AMENDED IN ASSEMBLY AUGUST 19, 2010

AMENDED IN ASSEMBLY AUGUST 2, 2010

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, upon a determination, *as specified,* by the director that additional time is necessary to review a grievance, 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, pursuant to specified procedures, as determined by the department. ~~The bill would also authorize the department to take specified actions in reviewing grievances that involve clinical services that have been denied on the basis of a coverage decision.~~

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 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.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used

by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

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

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

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's member identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the plan representative who took the call and resolved the grievance.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care 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 the request for review unless the director, in his or her discretion, determines that, *due to extraordinary circumstances,* additional time is reasonably necessary to fully and fairly evaluate the relevant ~~grievance. If the director determines~~ *grievance and that such delay is in the interest of the enrollee. If the director determines that extraordinary circumstances exist such* that additional time is necessary to evaluate a grievance and make a determination, *and that the delay*

is in the interest of the enrollee, the department shall do all of the following:

(i) Make a determination, within ~~30~~ *15* 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~~ *15* 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 *and the circumstances that necessitate the additional time*.

(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 calendar days of the department's ~~request. If the requested information cannot be provided to the department within this timeframe, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected. The department shall provide appropriate oversight to determine that the plan complies with information requests described in this subdivision. If the department determines~~ *request. If the department determines* that noncompliance with an information request is the result of factors that were within the purview and responsibility of the plan, the department shall impose an administrative fine upon the plan and all other appropriate remedies and corrective actions that the department deems necessary, including, but not limited to, any applicable regulatory penalties the department is authorized to impose. The amount of the fine shall be determined

by the department consistent with other administrative fines and penalties authorized under this chapter. The department shall notify the subscriber or enrollee in writing of all remedies and corrective actions imposed upon the plan under this provision.

(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:

(i) 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.

(ii) 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.

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

~~(6) If the grievances to the department involve clinical services that are being denied on the basis of a "coverage decision," the department may pursue the following:~~

~~(A) Provide the completed application to an independent health care provider, independent medical expert, or independent panel of appropriate medical specialists who are knowledgeable and qualified to address the issues in question.~~

~~(B) Request that the individual or individuals identified in subparagraph (A) review the completed application, as well as all relevant data and information, and provide findings and recommendations to the department that include, but are not limited to, the following:~~

~~(i) Whether the requested services are considered to be health care services.~~

~~(ii) Whether the requested services are considered to be non-health-care services.~~

~~(iii) Whether the requested services are a covered benefit.~~

~~(C) Any individual or individuals consulted for the purposes of this section, shall be identified by an independent medical review organization that substantially meets the requirements of Section 1374.32.~~

~~(7)~~

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

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

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

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

~~(8)~~

(7) 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.

~~(9)~~

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more 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 timeframes for grievance 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.

~~(10)~~

(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 timeframes for grievance 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 he or she has regarding compliance with or enforcement of this chapter.

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