

**ASSEMBLY BILL**

**No. 1268**

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**Introduced by Assembly Member Rodriguez**

February 21, 2019

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An act to amend Sections 1363.5 and 1367.01 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

AB 1268, as introduced, Rodriguez. Health care coverage: prospective review.

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 a health care service plan or health insurer to have written policies and procedures establishing the process by which the plan or insurer approves, modifies, delays, or denies requests for health care services based in whole or in part on medical necessity, including those plans or insurers that delegate these functions to medical groups, independent practice associations, or to other contracting providers. Existing law requires a plan or insurer to evaluate its criteria used to authorize, modify, or deny health care services at least annually.

This bill would require a health care service plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that each health care service was prospectively approved, modified, delayed, or denied. The bill would require a plan or insurer

to take the reported information into account when evaluating its criteria used to authorize, modify, or deny health care services. The bill would require each department to determine the form and manner of that reporting. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the 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 the plan, its  
5 contracting provider groups, or ~~any~~ *an* 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. A plan shall also disclose  
11 those processes to enrollees or persons designated by an enrollee,  
12 or to any other person or organization, upon request. The disclosure  
13 to the director shall include the policies, procedures, and the  
14 description of the process that are filed with the director pursuant  
15 to subdivision (b) of Section 1367.01.

16 (b) The criteria or guidelines used by ~~plans, a plan, or any~~  
17 ~~entities~~ *an entity* with which ~~plans contract~~ *a plan contracts* for  
18 services that include utilization review or utilization management  
19 functions, to determine whether to authorize, modify, or deny  
20 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.

1 (3) Be evaluated, *taking into account the information reported*  
2 *pursuant to subdivision (k) of Section 1367.01*, and updated if  
3 necessary, at least annually.

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

7 (5) Be available to the public upon request. A plan shall only  
8 be required to disclose the criteria or guidelines for the specific  
9 procedures or conditions requested. A plan may charge reasonable  
10 fees to cover administrative expenses related to disclosing criteria  
11 or guidelines pursuant to this paragraph, limited to copying and  
12 postage costs. The plan may also make the criteria or guidelines  
13 available through electronic communication means.

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

20 SEC. 2. Section 1367.01 of the Health and Safety Code is  
21 amended to read:

22 1367.01. (a) A health care service plan and ~~any~~ *an* entity with  
23 which it contracts for services that include utilization review or  
24 utilization management functions, that prospectively,  
25 retrospectively, or concurrently reviews and approves, modifies,  
26 delays, or denies, based in whole or in part on medical necessity,  
27 requests by providers ~~prior to, before,~~ retrospectively, or concurrent  
28 with the provision of health care services to enrollees, or that  
29 delegates these functions to medical groups or independent practice  
30 associations or to other contracting providers, shall comply with  
31 this section.

32 (b) A health care service plan that is subject to this section shall  
33 have written policies and procedures establishing the process by  
34 which the plan prospectively, retrospectively, or concurrently  
35 reviews and approves, modifies, delays, or denies, based in whole  
36 or in part on medical necessity, requests by providers of health  
37 care services for plan enrollees. These policies and procedures  
38 shall ensure that decisions based on the medical necessity of  
39 proposed health care services are consistent with criteria or  
40 guidelines that are supported by clinical principles and processes.

1 These criteria and guidelines shall be developed pursuant to Section  
2 1363.5. These policies and procedures, and a description of the  
3 process by which the plan reviews and approves, modifies, delays,  
4 or denies requests by providers ~~prior to~~, *before*, retrospectively,  
5 or concurrent with the provision of health care services to enrollees,  
6 shall be filed with the director for review and approval, and shall  
7 be disclosed by the plan to providers and enrollees upon request,  
8 and by the plan to the public upon request.

9 (c) A health care service plan subject to this section, except a  
10 plan that meets the requirements of Section 1351.2, shall employ  
11 or designate a medical director who holds an unrestricted license  
12 to practice medicine in this state issued pursuant to Section 2050  
13 of the Business and Professions Code or pursuant to the  
14 Osteopathic Act, or, if the plan is a specialized health care service  
15 plan, a clinical director with California licensure in a clinical area  
16 appropriate to the type of care provided by the specialized health  
17 care service plan. The medical director or clinical director shall  
18 ensure that the process by which the plan reviews and approves,  
19 modifies, or denies, based in whole or in part on medical necessity,  
20 requests by providers ~~prior to~~, *before*, retrospectively, or concurrent  
21 with the provision of health care services to enrollees, complies  
22 with the requirements of this section.

23 (d) If health plan personnel, or individuals under contract to the  
24 plan to review requests by providers, approve the provider's  
25 request, pursuant to subdivision (b), the decision shall be  
26 communicated to the provider pursuant to subdivision (h).

