

## Senate Bill No. 454

### CHAPTER 788

An act to amend Sections 1367 and 1368 of, and to add Section 1397.6 to, the Health and Safety Code, relating to health care service plans.

[Approved by Governor October 12, 1995. Filed  
with Secretary of State October 12, 1995.]

#### LEGISLATIVE COUNSEL'S DIGEST

SB 454, Russell. Health care service plans: grievances.

Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, willful violation of any of these provisions is a misdemeanor. Existing law requires every plan to establish and maintain a grievance system approved by the department under which enrollees may submit grievances to the plan.

This bill would, in addition, require every plan to include in its contracts with providers a dispute resolution system for the submission of disputes to the plan by providers. By changing the definition of a crime, this bill would impose a state-mandated local program.

This bill would also allow subscribers and enrollees, or their agents, to submit a grievance to the Department of Corporations for review after compliance with certain procedures, and would require the plan to provide notice of this right to subscribers or enrollees in a prescribed manner. The bill would authorize the department to refer any grievance or complaint to other appropriate state and federal entities for investigation and resolution, and would require the department to refer any grievance or complaint involving a Medi-Cal enrollee to the State Department of Health Services for investigation and resolution.

This bill would authorize a provider to join with, or otherwise assist, a subscriber or enrollee in submitting the grievance or complaint to the department and to assist with the department's grievance process. The bill would require the department to review the documents submitted, would authorize the department to request additional information and to hold meetings with the parties, and would require the department to send a written notice of the final disposition of the grievance and the reasons therefor to the subscriber or enrollee, or their agent, and the plan within 60 calendar days. This bill would require that distribution of the written notice not be deemed a waiver of any exemption or privilege under existing law

for any information disclosed in connection with the written notice, and would prohibit any person employed or in any way retained by the department from being required to testify regarding that information or notice. This bill would require the commissioner, on or before January 1, 1997, to establish and maintain a system of aging of complaints that are pending and unresolved for 60 days or more.

The bill would also authorize the subscriber or enrollee, or their agent, to request voluntary mediation with the plan prior to exercising their right to submit a complaint or grievance to the department, and would provide that choosing to use mediation services would not affect that right.

This bill would also require, on or before January 1, 1997, a plan's grievance system to include a system of aging of complaints that are pending and unresolved for 30 days or more.

This bill would provide that the procedures authorized by the bill are in addition to other procedures that may be available, and that failure to pursue or exhaust the remedies or to engage in the procedures described shall not preclude the use of any other remedy provided by law.

This bill would also authorize the commissioner to contract on a noncompetitive bid basis with necessary medical consultants to assist with the health care program of the department, and would exempt these contracts from certain provisions of the Public Contract Code.

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.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. Each health care service plan, and where applicable, each specialized health care service plan, shall meet the following requirements:

(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.



(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, 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.

(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the commissioner may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The commissioner shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Nothing in this section shall be construed to permit the commissioner to establish the rates charged subscribers and enrollees for contractual health care services.



The commissioner's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

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

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

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations which shall insure adequate consideration of enrollee grievances and rectification when appropriate.

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

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

(4) Keep in its files all copies of complaints, and the responses thereto, for a period of five years.

(b) (1)(A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 60 days, a subscriber or enrollee may submit the grievance or complaint to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or participate in the process for at least 60 days.

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

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance or complaint to the State Department of Health Services, the Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution, and shall refer any grievance or complaint involving a Medi-Cal enrollee to the State Department of Health Services for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance or complaint to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or



otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance or complaint to the department. In addition, following submission of the grievance or complaint to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a “relative” includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) Every health care service plan regulated by the department shall prominently display in every plan contract, on enrollee and subscriber evidence of coverage forms, on the complaint forms required under paragraph (3) of subdivision (a), and on all written responses to grievances and complaints, a notice of the right to submit unresolved grievances and complaints to the department for review.

(4) The department shall review the written documents submitted with the subscriber’s or the enrollee’s request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or complaint, or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. The department shall send a written notice of the final disposition of the grievance or complaint, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 60 calendar days of receipt of the request for review unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance or complaint. Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice. On or before January 1, 1997, the commissioner shall establish and maintain a system of aging of complaints that are pending and unresolved for 60 days or more, which system shall include a brief explanation of the reasons each complaint is pending and unresolved for 60 days or more.

(5) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance or complaint to the department. The use of mediation services shall not preclude the right to submit a grievance or complaint to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber



or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of complaints that are pending and unresolved for 30 days or more. On or before January 1, 1997, the plan shall provide a quarterly report to the commissioner with a brief explanation of the reasons each complaint is pending and unresolved for 30 days or more.

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

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

SEC. 3. Section 1397.6 is added to the Health and Safety Code, to read:

1397.6. The commissioner may contract with necessary medical consultants to assist with the health care program. These contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 4. It is the intent of the Legislature that the purpose of subdivision (b) of Section 1368 of the Health and Safety Code, as amended by Section 2 of this act, is to allow the filing of health care service complaints from subscribers and enrollees of health care service plans for the purpose of assisting the Department of Corporations in its enforcement of the Knox-Keene Health Care Service Plan Act of 1975, to the extent that the department is able to reach a conclusion on whether or not a plan is complying with its responsibilities under the act based on information submitted to the department.

SEC. 5. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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