SB 1913

Joint Senior Level Work Group
Year Three Report

January 1, 2006

California Department of Managed Health Care
and
California Department of Insurance

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EXECUTIVE SUMMARY

This is the third of five annual reports required by Senate Bill 1913 (Chapter 793), enacted in September 2002. This report provides an update and overview of the continuous collaborative work between the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) on behalf of California consumers covered by health insurance. The 2006 report builds on a foundation of shared responsibility established by a Joint Senior Level Work Group comprised of senior administrators from both departments.

At the direction of the Joint Senior Level Work Group, the DMHC and the CDI appointed departmental staff to form five Interagency Operational Work Groups to develop goals, objectives, and work plans in those areas where inter-departmental collaboration was most likely to have a positive impact on consumers. The operational work groups are:

- ✓ Consumer Protection and Outreach
- ✓ Market Conduct Examination Process
- ✓ Code Review
- ✓ Enforcement
- ✓ Regulations – Collaborative Drafting

During the period covered by this report, emphasis continued on improving communication between the departments and coordinating the handling of consumer complaints.

The **Consumer Work Group** focused on: (1) maintaining and updating both external and internal communication links and standards; (2) maintaining and updating communication to share knowledge with staff about internal processes – including holding interactive workshops; and (3) establishing a process for surveying various state websites to ensure that the DMHC and the CDI are correctly listed in related health care agency links. Joint agency meetings and activities continued, enhancing long term relationships established over the last three years for helping consumers.

In addition, during 2005, the DMHC and the CDI, represented by the Office of the Patient Advocate and the Consumer Education and Outreach Bureau, appeared together at three consumer educational outreach and awareness events: (1) Consumer Protection Day in San Diego, sponsored by the San Diego District Attorney's office, and attended by approximately 2,000 consumers; (2) Government Day in Panorama City, sponsored by the Los Angeles County Board of Supervisors, and attended by approximately 25,000 consumers; and (3) NBC 4 Health & Fitness Expo, sponsored by the NBC and Telemundo television networks, and attended by approximately 15,000 consumers.

During 2005, the **Market Conduct Work Group** analyzed each department's market conduct examination processes to evaluate the feasibility of collaborating on exams of affiliated companies with licenses from both DMHC and CDI. After evaluation and discussion, the work group determined that the processes and applicable laws for each department do not necessarily lend themselves to productive partnership examinations; however, the departments agreed to conduct at least one collaborative examination within the next 18 months to identify possible areas of mutual benefit.

The **Code Review Work Group** continued analysis of the Health and Safety Code and the Insurance Code, as well as the regulations of both departments, focusing on a comparison of

grievance resolution processes. The group charted similarities and differences to help in achieving consistency and clarity for consumers.

The **Enforcement Work Group** examined issues regarding the operations of discount health card entities in California, and discussed ways to streamline processes by utilizing best practices from both departments to ensure efficiency and consumer protection.

During 2005, the **Regulation – Collaborative Drafting Work Group** examined the regulatory requirements of AB 2179 (Access to Health Care) and SB 853 (Language Assistance), which affect both departments. The group began a collaborative effort to draft the required regulations over the next year.

CONCLUSION

Both the DMHC and the CDI continue to appreciate the occasion afforded by this legislation to more closely coordinate functions and ensure that consumers are not adversely impacted by California's unique split regulatory authority. The various work groups and combined staff meetings continue to provide opportunities to coordinate each department's internal workflow processes to reduce confusion about regulatory jurisdiction and grievance and consumer complaint resolution methods.

During 2006, the group's overall goals are to:

- Update and maintain the established communication plan designed to help DMHC and CDI staff share information to better help and protect enrollees and insureds.
- Continue all established efforts to reduce consumer confusion about health plan regulatory jurisdiction.
- Complete the monitoring of other state and federal agencies' web sites to ensure that both the DMHC and the CDI have web links on those sites.
- Continue to share information regarding "best practices" for handling consumer issues through interaction with stakeholders.
- Conduct periodic meetings to collaborate on ways to update and train DMHC and CDI staff on internal processes as organizational changes occur.
- Continue to maintain desktop tools and aids for use by both DMHC and CDI consumer services staff.
- Continue to participate jointly in consumer education and awareness events.
- Conduct one collaborative market conduct examination of an entity that holds dual licenses within 18 months and assess the feasibility of continuing efforts beyond 2007.
- Continue to work together to identify changes in market trends that may affect the way the DMHC and CDI do business.
- Compare grievance resolution processes, identify areas in which parity could be achieved, and propose legislation, if appropriate.
- Complete a Memorandum of Understanding regarding collaborative efforts to address problems with discount health card entities.
- Complete the drafting of regulations, as required by AB 2179 and SB 853.