27 (e) No individual, other than a licensed physician or a licensed  
28 health care professional who is competent to evaluate the specific  
29 clinical issues involved in the health care services requested by  
30 the provider, may deny or modify requests for authorization of  
31 health care services for an enrollee for reasons of medical necessity.  
32 The decision of the physician or other health care professional  
33 shall be communicated to the provider and the enrollee pursuant  
34 to subdivision (h).

35 (f) The criteria or guidelines used by the health care service  
36 plan to determine whether to approve, modify, or deny requests  
37 by providers ~~prior to~~, *before*, retrospectively, or concurrent with,  
38 the provision of health care services to enrollees shall be consistent  
39 with clinical principles and processes. These criteria and guidelines  
40 shall be developed pursuant to the requirements of Section 1363.5.

1 (g) If the health care service plan requests medical information  
2 from providers in order to determine whether to approve, modify,  
3 or deny requests for authorization, the plan shall request only the  
4 information reasonably necessary to make the determination.

5 (h) In determining whether to approve, modify, or deny requests  
6 by providers ~~prior to~~, *before*, retrospectively, or concurrent with  
7 the provision of health care services to enrollees, based in whole  
8 or in part on medical necessity, a health care service plan subject  
9 to this section shall meet the following requirements:

10 (1) Decisions to approve, modify, or deny, based on medical  
11 necessity, requests by providers ~~prior to~~, *before*, or concurrent with  
12 the provision of health care services to enrollees that do not meet  
13 the requirements for the time period for review required by  
14 paragraph (2), shall be made in a timely fashion appropriate for  
15 the nature of the enrollee's condition, not to exceed five business  
16 days from the plan's receipt of the information reasonably  
17 necessary and requested by the plan to make the determination. In  
18 cases where the review is retrospective, the decision shall be  
19 communicated to the individual who received services, or to the  
20 individual's designee, within 30 days of the receipt of information  
21 that is reasonably necessary to make this determination, and shall  
22 be communicated to the provider in a manner that is consistent  
23 with current law. For purposes of this section, retrospective reviews  
24 shall be for care rendered on or after January 1, 2000.

25 (2) When the enrollee's condition is such that the enrollee faces  
26 an imminent and serious threat to ~~his or her~~ *the enrollee's* health,  
27 including, but not limited to, the potential loss of life, limb, or  
28 other major bodily function, or the normal timeframe for the  
29 decisionmaking process, as described in paragraph (1), would be  
30 detrimental to the enrollee's life or health or could jeopardize the  
31 enrollee's ability to regain maximum function, decisions to  
32 approve, modify, or deny requests by providers ~~prior to~~, *before*,  
33 or concurrent with, the provision of health care services to  
34 enrollees, shall be made in a timely fashion appropriate for the  
35 nature of the enrollee's condition, not to exceed 72 hours or, if  
36 shorter, the period of time required under Section 2719 of the  
37 federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and  
38 any subsequent rules or regulations issued thereunder, after the  
39 plan's receipt of the information reasonably necessary and  
40 requested by the plan to make the determination. ~~Nothing in this~~

1 This section shall *not* be construed to alter the requirements of  
2 subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4,  
3 the requirements of this division shall be applicable to all health  
4 plans and other entities conducting utilization review or utilization  
5 management.

6 (3) Decisions to approve, modify, or deny requests by providers  
7 for authorization ~~prior to~~, *before*, or concurrent with, the provision  
8 of health care services to enrollees shall be communicated to the  
9 requesting provider within 24 hours of the decision. Except for  
10 concurrent review decisions pertaining to care that is underway,  
11 which shall be communicated to the enrollee's treating provider  
12 within 24 hours, decisions resulting in denial, delay, or  
13 modification of all or part of the requested health care service shall  
14 be communicated to the enrollee in writing within two business  
15 days of the decision. In the case of concurrent review, care shall  
16 not be discontinued until the enrollee's treating provider has been  
17 notified of the plan's decision and a care plan has been agreed  
18 upon by the treating provider that is appropriate for the medical  
19 needs of that patient.

20 (4) Communications regarding decisions to approve requests  
21 by providers ~~prior to~~, *before*, retrospectively, or concurrent with  
22 the provision of health care services to enrollees shall specify the  
23 specific health care service approved. Responses regarding  
24 decisions to deny, delay, or modify health care services requested  
25 by providers ~~prior to~~, *before*, retrospectively, or concurrent with  
26 the provision of health care services to enrollees shall be  
27 communicated to the enrollee in writing, and to providers initially  
28 by telephone or facsimile, except with regard to decisions rendered  
29 retrospectively, and then in writing, and shall include a clear and  
30 concise explanation of the reasons for the plan's decision, a  
31 description of the criteria or guidelines used, and the clinical  
32 reasons for the decisions regarding medical necessity. ~~Any~~ A  
33 written communication to a physician or other health care provider  
34 of a denial, delay, or modification of a request shall include the  
35 name and telephone number of the health care professional  
36 responsible for the denial, delay, or modification. The telephone  
37 number provided shall be a direct number or an extension, to allow  
38 the physician or health care provider easily to contact the  
39 professional responsible for the denial, delay, or modification.  
40 Responses shall also include information as to how the enrollee

1 may file a grievance with the plan pursuant to Section 1368, and  
2 in the case of Medi-Cal enrollees, shall explain how to request an  
3 administrative hearing and aid paid pending under Sections 51014.1  
4 and 51014.2 of Title 22 of the California Code of Regulations.

