

**Introduced by Senator Hernandez**February 19, 2016

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An act to amend Section 1363.5 of the Health and Safety Code, and to amend Section 10123.135 of the Insurance Code, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1471, as introduced, Hernandez. Health care coverage: services: authorization and denial.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and insurers to disclose or provide for the disclosure to specified entities persons and the process that the plan uses to authorize or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities.

This bill would expand the above requirement to include disclosure of the process the plan uses to authorize or deny behavioral health treatment. By changing the definition of an existing crime with respect to health care service 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. Section 1363.5 of the Health and Safety Code is  
2 amended to read:  
3 1363.5. (a) A plan shall disclose or provide for the disclosure  
4 to the director and to network providers the process *that* the plan,  
5 its contracting provider groups, or any entity with which the plan  
6 contracts for services that include utilization review or utilization  
7 management functions, uses to authorize, modify, or deny health  
8 care services under the benefits provided by the plan, including  
9 coverage for subacute care, transitional inpatient care, ~~or care~~  
10 provided in skilled nursing ~~facilities.~~ *facilities, and behavioral*  
11 *health treatment.* A plan shall also disclose those processes to  
12 enrollees or persons designated by an enrollee, or to any other  
13 person or organization, upon request. The disclosure to the director  
14 shall include the policies, procedures, and the description of the  
15 process that are filed with the director pursuant to subdivision (b)  
16 of Section 1367.01.

17 (b) The criteria or guidelines used by plans, or any entities with  
18 which plans contract for services that include utilization review  
19 or utilization management functions, to determine whether to  
20 authorize, modify, or deny health care services shall:

21 (1) Be developed with involvement from actively practicing  
22 health care providers.

23 (2) Be consistent with sound clinical principles and processes.

24 (3) Be evaluated, and updated if necessary, at least annually.

25 (4) If used as the basis of a decision to modify, delay, or deny  
26 services in a specified case under review, be disclosed to the  
27 provider and the enrollee in that specified case.

28 (5) Be available to the public upon request. A plan shall only  
29 be required to disclose the criteria or guidelines for the specific  
30 procedures or conditions requested. A plan may charge reasonable  
31 fees to cover administrative expenses related to disclosing criteria  
32 or guidelines pursuant to this paragraph, limited to copying and  
33 postage costs. The plan may also make the criteria or guidelines  
34 available through electronic communication means.

1 (c) The disclosure required by paragraph (5) of subdivision (b)  
2 shall be accompanied by the following notice: “The materials  
3 provided to you are guidelines used by this plan to authorize,  
4 modify, or deny care for persons with similar illnesses or  
5 conditions. Specific care and treatment may vary depending on  
6 individual need and the benefits covered under your contract.”

7 SEC. 2. Section 10123.135 of the Insurance Code is amended  
8 to read:

9 10123.135. (a) Every disability insurer, or an entity with which  
10 it contracts for services that include utilization review or utilization  
11 management functions, that covers hospital, medical, or surgical  
12 expenses and that prospectively, retrospectively, or concurrently  
13 reviews and approves, modifies, delays, or denies, based in whole  
14 or in part on medical necessity, requests by providers prior to,  
15 retrospectively, or concurrent with the provision of health care  
16 services to insureds, or that delegates these functions to medical  
17 groups or independent practice associations or to other contracting  
18 providers, shall comply with this section.

19 (b) A disability insurer that is subject to this section, or any  
20 entity with which an insurer contracts for services that include  
21 utilization review or utilization management functions, shall have  
22 written policies and procedures establishing the process by which  
23 the insurer prospectively, retrospectively, or concurrently reviews  
24 and approves, modifies, delays, or denies, based in whole or in  
25 part on medical necessity, requests by providers of health care  
26 services for insureds. These policies and procedures shall ensure  
27 that decisions based on the medical necessity of proposed health  
28 care services are consistent with criteria or guidelines that are  
29 supported by clinical principles and processes. These criteria and  
30 guidelines shall be developed pursuant to subdivision (f). These  
31 policies and procedures, and a description of the process by which  
32 an insurer, or an entity with which an insurer contracts for services  
33 that include utilization review or utilization management functions,  
34 reviews and approves, modifies, delays, or denies requests by  
35 providers prior to, retrospectively, or concurrent with the provision  
36 of health care services to insureds, shall be filed with the  
37 commissioner, and shall be disclosed by the insurer to insureds  
38 and providers upon request, and by the insurer to the public upon  
39 request.

1 (c) If the number of insureds covered under health benefit plans  
 2 in this state that are issued by an insurer subject to this section  
 3 constitute at least 50 percent of the number of insureds covered  
 4 under health benefit plans issued nationwide by that insurer, the  
 5 insurer shall employ or designate a medical director who holds an  
 6 unrestricted license to practice medicine in this state issued  
 7 pursuant to Section 2050 of the Business and Professions Code or  
 8 the Osteopathic Initiative Act, or the insurer may employ a clinical  
 9 director licensed in California whose scope of practice under  
 10 California law includes the right to independently perform all those  
 11 services covered by the insurer. The medical director or clinical  
 12 director shall ensure that the process by which the insurer reviews  
 13 and approves, modifies, delays, or denies, based in whole or in  
 14 part on medical necessity, requests by providers prior to,  
 15 retrospectively, or concurrent with the provision of health care  
 16 services to insureds, complies with the requirements of this section.  
 17 Nothing in this subdivision shall be construed as restricting the  
 18 existing authority of the Medical Board of California.

