# AB-510 Health care coverage: utilization review: peer-to-peer review. (2025-2026)



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CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

## ASSEMBLY BILL NO. 510

**Introduced by Assembly Member Addis**

**February 10, 2025**

An act to ~~amend Section 1368.01 of, and to~~ add Section 1367.017 ~~to,~~ *to* the Health and Safety Code, ~~to amend Section 10123.137 of,~~ and to add Section 10123.138 ~~to,~~ *to* the Insurance Code, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

AB 510, as amended, Addis. Health care coverage: utilization review: ~~appeals and grievances.~~ *peer-to-peer 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 the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. ~~Existing law requires a health care service plan or disability insurer to include in a response regarding decisions to deny, delay, or modify health care services, among other things, information on how the provider, enrollee, or insured may file a grievance or appeal with the plan or insurer. Existing law requires a health care service plan's grievance system to resolve grievances within 30 days, except as specified. Existing law requires a contract between a health insurer and a provider to contain provisions requiring a dispute resolution mechanism, and requires an insurer to resolve each provider dispute within 45 working days, as specified.~~

This ~~bill would, upon request, require that an appeal or grievance regarding~~ *bill, upon communication of* a decision by a health care service plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, ~~be reviewed by~~ *would authorize a provider to request review of the decision by* a licensed physician, or a licensed health care professional under specified circumstances, who is competent to evaluate the specific clinical issues involved in the health care service being requested, and *is* of the same or similar specialty as the requesting provider. The bill would authorize ~~review of a grievance or appeal by~~ a licensed health care professional *to be the reviewer* if the provider requesting *peer-to-peer* review is not a physician. The bill, notwithstanding ~~the above-described timelines,~~ *any other law,* would require these reviews to

occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or health insurer fails to meet those timelines, the bill would deem the request for the health care service as approved and supersede any prior delay, denial, or modification. ~~The bill would make conforming changes to related provisions.~~

Because a violation of these provisions by a health care service plan would be a crime, 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 Local Program: yes

## THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

**SECTION 1.** Section 1367.017 is added to the Health and Safety Code, to read:

**1367.017.** (a) Upon ~~request, an appeal or grievance regarding~~ *communication of* a decision by a health care service plan delaying, denying, or modifying a health care service based in whole or in part on medical necessity, ~~shall be reviewed~~ *a provider may request a review* by a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional. The *peer-to-peer* review process shall meet both of the following requirements:

(1) Upon a request for *peer-to-peer* review pursuant to this section, a health care service plan shall directly and expeditiously connect the requesting health care provider with a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional without requiring the requesting provider to communicate with any additional health care service plan employees or other individuals acting on behalf of the health care service plan.

(2) Notwithstanding any other law, a *peer-to-peer* review requested pursuant to this section shall occur within two business days of the request. However, if the enrollee faces an imminent and serious threat to their health as described in paragraph (2) of subdivision (h) of Section 1367.01, a *peer-to-peer* review requested pursuant to this section shall occur in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 24 hours after the request.

(b) If a health care service plan fails to meet the review timelines set forth in paragraph (2) of subdivision (a), the request for the health care service shall be deemed approved and supersede any prior delay, denial, or modification.

(c) ~~An appeal or grievance~~ *A peer-to-peer* review may be performed by a health care service plan's contracted specialist reviewer, provided the reviewer is a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional.

(d) If a provider requesting *peer-to-peer* review pursuant to this section is not a physician, ~~the appeal or grievance may be reviewed by a peer health care professional.~~ *a peer health care professional may be the reviewer.*

(e) For purposes of this section, the following definitions apply:

(1) "Peer health care professional" means a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care service being requested, and *is* of the same or similar specialty as the requesting provider.

(2) "Peer physician" means a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and *is* of the same or similar specialty as the requesting provider.

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

~~1368.01.(a)The grievance system shall require the plan to resolve grievances within 30 days, except as provided in subdivision (c) and Section 1367.017.~~

~~(b)The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance, except as provided in subdivision (c). Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.~~

~~(c)A health care service plan contract in the individual, small group, or large group markets that provides coverage for outpatient~~

~~prescription drugs shall comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~SEC. 3.Section 10123.137 of the Insurance Code is amended to read:~~

~~10123.137.(a)Each contract between a health insurer and a provider shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer, and requiring the insurer to inform its providers, upon contracting with the insurer, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.~~

~~(b)An insurer shall also ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.~~

~~(c)Disputes are to be submitted to the insurer in writing and shall include provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and, if applicable, billed and paid amounts. The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute, except as provided in Section 10123.138.~~

~~(d)On and after July 1, 2007, an insurer shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall be public information and include, at a minimum, information on the number of providers that utilized the dispute resolution mechanism and a summary of the disposition of those disputes. To the extent the commissioner requires detailed information disclosing emerging or established patterns of provider disputes or corrective action by the insurer, the commissioner may maintain the confidentiality of any information found to be proprietary, upon written request of the insurer. In no event shall the commissioner find the required minimum information described in this subdivision to be proprietary.~~

~~(e)If an insurer has an affiliated or subsidiary company that is licensed as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the insurer may use the same procedures relating to the provider dispute resolution process established by the affiliated or subsidiary entity pursuant to subdivision (h) of Section 1367 of the Health and Safety Code.~~

~~**SEC. 4.**~~***SEC. 2.*** Section 10123.138 is added to the Insurance Code, to read:

**10123.138.** (a) Upon~~ request, an appeal or grievance regarding~~ *communication of* a decision by a health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity,~~ shall be reviewed~~ *a provider may request a review* by a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional. The *peer-to-peer* review process shall meet both of the following requirements:

(1) Upon a request for *peer-to-peer* review pursuant to this section, a health insurer shall directly and expeditiously connect the requesting health care provider with a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional without requiring the requesting provider to communicate with any additional health insurer employees or other individuals acting on behalf of the health insurer.

(2) Notwithstanding any other law, a *peer-to-peer* review requested pursuant to this section shall occur within two business days of the request. However, if the insured faces an imminent and serious threat to their health as described in paragraph (2) of subdivision (h) of Section 10123.135, a *peer-to-peer* review requested pursuant to this section shall occur in a timely fashion appropriate for the nature of the insured's condition, not to exceed 24 hours after the request.

(b) If a health insurer fails to meet the review timelines set forth in paragraph (2) of subdivision (a), the request for the health care service shall be deemed approved and supersede any prior delay, denial, or modification.

(c) ~~An appeal or grievance~~ *A peer-to-peer* review may be performed by a health insurer's contracted specialist reviewer, provided the reviewer is a peer physician or, if authorized pursuant to subdivision (d), a peer health care professional.

(d) If a provider requesting *peer-to-peer* review pursuant to this section is not a physician,~~ the appeal or grievance may be reviewed by a peer health care professional.~~ *a peer health care professional may be the reviewer.*

(e) For purposes of this section, the following definitions apply:

(1) "Peer health care professional" means a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care service being requested, and *is* of the same or similar specialty as the requesting provider.

(2) “Peer physician” means a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and *is* of the same or similar specialty as the requesting provider.

~~**SEC. 5.**~~ ***SEC. 3.*** No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.