AMENDED IN SENATE MAY 28, 2010

AMENDED IN SENATE APRIL 27, 2010

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: 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 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 ~~delete the authority of~~*, upon a determination by* 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. The bill would require the department to specify the necessary information on its Internet Web site and on each application used for filing a grievance with the department~~ *set forth the procedures that would apply to the department with regard to the review of that grievance and the payment of specified costs by the department. Upon a failure of a health care service plan to comply with a request from the department for information related to the grievance, the bill would authorize the department to impose an administrative fine on that plan as determined by the department*.

Existing law requires the director to make and file annually with the department as a public record an aggregate summary of grievances against plans filed with the department, as specified.

This bill would require the director to include in that report ~~timeframe information, including, but not limited to, the average number of days before a grievance is closed, the number of cases resolved in less than 30 days and in more than 30 days, and specified data regarding the independent medical review process~~ *specified information related to the department's review of grievances against health care service plans*.

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

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

SECTION 1. 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 that shall ensure 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.

1 (3) Provide forms for grievances to be given to subscribers and
2 enrollees who wish to register written grievances. The forms used
3 by plans licensed pursuant to Section 1353 shall be approved by
4 the director in advance as to format.
5 (4) (A) Provide for a written acknowledgment within five
6 calendar days of the receipt of a grievance, except as noted in
7 subparagraph (B). The acknowledgment shall advise the
8 complainant of the following:
9 (i) That the grievance has been received.
10 (ii) The date of receipt.
11 (iii) The name of the plan representative and the telephone
12 number and address of the plan representative who may be
13 contacted about the grievance.
14 (B) Grievances received by telephone, by facsimile, by e-mail,
15 or online through the plan's Internet Web site pursuant to Section
16 1368.015, that are not coverage disputes, disputed health care
17 services involving medical necessity, or experimental or
18 investigational treatment and that are resolved by the next business
19 day following receipt are exempt from the requirements of
20 subparagraph (A) and paragraph (5). The plan shall maintain a log
21 of all these grievances. The log shall be periodically reviewed by
22 the plan and shall include the following information for each
23 complaint:
24 (i) The date of the call.
25 (ii) The name of the complainant.
26 (iii) The complainant's member identification number.
27 (iv) The nature of the grievance.
28 (v) The nature of the resolution.
29 (vi) The name of the plan representative who took the call and
30 resolved the grievance.
31 (5) Provide subscribers and enrollees with written responses to
32 grievances, with a clear and concise explanation of the reasons for
33 the plan's response. For grievances involving the delay, denial, or
34 modification of health care services, the plan response shall
35 describe the criteria used and the clinical reasons for its decision,
36 including all criteria and clinical reasons related to medical
37 necessity. If a plan, or one of its contracting providers, issues a
38 decision delaying, denying, or modifying health care services based
39 in whole or in part on a finding that the proposed health care
40 services are not a covered benefit under the contract that applies

to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) Keep in its files all copies of grievances, 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 30 days, a subscriber or enrollee may submit the grievance 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, severe pain, 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 to participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance 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 that does not pertain to compliance with this chapter to the State Department of Health Care Services, the State Department of Public Health, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity 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 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 to the department. In addition, following submission of the grievance 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) 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 who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall 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 *that is* 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) *(A)* 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 ~~all relevant information that the department shall have identified as necessary for it to complete a grievance review and make a determination. The department shall specify that necessary information publicly on its Internet Web site and on each application used for filing a grievance with the department. In~~ *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. If the director determines that additional time is necessary to evaluate a grievance and make a determination, the department shall do all of the following:

(i) Make a determination, within 30 calendar days of receipt of the request for review, as to what additional information is necessary for the department to complete its review of the grievance and make a determination.

(ii) Notify the subscriber or the enrollee in writing, within 30 calendar days of receipt of the request for review, of the additional information that the department has identified for it to complete the grievance review and to make a determination.

(iii) Upon receipt of all information that constitutes a completed application, notify the subscriber or the enrollee, in writing within five business days, of the date the application was completed.

(iv) Make a determination of the final disposition of the grievance, and the reasons therefor, within 30 calendar days of having established a completed application.