5 (5) If the health care service plan cannot make a decision to  
6 approve, modify, or deny the request for authorization within the  
7 timeframes specified in paragraph (1) or (2) because the plan is  
8 not in receipt of all of the information reasonably necessary and  
9 requested, or because the plan requires consultation by an expert  
10 reviewer, or because the plan has asked that an additional  
11 examination or test be performed upon the enrollee, provided the  
12 examination or test is reasonable and consistent with good medical  
13 practice, the plan shall, immediately upon the expiration of the  
14 timeframe specified in paragraph (1) or (2) or as soon as the plan  
15 becomes aware that it will not meet the timeframe, whichever  
16 occurs first, notify the provider and the enrollee, in writing, that  
17 the plan cannot make a decision to approve, modify, or deny the  
18 request for authorization within the required timeframe, and specify  
19 the information requested but not received, or the expert reviewer  
20 to be consulted, or the additional examinations or tests required.  
21 The plan shall also notify the provider and enrollee of the  
22 anticipated date on which a decision may be rendered. Upon receipt  
23 of all information reasonably necessary and requested by the plan,  
24 the plan shall approve, modify, or deny the request for authorization  
25 within the timeframes specified in paragraph (1) or (2), whichever  
26 applies.

27 (6) If the director determines that a health care service plan has  
28 failed to meet ~~any~~ of the timeframes in this section, or has failed  
29 to meet any other requirement of this section, the director may  
30 assess, by order, administrative penalties for each failure. A  
31 proceeding for the issuance of an order assessing administrative  
32 penalties shall be subject to appropriate notice to, and an  
33 opportunity for a hearing with regard to, the person affected, in  
34 accordance with subdivision (a) of Section 1397. The  
35 administrative penalties shall not be deemed an exclusive remedy  
36 for the director. These penalties shall be paid to the Managed Care  
37 Administrative Fines and Penalties Fund and shall be used for the  
38 purposes specified in Section 1341.45.

1 (i) A health care service plan subject to this section shall  
2 maintain telephone access for providers to request authorization  
3 for health care services.

4 (j) A health care service plan subject to this section that reviews  
5 requests by providers ~~prior to~~, *before*, retrospectively, or concurrent  
6 with, the provision of health care services to enrollees shall  
7 establish, as part of the quality assurance program required by  
8 Section 1370, a process by which the plan’s compliance with this  
9 section is assessed and evaluated. The process shall include  
10 provisions for evaluation of complaints, assessment of trends,  
11 implementation of actions to correct identified problems,  
12 mechanisms to communicate actions and results to the appropriate  
13 health plan employees and contracting providers, and provisions  
14 for evaluation of any corrective action plan and measurements of  
15 performance.

16 (k) (1) *On or before July 1, 2020, and annually on July 1*  
17 *thereafter, a health care service plan that prospectively reviews*  
18 *and approves, modifies, delays, or denies, based in whole or in*  
19 *part on medical necessity, requests by providers before the*  
20 *provision of health care services to enrollees, or that delegates*  
21 *these functions to medical groups or independent practice*  
22 *associations or to other contracting providers, shall, for each*  
23 *health care service subject to prospective review, report to the*  
24 *department the number of times in the preceding calendar year*  
25 *the service was approved, modified, delayed, or denied.*

26 (2) *The form and manner of the reporting required pursuant to*  
27 *paragraph (1) shall be determined by the department.*

28 ~~(k)~~

29 (l) The director shall review a health care service plan’s  
30 compliance with this section as part of its periodic onsite medical  
31 survey of each plan undertaken pursuant to Section 1380, and shall  
32 include a discussion of compliance with this section as part of its  
33 report issued pursuant to that section.

34 ~~(l)~~

35 (m) This section shall not apply to decisions made for the care  
36 or treatment of the sick who depend upon prayer or spiritual means  
37 for healing in the practice of religion as set forth in subdivision  
38 (a) of Section 1270.

39 ~~(m) Nothing in this~~



1 (n) This section shall *not* cause a health care service plan to be  
2 defined as a health care provider for purposes of any ~~provision of~~  
3 law, including, but not limited to, Section 6146 of the Business  
4 and Professions Code, Sections 3333.1 and 3333.2 of the Civil  
5 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the  
6 Code of Civil Procedure.

