

AMENDED IN SENATE APRIL 17, 2001

SENATE BILL

No. 1092

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 amended, 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. *The bill would also define the term "complaint" and would make distinctions between grievances and complaints. This bill would also require each plan to develop a mechanism for logging, tracking, and reviewing complaints submitted by subscribers and enrollees.*

Because this bill would place additional requirements on health care service plans which are governed by the Knox-Keene Health Care Service Plan Act of 1975, a violation of which is a crime, it would create 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: ~~no~~—yes.
State-mandated local program: ~~no~~—yes.

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 delegated
11 authority to resolve grievances on behalf of the plan. Any
12 uncertainty as to whether any expression of dissatisfaction is an
13 inquiry or grievance shall be resolved by finding it a grievance.
14 Each system shall provide reasonable procedures in accordance
15 with department regulations that shall ensure adequate
16 consideration of *subscriber or enrollee* grievances and
17 rectification when appropriate. *Expressions of dissatisfaction*
18 *received over the telephone that are not coverage disputes,*
19 *disputes over health care services involving medical necessity, or*
20 *disputes involving experimental or investigational treatment shall*
21 *be exempt from the definition of grievance if they are resolved to*
22 *the satisfaction of the enrollee within one business day of receipt.*
23 *These expressions of dissatisfaction shall be defined as*
24 *“complaints.”*

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

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



1 (4) Provide subscribers and enrollees with written responses to
2 grievances, with a clear and concise explanation of the reasons for
3 the plan's response. For grievances involving the delay, denial, or
4 modification of health care services, the plan response shall
5 describe the criteria used and the clinical reasons for its decision,
6 including all criteria and clinical reasons related to medical
7 necessity. If a plan, or one of its contracting providers, issues a
8 decision delaying, denying, or modifying health care services
9 based in whole or in part on a finding that the proposed health care
10 services are not a covered benefit under the contract that applies
11 to the enrollee, the decision shall clearly specify the provisions in
12 the contract that exclude that coverage.

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

15 (6) *Maintain a written or electronic log of all complaints, as*
16 *defined in paragraph (1). This log shall contain the date of the call,*
17 *the name of the complainant, the member identification number,*
18 *the nature of the complaint, the nature of the resolution, and the*
19 *identification of the plan representative who took the call and*
20 *resolved the complaint. This complaint log shall be reviewed by the*
21 *plan officer responsible for the grievance process.*

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

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

36 (C) Notwithstanding subparagraphs (A) and (B), the
37 department may refer any grievance that does not pertain to
38 compliance with this chapter to the State Department of Health
39 Services, the California Department of Aging, the federal Health



1 Care Financing Administration, or any other appropriate
2 governmental entity for investigation and resolution.

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

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

31 (4) If after reviewing the record of a grievance, the department
32 concludes that a health care service eligible for coverage and
33 payment under a health care service plan contract has been
34 delayed, denied, or modified by a plan, or by one of its contracting
35 providers, in whole or in part due to a determination that the
36 service is not medically necessary, and that determination was not
37 communicated to the enrollee in writing along with a notice of the
38 enrollee’s potential right to participate in the independent medical
39 review system, as required by this chapter, the director shall, by
40 order, assess administrative penalties. A proceeding for the



1 issuance of an order assessing administrative penalties shall be
2 subject to appropriate notice of, and the opportunity for, a hearing
3 with regard to the person affected in accordance with Section
4 1397. The administrative penalties shall not be deemed an
5 exclusive remedy available to the director. These penalties shall be
6 paid to the State Managed Care Fund.

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

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

21 (B) A discussion of the department's contact with any medical
22 provider, or any other independent expert relied on by the
23 department, along with a summary of the views and qualifications
24 of that provider or expert.

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

27 (6) In any department review of a grievance involving a
28 disputed health care service, as defined in subdivision (b) of
29 Section 1374.30, that is not eligible for the independent medical
30 review system established pursuant to Article 5.55 (commencing
31 with Section 1374.30), in which the department finds that the plan
32 has delayed, denied, or modified health care services that are
33 medically necessary, based on the specific medical circumstances
34 of the enrollee, and those services are a covered benefit under the
35 terms and conditions of the health care service plan contract, the
36 department's written notice shall either: (A) order the plan to
37 promptly offer and provide those health care services to the
38 enrollee, or (B) order the plan to promptly reimburse the enrollee
39 for any reasonable costs associated with urgent care or emergency
40 services, or other extraordinary and compelling health care



1 services, when the department finds that the enrollee's decision to
2 secure those services outside of the plan network was reasonable
3 under the circumstances. The department's order shall be binding
4 on the plan.

5 (7) Distribution of the written notice shall not be deemed a
6 waiver of any exemption or privilege under existing law,
7 including, but not limited to, Section 6254.5 of the Government
8 Code, for any information in connection with and including the
9 written notice, nor shall any person employed or in any way
10 retained by the department be required to testify as to that
11 information or notice.

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

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

28 (c) The plan's grievance system shall include a system of aging
29 of grievances that are pending and unresolved for 30 days or more.
30 The plan shall provide a quarterly report to the director of
31 grievances pending and unresolved for 30 or more days with
32 separate categories of grievances for Medicare enrollees and
33 Medi-Cal enrollees. The plan shall include with the report a brief
34 explanation of the reasons each grievance is pending and
35 unresolved for 30 days or more. The plan may include the
36 following statement in the quarterly report that is made available
37 to the public by the director:

38
39 "Under Medicare and Medi-Cal law, Medicare enrollees and
40 Medi-Cal enrollees each have separate avenues of appeal that



1 are not available to other enrollees. Therefore, grievances
2 pending and unresolved may reflect enrollees pursuing their
3 Medicare or Medi-Cal appeal rights.”
4

5 If requested by a plan, the director shall include this statement in
6 a written report made available to the public and prepared by the
7 director that describes or compares grievances that are pending
8 and unresolved with the plan for 30 days or more. Additionally, the
9 director shall, if requested by a plan, append to that written report
10 a brief explanation, provided in writing by the plan, of the reasons
11 why grievances described in that written report are pending and
12 unresolved for 30 days or more. The director shall not be required
13 to include a statement or append a brief explanation to a written
14 report that the director is required to prepare under this chapter,
15 including Sections 1380 and 1397.5.

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

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

31 *SEC. 2. No reimbursement is required by this act pursuant to*
32 *Section 6 of Article XIII B of the California Constitution because*
33 *the only costs that may be incurred by a local agency or school*
34 *district will be incurred because this act creates a new crime or*
35 *infraction, eliminates a crime or infraction, or changes the penalty*
36 *for a crime or infraction, within the meaning of Section 17556 of*
37 *the Government Code, or changes the definition of a crime within*



1 *the meaning of Section 6 of Article XIII B of the California*
2 *Constitution.*

O