(v) Notify the subscriber or enrollee of the decision in writing within five business days of the final disposition of the grievance.

(B) Notwithstanding the requirements of subparagraph (A), the department may not request from the subscriber or enrollee any information, data, or further evaluation that imposes additional costs, expenses, or other fiscal responsibilities upon the subscriber or enrollee, unless paid for by the department.

(C) A plan shall provide all information that is requested by the department pursuant to subparagraph (A) within five business days of the department's request. If the plan fails to comply with that request, the department shall impose an administrative fine upon the plan. The amount of the fine shall be determined by the department consistent with other administrative fines and penalties authorized under this chapter.

(D) 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)~~

1 *(i)* A summary of its findings and the reasons why the
2 department found the plan to be, or not to be, in compliance with
3 any applicable laws, regulations, or orders of the director.
4 ~~(B)~~
5 *(ii)* A discussion of the department's contact with any medical
6 provider, or any other independent expert relied on by the
7 department, along with a summary of the views and qualifications
8 of that provider or expert.
9 ~~(C)~~
10 *(iii)* If the enrollee's grievance is sustained in whole or in part,
11 information about any corrective action taken.
12 (6) In any department review of a grievance involving a disputed
13 health care service, as defined in subdivision (b) of Section
14 1374.30, that is not eligible for the independent medical review
15 system established pursuant to Article 5.55 (commencing with
16 Section 1374.30), in which the department finds that the plan has
17 delayed, denied, or modified health care services that are medically
18 necessary, based on the specific medical circumstances of the
19 enrollee, and those services are a covered benefit under the terms
20 and conditions of the health care service plan contract, the
21 department's written notice shall do either of the following:
22 (A) Order the plan to promptly offer and provide those health
23 care services to the enrollee.
24 (B) Order the plan to promptly reimburse the enrollee for any
25 reasonable costs associated with urgent care or emergency services,
26 or other extraordinary and compelling health care services, when
27 the department finds that the enrollee's decision to secure those
28 services outside of the plan network was reasonable under the
29 circumstances.
30 The department's order shall be binding on the plan.
31 (7) Distribution of the written notice shall not be deemed a
32 waiver of any exemption or privilege under existing law, including,
33 but not limited to, Section 6254.5 of the Government Code, for
34 any information in connection with and including the written
35 notice, nor shall any person employed or in any way retained by
36 the department be required to testify as to that information or
37 notice.
38 (8) The director shall establish and maintain a system of aging
39 of grievances that are pending and unresolved for 30 days or more
40 that shall include a brief explanation of the reasons each grievance

is pending and unresolved for 30 days or more. The director shall also include, in its annually published report that details the number and types of complaints or grievances received during the calendar year pursuant to Section 1397.5, data regarding the ~~timeframe~~ *timeframes* for grievance ~~resolutions~~ *resolution*. This data shall include, but is not limited to, the average number of days before a grievance is closed, the average number of days before a grievance is sent to independent medical review, the average number of days before the independent medical review process is resolved and a decision *is* rendered by the director, and a breakdown of the number of cases resolved in less than 30 days and in more than 30 days. *The director shall also include in the report a review of the grievances not resolved within 30 days and shall report on the number, proportion by type and medical condition, and causes of the grievances, as well as the reasons for the failure to resolve any grievance pending for more than 30 days.*

(9) 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 to the department. The use of mediation services shall not preclude the right to submit a grievance 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 grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan shall also include in the quarterly report data regarding the ~~timeframe~~ *timeframes* for grievance ~~resolutions, as determined by the department~~ *resolution. This data shall include, but is not limited to, the average number of days before a grievance is closed, a breakdown of the number of cases resolved in less than 30 days and in more than 30 days,*

and for grievances not resolved within 30 days, the number, proportion by type and medical condition, and causes of the grievances, as well as the reasons for the failure to resolve any grievance pending for more than 30 days. The plan may include the following statement in the quarterly report that is made available to the public by the director:

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

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

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance 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 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

1 he or she has regarding compliance with or enforcement of this
2 chapter.

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