7 SEC. 3. Section 10123.135 of the Insurance Code is amended  
8 to read:

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

19 (b) A disability insurer that is subject to this section, or ~~any an~~  
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, before,~~ retrospectively, or concurrent with the  
36 provision of health care services to insureds, shall be filed with  
37 the 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, before,~~  
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~~ *This* subdivision ~~shall be construed as restricting~~  
18 *does not restrict* the existing authority of the Medical Board of  
19 California.

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

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

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

1 by a policyholder, or to any other person or organization, upon  
2 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, *taking into account the information reported*  
12 *pursuant to subdivision (j)*, and updated if necessary, at least  
13 annually.

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

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

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

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

37 (h) In determining whether to approve, modify, or deny requests  
38 by providers ~~prior to~~, *before*, retrospectively, or concurrent with  
39 the provision of health care services to insureds, based in whole

1 or in part on medical necessity, every insurer subject to this section  
2 shall meet the following requirements:

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

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

34 (3) Decisions to approve, modify, or deny requests by providers  
35 for authorization ~~prior to~~, *before*, or concurrent with, the provision  
36 of health care services to insureds shall be communicated to the  
37 requesting provider within 24 hours of the decision. Except for  
38 concurrent review decisions pertaining to care that is underway,  
39 which shall be communicated to the insured's treating provider  
40 within 24 hours, decisions resulting in denial, delay, or

1 modification of all or part of the requested health care service shall  
2 be communicated to the insured in writing within two business  
3 days of the decision. In the case of concurrent review, care shall  
4 not be discontinued until the insured's treating provider has been  
5 notified of the insurer's decision and a care plan has been agreed  
6 upon by the treating provider that is appropriate for the medical  
7 needs of that patient.

8 (4) Communications regarding decisions to approve requests  
9 by providers ~~prior to, before,~~ retrospectively, or concurrent with  
10 the provision of health care services to insureds shall specify the  
11 specific health care service approved. Responses regarding  
12 decisions to deny, delay, or modify health care services requested  
13 by providers ~~prior to, before,~~ retrospectively, or concurrent with  
14 the provision of health care services to insureds shall be  
15 communicated to insureds in writing, and to providers initially by  
16 telephone or facsimile, except with regard to decisions rendered  
17 retrospectively, and then in writing, and shall include a clear and  
18 concise explanation of the reasons for the insurer's decision, a  
19 description of the criteria or guidelines used, and the clinical  
20 reasons for the decisions regarding medical necessity. ~~Any~~ A  
21 written communication to a physician or other health care provider  
22 of a denial, delay, or modification or a request shall include the  
23 name and telephone number of the health care professional  
24 responsible for the denial, delay, or modification. The telephone  
25 number provided shall be a direct number or an extension, to allow  
26 the physician or health care provider easily to contact the  
27 professional responsible for the denial, delay, or modification.  
28 Responses shall also include information as to how the provider  
29 or the insured may file an appeal with the insurer or seek  
30 department review under the unfair practices provisions of Article  
31 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of  
32 Division 1 and the regulations adopted thereunder.

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

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

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

24 (i) Every insurer subject to this section shall maintain telephone  
 25 access for providers to request authorization for health care  
 26 services.

27 (j) *(1) On or before July 1, 2020, and annually on July 1*  
 28 *thereafter, a disability insurer that prospectively reviews and*  
 29 *approves, modifies, delays, or denies, based in whole or in part*  
 30 *on medical necessity, requests by providers before the provision*  
 31 *of health care services to enrollees, or that delegates these*  
 32 *functions to medical groups or independent practice associations*  
 33 *or to other contracting providers, shall, for each health care*  
 34 *service subject to prospective review, report to the department the*  
 35 *number of times in the preceding calendar year the service was*  
 36 *approved, modified, delayed, or denied.*

37 (2) *The form and manner of the reporting required pursuant to*  
 38 *paragraph (1) shall be determined by the department.*

39 ~~(j) Nothing in this~~

1     (k) *This* section shall *not* cause a disability insurer to be defined  
2 as a health care provider for purposes of any ~~provision~~ of law,  
3 including, but not limited to, Section 6146 of the Business and  
4 Professions Code, Sections 3333.1 and 3333.2 of the Civil Code,  
5 and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of  
6 Civil Procedure.

7     SEC. 4. No reimbursement is required by this act pursuant to  
8 Section 6 of Article XIII B of the California Constitution because  
9 the only costs that may be incurred by a local agency or school  
10 district will be incurred because this act creates a new crime or  
11 infraction, eliminates a crime or infraction, or changes the penalty  
12 for a crime or infraction, within the meaning of Section 17556 of  
13 the Government Code, or changes the definition of a crime within  
14 the meaning of Section 6 of Article XIII B of the California  
15 Constitution.

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