INTRODUCTION

The 2005 Senior Level Executive Committee identified several areas in which to concentrate efforts: (1) consumer protection and consumer outreach; (2) market conduct examination; (3) code review; (4) enforcement; and (5) collaborative drafting of regulations.

As in past years, all work groups prepared work plans for approval by the Joint Senior Level Work Group. The Joint Senior Level Work Group and the Operations Work Groups continue to meet regularly to discuss and resolve problems arising in day-to-day interagency operations.

Regular inter-departmental meetings encouraged teamwork, and assisted in setting priorities and measuring progress on planned activities. Ongoing collaboration at the senior level fostered communication about each department's priorities, and enhanced the level of cooperation between both departments. Working closely together on both short and long term issues continued to strengthen the relationship between the two departments.

CONSUMER PROTECTION AND OUTREACH

The DMHC and CDI are continuing collaborative efforts to reduce consumer confusion regarding regulatory jurisdiction, and to ensure that consumers obtain timely assistance from the appropriate department. Previously, consumers who called with a problem or question complained that they were sometimes bounced back and forth between the two departments because of staff confusion over which department had jurisdiction to handle which problem. The Work Group for Consumer Protection and Outreach is improving communication between each department's frontline program staff, those who are tasked with educating consumers about their respective responsibilities.

The work group achieved all planned goals and objectives, as detailed below, in 2005.

CONSUMER WORK GROUP GOALS FOR 2005

GOAL #1: MAINTAIN DEPARTMENTAL EXTERNAL AND INTERNAL COMMUNICATION LINKS AND STANDARDS

Objective 1: Annually update the contact list used to transition enrollees/insured from one department to another, to reduce caller confusion and eliminate the "ping-pong" effect.

Objective 2: Increase staff awareness of operational oversight, roles, and responsibilities of each department.

OVERVIEW OF ACCOMPLISHMENTS:

Even though staff and operational changes occurred in both departments, the Consumer Protection Work Group continued to identify knowledgeable

supervisory and managerial staff to oversee jurisdictional questions as they arose. To help both departments to determine which department has jurisdiction in any given situation, and to whom the caller should be referred, the work group developed a table showing DMHC/CDI supervisory and managerial roles and each department's responsibility in direct consumer contact. The table lists the each department contact's full name, title, e-mail address, and role in the process. The table also lists direct phone numbers for specific divisions within each department, as well as a statement that defines the oversight roles and responsibilities for each department. In addition, the work group created functional organization charts outlining the oversight authority for consumer complaint and grievance processes in both departments.

These tools contributed to successful collaboration by significantly improving the departments' ability to reduce consumer confusion over which department to contact for help with a problem. To track the effectiveness of these efforts, the DMHC developed a system for tracking "bounce back" referrals from CDI (i.e. inquiries and calls referred to the DMHC from the CDI, in which jurisdiction was unclear). Between January and June of 2005, only 36 such referred inquiries/calls were returned from the DMHC to the CDI. These collaborative efforts have been successful in helping consumers get assistance from the appropriate regulator in a timely and efficient manner.

GOAL #2: MAINTAIN AND UPDATE COMMUNICATION EFFORTS TO SHARE KNOWLEDGE AND INFORMATION BETWEEN DMHC AND CDI STAFF ABOUT INTERNAL PROCESSES AND TO IMPROVE INTERAGENCY RELATIONS

Objective: Ensure that both departments consistently give accurate information to consumers and that they are able to clearly explain patient rights.

