

AMENDED IN SENATE APRIL 8, 2010

SENATE BILL

No. 1283

Introduced by Senator Steinberg

February 19, 2010

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

LEGISLATIVE COUNSEL'S DIGEST

SB 1283, as amended, Steinberg. Health care coverage: ~~autism grievance system.~~

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. A willful violation of the act constitutes a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, including, but not limited to, pervasive developmental disorder or autism, under the same terms and conditions applied to other medical conditions, as specified requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit a grievance to the plan. Existing law authorizes a subscriber or enrollee to submit his or her grievance to the department for review after completing the grievance process or after having participated in that process for at least 30 days. Existing law requires the department to send a written notice of the final disposition of the grievance to an enrollee or subscriber within 30 days of receiving the request for review,

unless the director determines that additional time is reasonably necessary to fully review the grievance.

~~This bill would state the intent of the Legislature to enact legislation to provide clarification on the duties imposed upon health care service plans and health insurers, under the existing mental health parity law, to provide medically necessary services for the diagnosis and treatment of autism spectrum disorders delete the authority of the director to determine that additional time is necessary to review a grievance, and instead require the department to send the written notice of the final disposition within 30 days of receipt of all relevant information that is necessary to make a coverage decision.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ yes.
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 enrollees may submit their grievances to
- 6 the plan. Each system shall provide reasonable procedures in
- 7 accordance with department regulations that shall ensure adequate
- 8 consideration of enrollee grievances and rectification when
- 9 appropriate.
- 10 (2) Inform its subscribers and enrollees upon enrollment in the
- 11 plan and annually thereafter of the procedure for processing and
- 12 resolving grievances. The information shall include the location
- 13 and telephone number where grievances may be submitted.
- 14 (3) Provide forms for grievances to be given to subscribers and
- 15 enrollees who wish to register written grievances. The forms used
- 16 by plans licensed pursuant to Section 1353 shall be approved by
- 17 the director in advance as to format.
- 18 (4) (A) Provide for a written acknowledgment within five
- 19 calendar days of the receipt of a grievance, except as noted in
- 20 subparagraph (B). The acknowledgment shall advise the
- 21 complainant of the following:
- 22 (i) That the grievance has been received.
- 23 (ii) The date of receipt.

1 (iii) The name of the plan representative and the telephone
2 number and address of the plan representative who may be
3 contacted about the grievance.

4 (B) Grievances received by telephone, by facsimile, by e-mail,
5 or online through the plan's Internet Web site pursuant to Section
6 1368.015, that are not coverage disputes, disputed health care
7 services involving medical necessity, or experimental or
8 investigational treatment and that are resolved by the next business
9 day following receipt are exempt from the requirements of
10 subparagraph (A) and paragraph (5). The plan shall maintain a log
11 of all these grievances. The log shall be periodically reviewed by
12 the plan and shall include the following information for each
13 complaint:

- 14 (i) The date of the call.
- 15 (ii) The name of the complainant.
- 16 (iii) The complainant's member identification number.
- 17 (iv) The nature of the grievance.
- 18 (v) The nature of the resolution.
- 19 (vi) The name of the plan representative who took the call and
20 resolved the grievance.

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

33 (6) Keep in its files all copies of grievances, and the responses
34 thereto, for a period of five years.

35 (b) (1) (A) After either completing the grievance process
36 described in subdivision (a), or participating in the process for at
37 least 30 days, a subscriber or enrollee may submit the grievance
38 to the department for review. In any case determined by the
39 department to be a case involving an imminent and serious threat
40 to the health of the patient, including, but not limited to, severe

1 pain, the potential loss of life, limb, or major bodily function, or
2 in any other case where the department determines that an earlier
3 review is warranted, a subscriber or enrollee shall not be required
4 to complete the grievance process or to participate in the process
5 for at least 30 days before submitting a grievance to the department
6 for review.

