

Introduced by Senator Sher

February 23, 2001

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

LEGISLATIVE COUNSEL'S DIGEST

SB 1092, as introduced, Sher. Health care service plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care. The act requires, as part of this regulation, that each plan establish and maintain a system approved by the department whereby subscribers and enrollees may submit their grievances to the plan.

This bill would define the term grievance for these purposes.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

1 SECTION 1. 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 approved by the
 5 department under which *subscribers and* enrollees may submit
 6 their grievances to the plan. *For these purposes, "grievance"*
 7 *means any written or oral expression of dissatisfaction and shall*
 8 *include any complaint, dispute, request for reconsideration, or*
 9 *appeal made by a subscriber or enrollee or by his or her*
 10 *representative to a plan or to an entity to which a plan has*



1 *delegated authority to resolve grievances on behalf of the plan.*
2 *Any uncertainty as to whether any expression of dissatisfaction is*
3 *an inquiry or grievance shall be resolved by finding it a grievance.*
4 Each system shall provide reasonable procedures in accordance
5 with department regulations that shall ensure adequate
6 consideration of enrollee grievances and rectification when
7 appropriate.

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

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

16 (4) Provide subscribers and enrollees with written responses to
17 grievances, with a clear and concise explanation of the reasons for
18 the plan's response. For grievances involving the delay, denial, or
19 modification of health care services, the plan response shall
20 describe the criteria used and the clinical reasons for its decision,
21 including all criteria and clinical reasons related to medical
22 necessity. If a plan, or one of its contracting providers, issues a
23 decision delaying, denying, or modifying health care services
24 based in whole or in part on a finding that the proposed health care
25 services are not a covered benefit under the contract that applies
26 to the enrollee, the decision shall clearly specify the provisions in
27 the contract that exclude that coverage.

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

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



1 at least 30 days before submitting a grievance to the department for
2 review.

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

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

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

24 (3) The department shall review the written documents
25 submitted with the subscriber’s or the enrollee’s request for
26 review, or submitted by the agent on behalf of the subscriber or
27 enrollee. The department may ask for additional information, and
28 may hold an informal meeting with the involved parties, including
29 providers who have joined in submitting the grievance or who are
30 otherwise assisting or advocating on behalf of the subscriber or
31 enrollee. If after reviewing the record, the department concludes
32 that the grievance, in whole or in part, is eligible for review under
33 the independent medical review system established pursuant to
34 Article 5.55 (commencing with Section 1374.30), the department
35 shall immediately notify the subscriber or enrollee, or agent, of
36 that option and shall, if requested orally or in writing, assist the
37 subscriber or enrollee in participating in the independent medical
38 review system.

39 (4) If after reviewing the record of a grievance, the department
40 concludes that a health care service eligible for coverage and



1 payment under a health care service plan contract has been
2 delayed, denied, or modified by a plan, or by one of its contracting
3 providers, in whole or in part due to a determination that the
4 service is not medically necessary, and that determination was not
5 communicated to the enrollee in writing along with a notice of the
6 enrollee's potential right to participate in the independent medical
7 review system, as required by this chapter, the director shall, by
8 order, assess administrative penalties. A proceeding for the
9 issuance of an order assessing administrative penalties shall be
10 subject to appropriate notice of, and the opportunity for, a hearing
11 with regard to the person affected in accordance with Section
12 1397. The administrative penalties shall not be deemed an
13 exclusive remedy available to the director. These penalties shall be
14 paid to the State Managed Care Fund.

15 (5) The department shall send a written notice of the final
16 disposition of the grievance, and the reasons therefor, to the
17 subscriber or enrollee, the agent, to any provider that has joined
18 with or is otherwise assisting the subscriber or enrollee, and to the
19 plan, within 30 calendar days of receipt of the request for review
20 unless the director, in his or her discretion, determines that
21 additional time is reasonably necessary to fully and fairly evaluate
22 the relevant grievance. In any case not eligible for the independent
23 medical review system established pursuant to Article 5.55
24 (commencing with Section 1374.30), the department's written
25 notice shall include, at a minimum, the following:

26 (A) A summary of its findings and the reasons why the
27 department found the plan to be, or not to be, in compliance with
28 any applicable laws, regulations, or orders of the director.