OVERVIEW OF ACCOMPLISHMENTS:

The departments worked together to co-host a video-conferenced workshop in June 2005 for staff who handle consumer health issues. This workshop fostered open communication in a wide-ranging discussion of comparable consumer issues, common workplace challenges, and jurisdictional questions. Additionally, each department made a presentation about its consumer services structure, operations, and functions.

These forums provided an additional opportunity for educating staff and reducing confusion regarding regulatory authority and each agency's resolution process. Participants gained a better understanding of each department's critical roles and functions in the consumer complaint and grievance process. The departments will continue to meet in this successful forum at least twice a year.

GOAL #3: SET UP PROCESS TO AUDIT STATE WEB SITES AND ENSURE THAT THE DMHC AND THE CDI ARE LISTED UNDER RELATED HEALTH CARE AGENCY LINKS

Objective: Set up a process to audit state agency web sites and ensure that the DMHC and CDI are represented on each with a web link.

OVERVIEW OF ACCOMPLISHMENTS:

The Consumer Work Group identified forty-two state web sites that should contain links to the DMHC and CDI web sites, and will develop a standard procedure for ensuring that links are added. The work group anticipates completing this goal during 2006.

GOAL #4: PARTICIPATE IN OUTREACH EVENTS

Objective: Identify opportunities for the Consumer Education and Outreach Bureau of the CDI and the DMHC's Office of the Patient Advocate to jointly participate in consumer outreach events.

OVERVIEW OF ACCOMPLISHMENTS:

During 2005, the DMHC and CDI, represented by the Office of the Patient Advocate and the Consumer Education and Outreach Bureau, combined efforts to participate in three consumer education outreach and awareness events:
(1) Consumer Protection Day in San Diego, sponsored by the San Diego District Attorney's office, and attended by approximately 2,000 consumers;
(2) Government Day in Panorama City, sponsored by the Los Angeles County Board of Supervisors, and attended by approximately 25,000 consumers; and
(3) NBC 4 Health & Fitness Expo, sponsored by the NBC and Telemundo television networks, and attended by approximately 15,000 consumers. The focus of these efforts was for both departments to help consumers understand health issues and regulatory jurisdiction, and to answer consumer questions.

MARKET CONDUCT WORK GROUP

The Market Conduct Work Group studied the affiliated companies with licenses from both DMHC and CDI to determine whether collaborative examination might be productive. The work group concluded that the two departments' examination processes are not comparable and that a collaborative examination would require special effort.

MARKET CONDUCT WORK GROUP GOALS FOR 2005

GOAL: DISCUSS MARKET CONDUCT EXAMINATION PROCESSES

Objective 1: Compare examination processes.

Objective 2: Identify affiliated companies with licenses from both DMHC and CDI and determine whether collaborative examination would be productive.

OVERVIEW OF ACCOMPLISHMENTS:

The work group discussed the details of each agency's market conduct examination processes. While CDI conducts an in-depth review of individual claim files to identify trends and patterns of potential unfair practices as outlined in various insurance laws and regulations, DMHC performs a broad review of information developed during the financial examination process. The DMHC process uses audit software to review entire populations of claims, whereas the CDI examination process involves a file-by-file review of a sample of the claims population to determine compliance with laws and regulations.

Despite the disparities, the work group decided to conduct one examination during the next 18 months to identify potential areas of mutual benefit.

CODE REVIEW

As previously reported, the legal staff from both departments developed a code review project plan divided into five phases:

- Phase I Identification and Review of All Codes and Regulations
- Phase II Analysis of Codes
- Phase III Assessment of Codes
- Phase IV Reconciliation Determination of Code Sections
- Phase V Development of Recommendations

The work group has completed the first three phases. The detailed review identified additional code sections that impact the healthcare consumer, including claims payment provisions, and added them to the chart listing all Health and Safety Code and Insurance Code provisions. This combined chart will help both departments as they enter Phase IV – Reconciliation Determination of Code Sections.

CODE REVIEW WORK GROUP GOALS FOR 2005

GOAL: COMPLETE REVIEW, ANALYSIS, AND ASSESSMENT OF CODES

Objective 1: Develop a matrix comparison format to facilitate legal review of codes.