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

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

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

29 (3) The department shall review the written documents submitted
30 with the subscriber’s or the enrollee’s request for review, or
31 submitted by the agent on behalf of the subscriber or enrollee. The
32 department may ask for additional information, and may hold an
33 informal meeting with the involved parties, including providers
34 who have joined in submitting the grievance or who are otherwise
35 assisting or advocating on behalf of the subscriber or enrollee. If
36 after reviewing the record, the department concludes that the
37 grievance, in whole or in part, is eligible for review under the
38 independent medical review system established pursuant to Article
39 5.55 (commencing with Section 1374.30), the department shall
40 immediately notify the subscriber or enrollee, or agent, of that

option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(5) The department shall send a written notice of the final disposition of the grievance, 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 30 calendar days of receipt of the request for review ~~unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance~~ *all relevant information necessary to enable the department to make a coverage decision*. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

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

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

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

3 (6) In any department review of a grievance involving a disputed
4 health care service, as defined in subdivision (b) of Section
5 1374.30, that is not eligible for the independent medical review
6 system established pursuant to Article 5.55 (commencing with
7 Section 1374.30), in which the department finds that the plan has
8 delayed, denied, or modified health care services that are medically
9 necessary, based on the specific medical circumstances of the
10 enrollee, and those services are a covered benefit under the terms
11 and conditions of the health care service plan contract, the
12 department's written notice shall do either of the following:

13 (A) Order the plan to promptly offer and provide those health
14 care services to the enrollee.

15 (B) Order the plan to promptly reimburse the enrollee for any
16 reasonable costs associated with urgent care or emergency services,
17 or other extraordinary and compelling health care services, when
18 the department finds that the enrollee's decision to secure those
19 services outside of the plan network was reasonable under the
20 circumstances.

21 The department's order shall be binding on the plan.

22 (7) Distribution of the written notice shall not be deemed a
23 waiver of any exemption or privilege under existing law, including,
24 but not limited to, Section 6254.5 of the Government Code, for
25 any information in connection with and including the written
26 notice, nor shall any person employed or in any way retained by
27 the department be required to testify as to that information or
28 notice.

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

33 (9) A subscriber or enrollee, or the agent acting on behalf of a
34 subscriber or enrollee, may also request voluntary mediation with
35 the plan prior to exercising the right to submit a grievance to the
36 department. The use of mediation services shall not preclude the
37 right to submit a grievance to the department upon completion of
38 mediation. In order to initiate mediation, the subscriber or enrollee,
39 or the agent acting on behalf of the subscriber or enrollee, and the
40 plan shall voluntarily agree to mediation. Expenses for mediation

1 shall be borne equally by both sides. The department shall have
2 no administrative or enforcement responsibilities in connection
3 with the voluntary mediation process authorized by this paragraph.

4 (c) The plan's grievance system shall include a system of aging
5 of grievances that are pending and unresolved for 30 days or more.
6 The plan shall provide a quarterly report to the director of
7 grievances pending and unresolved for 30 or more days with
8 separate categories of grievances for Medicare enrollees and
9 Medi-Cal enrollees. The plan shall include with the report a brief
10 explanation of the reasons each grievance is pending and
11 unresolved for 30 days or more. The plan may include the
12 following statement in the quarterly report that is made available
13 to the public by the director:

14
15 "Under Medicare and Medi-Cal law, Medicare enrollees and
16 Medi-Cal enrollees each have separate avenues of appeal that
17 are not available to other enrollees. Therefore, grievances
18 pending and unresolved may reflect enrollees pursuing their
19 Medicare or Medi-Cal appeal rights."

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

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

38 (e) Nothing in this section shall be construed to allow the
39 submission to the department of any provider grievance under this
40 section. However, as part of a provider's duty to advocate for

1 medically appropriate health care for his or her patients pursuant
2 to Sections 510 and 2056 of the Business and Professions Code,
3 nothing in this subdivision shall be construed to prohibit a provider
4 from contacting and informing the department about any concerns
5 he or she has regarding compliance with or enforcement of this
6 chapter.

7 ~~SECTION 1. It is the intent of the Legislature to enact~~
8 ~~legislation to provide clarification on the duties imposed upon~~
9 ~~health care service plans and health insurers, under the existing~~
10 ~~mental health parity law, to provide medically necessary services~~
11 ~~for the diagnosis and treatment of autism spectrum disorders.~~