19 (d) If an insurer subject to this section, or individuals under  
 20 contract to the insurer to review requests by providers, approve  
 21 the provider’s request pursuant to subdivision (b), the decision  
 22 shall be communicated to the provider pursuant to subdivision (h).

23 (e) An individual, other than a licensed physician or a licensed  
 24 health care professional who is competent to evaluate the specific  
 25 clinical issues involved in the health care services requested by  
 26 the provider, may not deny or modify requests for authorization  
 27 of health care services for an insured for reasons of medical  
 28 necessity. The decision of the physician or other health care  
 29 provider shall be communicated to the provider and the insured  
 30 pursuant to subdivision (h).

31 (f) (1) An insurer shall disclose, or provide for the disclosure,  
 32 to the commissioner and to network providers, the process *that*  
 33 the insurer, its contracting provider groups, or any entity with  
 34 which it contracts for services that include utilization review or  
 35 utilization management functions, uses to authorize, delay, modify,  
 36 or deny health care services under the benefits provided by the  
 37 insurance contract, including coverage for subacute care,  
 38 transitional inpatient care, ~~or care provided in skilled nursing~~  
 39 ~~facilities.~~ *facilities, and behavioral health treatment.* An insurer  
 40 shall also disclose those processes to policyholders or persons

1 designated by a policyholder, or to any other person or  
2 organization, upon request.

3 (2) The criteria or guidelines used by an insurer, or an entity  
4 with which an insurer contracts for utilization review or utilization  
5 management functions, to determine whether to authorize, modify,  
6 delay, or deny health care services, shall comply with all of the  
7 following:

8 (A) Be developed with involvement from actively practicing  
9 health care providers.

10 (B) Be consistent with sound clinical principles and processes.

11 (C) Be evaluated, and updated if necessary, at least annually.

12 (D) If used as the basis of a decision to modify, delay, or deny  
13 services in a specified case under review, be disclosed to the  
14 provider and the policyholder in that specified case.

15 (E) Be available to the public upon request. An insurer shall  
16 only be required to disclose the criteria or guidelines for the  
17 specific procedures or conditions requested. An insurer may charge  
18 reasonable fees to cover administrative expenses related to  
19 disclosing criteria or guidelines pursuant to this paragraph that are  
20 limited to copying and postage costs. The insurer may also make  
21 the criteria or guidelines available through electronic  
22 communication means.

23 (3) The disclosure required by subparagraph (E) of paragraph  
24 (2) shall be accompanied by the following notice: “The materials  
25 provided to you are guidelines used by this insurer to authorize,  
26 modify, or deny health care benefits for persons with similar  
27 illnesses or conditions. Specific care and treatment may vary  
28 depending on individual need and the benefits covered under your  
29 insurance contract.”

30 (g) If an insurer subject to this section requests medical  
31 information from providers in order to determine whether to  
32 approve, modify, or deny requests for authorization, the insurer  
33 shall request only the information reasonably necessary to make  
34 the determination.

35 (h) In determining whether to approve, modify, or deny requests  
36 by providers prior to, retrospectively, or concurrent with the  
37 provision of health care services to insureds, based in whole or in  
38 part on medical necessity, every insurer subject to this section shall  
39 meet the following requirements:

1 (1) Decisions to approve, modify, or deny, based on medical  
2 necessity, requests by providers prior to, or concurrent with, the  
3 provision of health care services to insureds that do not meet the  
4 requirements for the time period for review required by paragraph  
5 (2), shall be made in a timely fashion appropriate for the nature of  
6 the insured's condition, not to exceed five business days from the  
7 insurer's receipt of the information reasonably necessary and  
8 requested by the insurer to make the determination. In cases where  
9 the review is retrospective, the decision shall be communicated to  
10 the individual who received services, or to the individual's  
11 designee, within 30 days of the receipt of information that is  
12 reasonably necessary to make this determination, and shall be  
13 communicated to the provider in a manner that is consistent with  
14 current law. For purposes of this section, retrospective reviews  
15 shall be for care rendered on or after January 1, 2000.

16 (2) When the insured's condition is such that the insured faces  
17 an imminent and serious threat to his or her health, including, but  
18 not limited to, the potential loss of life, limb, or other major bodily  
19 function, or the normal timeframe for the decisionmaking process,  
20 as described in paragraph (1), would be detrimental to the insured's  
21 life or health or could jeopardize the insured's ability to regain  
22 maximum function, decisions to approve, modify, or deny requests  
23 by providers prior to, or concurrent with, the provision of health  
24 care services to insureds shall be made in a timely fashion,  
25 appropriate for the nature of the insured's condition, but not to  
26 exceed 72 hours or, if shorter, the period of time required under  
27 Section 2719 of the federal Public Health Service Act (42 U.S.C.  
28 Sec. 300gg-19) and any subsequent rules or regulations issued  
29 thereunder, after the insurer's receipt of the information reasonably  
30 necessary and requested by the insurer to make the determination.