Objective 2: Complete comparisons through the exchange of information between DMHC/CDI legal staff.

OVERVIEW OF ACCOMPLISHMENTS:

The work group began by updating the matrix developed in 2004, which will establish the foundation for accomplishing Phase IV in 2006. (See appendices.)

The detailed comparison of the statutes and regulations of the two departments was highly technical and complex legal work, requiring allocation of both legal and consumer services staff from limited legal resources in both departments. Code review and updating will continue throughout years four and five to ensure maximum consumer protection, and will result in recommendations.

ENFORCEMENT WORK GROUP

The Enforcement Work Group addressed enforcement issues involving the operations of discount health card entities in California. While there are legitimate discount health card entities operating in the marketplace, it is necessary to curtail the activities of those that are not. Illegal discount health cards are widely offered to the public through newspaper ads, flyer solicitations, hotel meetings, and via the Internet. The premise is that buyers usually pay a one-time or monthly fee and present the card to receive a discounted fee from the list of medical practitioners that is provided to them.

ENFORCEMENT WORK GROUP GOALS FOR 2005

GOAL: MEET TO DISCUSS DISCOUNT HEALTH CARD ISSUES

Objective 1: Identify major problem areas.

Objective 2. Agree on jurisdictional issues.

Objective 3. Establish a plan to collaborate on enforcement.

OVERVIEW OF ACCOMPLISHMENTS:

The work group found that:

- Vendors are often aggressively advertising and selling the product.
- Marketing is misleading and high pressure.
- Some consumers incorrectly believe they are purchasing health coverage.
- Some "obligated" healthcare providers are unaware of the program and/or discounts.
- Healthcare providers are not obligated to offer discounts as promised by the vendor.
- Consumers do not have adequate redress for complaints.

Because DMHC resources are limited, the CDI agreed to support DMHC with investigative help whenever there is an insurance connection (i.e. cases in which the entity misrepresented the product as an insurance product and/or a licensed insurance agent unlawfully sold the product). When deemed appropriate, both departments have agreed to investigate criminal violations jointly with CDI as lead. The work group agreed to develop a Memorandum of Understanding

(MOU) in 2006 to flesh out the details of a working enforcement relationship for curtailing illegal activities by discount health card entities.

REGULATIONS - COLLABORATIVE DRAFTING WORK GROUP

The Regulations Work Group collaborated in drafting regulations mandated by both the Health and Safety Code and the Insurance Code, as outlined in SB 853 and AB 2179. The regulation group established a work plan for completing the process during the 2006 calendar year.

REGULATIONS - COLLABORATIVE DRAFTING WORK GROUP GOALS FOR 2005

GOAL: MEET TO DISCUSS SB 853 AND AB 2179

Objective 1: Analyze existing laws and regulations.

Objective 2: Compare the effect of SB 853 and AB 2179 on DMHC and CDI regulatory requirements.

Objective 3: Establish a time frame for drafting regulations.

OVERVIEW OF ACCOMPLISHMENTS:

During 2005, the work group analyzed the Health and Safety Code and the Insurance Code statutes applicable to each department, as well as the requirements in both SB 853 and AB 2179 to compare and contrast the effect these bills have on both departments.

SB 853 was enacted to ensure that consumers receive access to translated materials and language assistance in obtaining covered benefits from both health care plans and insurance companies. The work group will complete the drafting of the regulations during 2006.

AB 2179 was enacted to ensure that consumers have timely access to health care. The work group has contacted health care plans and insurance companies to obtain information necessary for drafting regulations during 2006.

CONCLUSION

The work undertaken in Year Three has presented challenges and opportunities for refining interagency operations and reconciling conflicts that may pose barriers to consumers. Specifically:

- The **Consumer Protection and Outreach Work Group** has continued the collaborative relationship forged during the two prior years to strengthen interagency communication and teamwork. Staff from both departments have developed a better understanding of both departments' responsibilities and processes, enabling them to provide efficient, accurate information to consumers.

- The **Market Conduct Work Group** compared and contrasted each department's processes. While those processes and regulatory responsibilities substantially differ, the work group decided to conduct one collaborative examination during the next 18 months to determine whether a joint examination could be productive.