29 (B) A discussion of the department's contact with any medical
30 provider, or any other independent expert relied on by the
31 department, along with a summary of the views and qualifications
32 of that provider or expert.

33 (C) If the enrollee's grievance is sustained in whole or part,
34 information about any corrective action taken.

35 (6) In any department review of a grievance involving a
36 disputed health care service, as defined in subdivision (b) of
37 Section 1374.30, that is not eligible for the independent medical
38 review system established pursuant to Article 5.55 (commencing
39 with Section 1374.30), in which the department finds that the plan
40 has delayed, denied, or modified health care services that are



1 medically necessary, based on the specific medical circumstances
2 of the enrollee, and those services are a covered benefit under the
3 terms and conditions of the health care service plan contract, the
4 department's written notice shall either: (A) order the plan to
5 promptly offer and provide those health care services to the
6 enrollee, or (B) order the plan to promptly reimburse the enrollee
7 for any reasonable costs associated with urgent care or emergency
8 services, or other extraordinary and compelling health care
9 services, when the department finds that the enrollee's decision to
10 secure those services outside of the plan network was reasonable
11 under the circumstances. The department's order shall be binding
12 on the plan.

13 (7) Distribution of the written notice shall not be deemed a
14 waiver of any exemption or privilege under existing law,
15 including, but not limited to, Section 6254.5 of the Government
16 Code, for any information in connection with and including the
17 written notice, nor shall any person employed or in any way
18 retained by the department be required to testify as to that
19 information or notice.

20 (8) The director shall establish and maintain a system of aging
21 of grievances that are pending and unresolved for 30 days or more,
22 that shall include a brief explanation of the reasons each grievance
23 is pending and unresolved for 30 days or more.

24 (9) A subscriber or enrollee, or the agent acting on behalf of a
25 subscriber or enrollee, may also request voluntary mediation with
26 the plan prior to exercising the right to submit a grievance to the
27 department. The use of mediation services shall not preclude the
28 right to submit a grievance to the department upon completion of
29 mediation. In order to initiate mediation, the subscriber or
30 enrollee, or the agent acting on behalf of the subscriber or enrollee,
31 and the plan shall voluntarily agree to mediation. Expenses for
32 mediation shall be borne equally by both sides. The department
33 shall have no administrative or enforcement responsibilities in
34 connection with the voluntary mediation process authorized by
35 this paragraph.

36 (c) The plan's grievance system shall include a system of aging
37 of grievances that are pending and unresolved for 30 days or more.
38 The plan shall provide a quarterly report to the director of
39 grievances pending and unresolved for 30 or more days with
40 separate categories of grievances for Medicare enrollees and



1 Medi-Cal enrollees. The plan shall include with the report a brief
2 explanation of the reasons each grievance is pending and
3 unresolved for 30 days or more. The plan may include the
4 following statement in the quarterly report that is made available
5 to the public by the director:

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7 “Under Medicare and Medi-Cal law, Medicare enrollees and
8 Medi-Cal enrollees each have separate avenues of appeal that
9 are not available to other enrollees. Therefore, grievances
10 pending and unresolved may reflect enrollees pursuing their
11 Medicare or Medi-Cal appeal rights.”

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13 If requested by a plan, the director shall include this statement in
14 a written report made available to the public and prepared by the
15 director that describes or compares grievances that are pending
16 and unresolved with the plan for 30 days or more. Additionally, the
17 director shall, if requested by a plan, append to that written report
18 a brief explanation, provided in writing by the plan, of the reasons
19 why grievances described in that written report are pending and
20 unresolved for 30 days or more. The director shall not be required
21 to include a statement or append a brief explanation to a written
22 report that the director is required to prepare under this chapter,
23 including Sections 1380 and 1397.5.

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

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

