ~~commissioner, to pay for the estimated annual costs~~
23 ~~associated with carrying out, overseeing, and evaluating~~
24 ~~the independent review system and independent health~~
25 ~~care ombudsprogram. In determining the amount to be~~
26 ~~assessed, the commissioner shall consider all existing~~
27 ~~assessments and appropriations available for the support~~
28 ~~of this chapter including any offsetting funds that can be~~
29 ~~made available as a result of enrollee grievances being~~
30 ~~diverted from the department and reviewed instead by~~
31 ~~independent review organizations with enrollees assisted~~
32 ~~by the independent health care ombudsprogram instead~~
33 ~~of by department staff. The commissioner may adjust fees~~
34 ~~upward or downward, on a schedule set by the~~
35 ~~department, to address shortages or overpayments.~~

36 ~~(b) The portion of the assessment fee imposed by~~
37 ~~subdivision (a) to pay for the independent health care~~
38 ~~ombudsprogram shall not apply to any health care service~~
39 ~~plan that is funding and has in place by July 1, 2000, or~~
40 ~~thereafter, an independent, external health care~~



1 ~~ombudsprogram certified by the commissioner as~~
 2 ~~substantially complying with the selection criteria for~~
 3 ~~eligibility utilized under this chapter, and provided that~~
 4 ~~the health plan ombudsprogram agrees to collect and~~
 5 ~~provide reasonable data to the department and its~~
 6 ~~evaluator in accordance with subdivisions (a) and (b) of~~
 7 ~~Section 1399.88. The commissioner's certification review~~
 8 ~~shall be done in consultation with the panel established~~
 9 ~~pursuant to subdivision (c) of Section 1399.86.~~

10 (e)

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

18 ~~1399.88.~~

19 ~~1399.87.~~ (a) The department shall contract with an
 20 independent expert entity to undertake an evaluation of
 21 the independent review system ~~and the independent~~
 22 ~~health care ombudsprogram.~~

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

36 (c) The evaluation shall assess the long-term efficacy
 37 of ~~these programs~~ *the program* as a means of providing
 38 timely and effective resolution of enrollee grievances
 39 with plans, and for improving access to and the quality of
 40 health care services, and as a catalyst for systemic



1 improvements in the delivery of health care services. In
2 addition to reviewing data generated by ~~these~~ *this* new
3 California ~~programs~~ *program*, the evaluator shall survey
4 and report on similar programs underway in other states.

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

20 ~~1399.89.~~

21 *1399.88.* A plan's coverage decision regarding
22 experimental or investigational therapies for individual
23 enrollees shall be subject to this article.

24 ~~1399.90.~~

25 *1399.89.* 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 to, the method of selecting expert reviewers
17 and matching the expert reviewers to specific cases.

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

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

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

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

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

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

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



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

6 (D) Ensures the confidentiality of medical records
7 and the review materials, consistent with the
8 requirements of this section.

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

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

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

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

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

33 SEC. 11. Section 10145.3 is added to the Insurance
34 Code, to read:

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



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

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

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

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

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



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

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

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

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

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

37 (A) The insurer.

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



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

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

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

9 (4) For purposes of this section, the following terms
10 have the following meanings:

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

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

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

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

37 (6) The insurer shall provide to the independent
38 entity arranging for the panel of experts a copy of the
39 following documents within five business days of the



1 insurer's receipt of a request by an insured or insured's
2 physician for an external independent review.

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

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

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

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

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



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

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

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

36 (11) The insurer shall have written policies describing
37 the external, independent review process. The insurer
38 shall disclose the availability of the external, independent
39 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 startup 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.~~

27 ~~10145.86. (a) The costs of the independent review~~
28 ~~system and independent health care ombudsprogram~~
29 ~~shall be borne by disability insurers that cover hospital,~~
30 ~~medical, or surgical benefits pursuant to an assessment~~
31 ~~fee system established by the commissioner. Every~~
32 ~~insurer subject to this article shall pay annually to the~~
33 ~~department, on the date or dates set by the department,~~
34 ~~its prorated share of fees, as determined by the~~
35 ~~commissioner, to pay for the estimated annual costs~~
36 ~~associated with carrying out, overseeing, and evaluating~~
37 ~~the independent review system and independent health~~
38 ~~care ombudsprogram. In determining the amount to be~~
39 ~~assessed, the commissioner shall consider all existing~~
40 ~~assessments and appropriations available for the support~~



1 of this chapter. The commissioner may adjust fees
2 upward or downward, on a schedule set by the
3 department, to address shortages or overpayments.

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

18 (e)

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

26 ~~10145.88.~~

27 ~~10145.87.~~ (a) The department shall contract with an
28 independent expert entity to undertake an evaluation of
29 the independent review system ~~and the independent
30 health care ombudsprogram.~~

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



1 department workload attributed to ~~insured use of the~~
2 ~~ombudsprogram~~ and the referral of grievances to the
3 independent review system.

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

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

28 ~~10145.89.~~

29 *10145.88.* An insurer's coverage decision regarding
30 experimental or investigational therapies for individual
31 insureds shall be subject to this article.

32 ~~10145.90.~~

33 *10145.89.* This article shall remain in effect only until
34 January 1, 2004, and as of that date is repealed, unless a
35 later enacted statute, that is enacted before January 1,
36 2004, deletes or extends that date.

37 SEC. 13. No reimbursement is required by this act
38 pursuant to Section 6 of Article XIII B of the California
39 Constitution because the only costs that may be incurred
40 by a local agency or school district will be incurred



1 because this act creates a new crime or infraction,
2 eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section
4 17556 of the Government Code, or changes the definition
5 of a crime within the meaning of Section 6 of Article
6 XIII B of the California Constitution.

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