- The **Code Review Work Group** continued to identify and compare codes and regulations to build a foundation for producing constructive recommendations by Year Five of this on-going effort.

- The **Enforcement Work Group** studied the problems surrounding the operations of discount health card entities in California. CDI will support the DMHC with investigatory resources and expertise, which the group will define in a Memorandum of Understanding (MOU) developed over the next working year.

- **The Regulations - Collaborative Drafting Work Group** worked together, with input from health plans and consumer groups, in drafting the regulations required by SB 853 and AB 2179.

Future activities will continue the successful collaborative efforts developed over the past three years to further reduce consumer confusion, to foster open communication between the two departments and other agencies or organizations that deal with health-related issues, and to collaborate in consumer education and awareness events. The Senior Level Working Group will continue to lead the effort to streamline communication and strengthen working relationships between the departments in order to provide both insureds and enrollees with information and assistance in a timely, efficient, and standardized manner.

APPENDICES

APPENDIX A: COMPARISON OF GRIEVANCE RESOLUTION PROCESSES

Issue / Variable	Department of Managed Health Care (DMHC)	California Department of Insurance (CDI)
Key Grievance Code Provisions	California Health and Safety Code, section 1368 et seq. California Code of Regulations, title 28, section 1300.68	California Insurance Code, sections 510, 12921.1; 12921.3; and 12921.4; California Code of Regulations, title 10, section 2694,
Regulation of Health Plan / Insurer Grievance Process	Health and Safety Code section 1368: ▪ Every health plan is required to establish and maintain a grievance system approved by the DMHC under which enrollees may submit their grievances to the plan. ▪ Grievances may be submitted in writing, verbally, or through the plan's website. The grievance system must address the linguistic and cultural needs of enrollees, as well as the needs of enrollees with disabilities. ▪ Health plans must provide written acknowledgement of enrollee grievances within five calendar days of receipt. ▪ Health plans must provide enrollees with written responses to the grievance, including a clear and concise explanation of the reason for the plan's response, within 30 calendar days of receipt of the grievance. ▪ Health plans are required to provide DMHC with a quarterly report of grievances that were pending and unresolved with the plan for 30 days or more.	Insurance Code section 10192.10 (k) provides the following requirements for Medicare Select issuers: ▪ Medicare Select issuers must have procedures for hearing complaints and resolving written appeals and grievances. ▪ Complaints must be reviewed and corrected in a timely manner and all involved parties must be notified as to resolution of the complaint. ▪ Issuers must report on all grievances to the CDI Commissioner each year and maintain grievance records for five years. Insurance Code section 510 requires insurers to provide a written disclosure containing the name, address, and toll-free telephone number of CDI's complaint handling unit with every insurance policy issued. Consumers are not required to file a complaint with an insurer prior to seeking help from CDI. Consumers may pursue their complaints at any time without restrictions.
Urgent Grievances	Health and Safety Code section 1368.01(b): ▪ Grievance systems must include a requirement for the expedited review of grievances in cases involving an imminent and serious threat to the health of the enrollee. ▪ Health plans must advise the enrollee and the DMHC in writing of the disposition or pending status of the urgent grievance no later than three days from receipt of the grievance.	Insurance Code section 10145.3 ▪ Requires health insurers to establish an external independent review process regarding experimental or investigational therapies for insureds with a life-threatening or debilitating condition. The insurer must advise insureds of this program within five business days of a decision to deny coverage. ▪ This requirement does not interfere with the insured's ability to file a complaint with CDI. .