31 (3) Decisions to approve, modify, or deny requests by providers  
32 for authorization prior to, or concurrent with, the provision of  
33 health care services to insureds shall be communicated to the  
34 requesting provider within 24 hours of the decision. Except for  
35 concurrent review decisions pertaining to care that is underway,  
36 which shall be communicated to the insured's treating provider  
37 within 24 hours, decisions resulting in denial, delay, or  
38 modification of all or part of the requested health care service shall  
39 be communicated to the insured in writing within two business  
40 days of the decision. In the case of concurrent review, care shall

1 not be discontinued until the insured’s treating provider has been  
2 notified of the insurer’s decision and a care plan has been agreed  
3 upon by the treating provider that is appropriate for the medical  
4 needs of that patient.

5 (4) Communications regarding decisions to approve requests  
6 by providers prior to, retrospectively, or concurrent with the  
7 provision of health care services to insureds shall specify the  
8 specific health care service approved. Responses regarding  
9 decisions to deny, delay, or modify health care services requested  
10 by providers prior to, retrospectively, or concurrent with the  
11 provision of health care services to insureds shall be communicated  
12 to insureds in writing, and to providers initially by telephone or  
13 facsimile, except with regard to decisions rendered retrospectively,  
14 and then in writing, and shall include a clear and concise  
15 explanation of the reasons for the insurer’s decision, a description  
16 of the criteria or guidelines used, and the clinical reasons for the  
17 decisions regarding medical necessity. Any written communication  
18 to a physician or other health care provider of a denial, delay, or  
19 modification or a request shall include the name and telephone  
20 number of the health care professional responsible for the denial,  
21 delay, or modification. The telephone number provided shall be a  
22 direct number or an extension, to allow the physician or health  
23 care provider easily to contact the professional responsible for the  
24 denial, delay, or modification. Responses shall also include  
25 information as to how the provider or the insured may file an appeal  
26 with the insurer or seek department review under the unfair  
27 practices provisions of Article 6.5 (commencing with Section 790)  
28 of Chapter 1 of Part 2 of Division 1 and the regulations adopted  
29 thereunder.

30 (5) If the insurer cannot make a decision to approve, modify,  
31 or deny the request for authorization within the timeframes  
32 specified in paragraph (1) or (2) because the insurer is not in receipt  
33 of all of the information reasonably necessary and requested, or  
34 because the insurer requires consultation by an expert reviewer,  
35 or because the insurer has asked that an additional examination or  
36 test be performed upon the insured, provided that the examination  
37 or test is reasonable and consistent with good medical practice,  
38 the insurer shall, immediately upon the expiration of the timeframe  
39 specified in paragraph (1) or (2), or as soon as the insurer becomes  
40 aware that it will not meet the timeframe, whichever occurs first,

1 notify the provider and the insured, in writing, that the insurer  
 2 cannot make a decision to approve, modify, or deny the request  
 3 for authorization within the required timeframe, and specify the  
 4 information requested but not received, or the expert reviewer to  
 5 be consulted, or the additional examinations or tests required. The  
 6 insurer shall also notify the provider and enrollee of the anticipated  
 7 date on which a decision may be rendered. Upon receipt of all  
 8 information reasonably necessary and requested by the insurer,  
 9 the insurer shall approve, modify, or deny the request for  
 10 authorization within the timeframes specified in paragraph (1) or  
 11 (2), whichever applies.

12 (6) If the commissioner determines that an insurer has failed to  
 13 meet any of the timeframes in this section, or has failed to meet  
 14 any other requirement of this section, the commissioner may assess,  
 15 by order, administrative penalties for each failure. A proceeding  
 16 for the issuance of an order assessing administrative penalties shall  
 17 be subject to appropriate notice to, and an opportunity for a hearing  
 18 with regard to, the person affected. The administrative penalties  
 19 shall not be deemed an exclusive remedy for the commissioner.  
 20 These penalties shall be paid to the Insurance Fund.

21 (i) Every insurer subject to this section shall maintain telephone  
 22 access for providers to request authorization for health care  
 23 services.

24 (j) Nothing in this section shall cause a disability insurer to be  
 25 defined as a health care provider for purposes of any provision of  
 26 law, including, but not limited to, Section 6146 of the Business  
 27 and Professions Code, Sections 3333.1 and 3333.2 of the Civil  
 28 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the  
 29 Code of Civil Procedure.

30 SEC. 3. No reimbursement is required by this act pursuant to  
 31 Section 6 of Article XIII B of the California Constitution because  
 32 the only costs that may be incurred by a local agency or school  
 33 district will be incurred because this act creates a new crime or  
 34 infraction, eliminates a crime or infraction, or changes the penalty  
 35 for a crime or infraction, within the meaning of Section 17556 of  
 36 the Government Code, or changes the definition of a crime within  
 37 the meaning of Section 6 of Article XIII B of the California  
 38 Constitution.

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