Issue / Variable	Department of Managed Health Care (DMHC)	California Department of Insurance (CDI)
DMHC / CDI Complaint Processes	Health and Safety Code section 1368: ▪ Enrollees may submit a complaint to the DMHC if their grievances have been resolved or if they have participated in their plan's grievance process for at least 30 calendar days. ▪ Enrollees may present their complaints to the DMHC immediately if they involve an urgent grievance, or in any other case where the DMHC determines that an earlier review is warranted. ▪ The DMHC must notify the health plan of the complaint and within five calendar days of notification, the health plan must provide the DMHC with a written response. ▪ The DMHC must send a written notice of the final disposition of the enrollee's grievance, and the reasons therefore, to the enrollee within 30 calendar days of receipt. ▪ The DMHC Director is required to establish and maintain an aging system for grievances that remain pending and unresolved for 30 days or more.	Insurance Code sections 12921.1; 12921.3 and 12921.4: ▪ The CDI must receive complaints and inquiries, and investigate complaints and prosecute insurers when appropriate. ▪ Enrollees are permitted to file a complaint unrelated to medical necessity directly to the CDI without first participating in their plan's grievance process. ▪ The CDI must acknowledge receipt of the complaint within ten working days, but is not required to resolve complaints within any specified timeframe. However, the CDI must notify the complainant of the final action taken on the complaint within 30 days of the final action. ▪ The CDI is required to provide a complaint evaluation form in randomly selected final notification letters, seeking an evaluation of how the CDI handled the grievance. ▪ The CDI must inform the insurance plan about any complaints received and deemed justified (as determined by Rule 2694), providing the name of the complainant, the facts of the complaint, and the statement of the CDI's rationale for resolving the complaint. ▪ The CDI complaint program must include guidelines for disseminating complaint and enforcement information on insurers to members of the public.
Disclosure of Complaint Process	Health & Safety Code section 1368.02: ▪ Plans must publish their phone numbers and Internet addresses, as well as the DMHC's toll-free telephone number and the TDD line number, on every plan contract, evidence of coverage, copy of plan grievance procedures, complaint forms, and on all written notices to enrollees required under the grievance process of the plan.	Insurance Code section 12921.1 and 510, and Code of Regulations, title 10, section 2695.7: ▪ The CDI must communicate the existence of its complaint program to insured through public service announcements and provide them with a toll-free number and complaint forms. ▪ Claim denials must be accompanied by written notification that the matter may be reviewed by the CDI, and must include the CDI address and telephone number. ▪ The insurer must provide a written disclosure containing the name, address and toll-free telephone number of the CDI's complaint handling unit with every insurance policy issued. Consumers are not required to file a complaint with an insurer prior to seeking help from the CDI. Consumers may pursue their complaints at any time without restrictions.

APPENDIX B: COMPARISON OF INDEPENDENT MEDICAL REVIEW (IMR) LAWS

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Independent Medical Review (IMR) Codes and Regulations	California Health and Safety Code, sections 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.34, and 1374.35 California Code of Regulations, title 28, sections 1300.68, 1300.70.4, and 1300.74.30	California Insurance Code, sections 10145.3, 10169, 10169.1, 10169.2, 10169.3, and 10169.5
Disputes that Qualify for IMR	Health and Safety Code, section 1374.30: ▪ Any health care service eligible for coverage and payment under a health care service plan contract that has been denied by the plan or the enrollee's contracting provider in whole or in part because the service was not medically necessary. ▪ Coverage decisions that approve or deny a health care service because it is excluded as a covered benefit under the health care service plan contract are not eligible for review under the IMR System, but are eligible for review by the DMHC as a grievance. ▪ The DMHC is the final arbiter as to whether an enrollee's grievance is a disputed health care service or a coverage decision.	Insurance Code section 10169 contains provisions substantially similar to those contained in Health and Safety Code, section 1374.30.
Persons who Qualify for IMR	Health and Safety Code, section 1374.30(e): ▪ Any enrollee who is covered by a health care service plan contract issued, amended, renewed, or delivered in California on or after January 1, 2000, is eligible to seek an IMR, effective January 1, 2001, if the enrollee's dispute qualifies for IMR. ▪ The enrollee may designate an agent to act on his or her behalf. ▪ The provider may assist and advocate on behalf of the enrollee. Code of Regulations, title 28, section 1300.74.30(f)(3): ▪ Medi-Cal plan enrollees are eligible for IMR if they have not submitted the disputed service for resolution by the Medi-Cal fair hearing process.	Insurance Code section 10169(e) contains provisions substantially similar to those contained in Health and Safety Code section 1374.30(e).

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Qualifying Conditions to Apply for IMR	Health and Safety Code, section 1374.30(j): ▪ An enrollee may apply to the department for IMR when all of the following conditions are met: • The enrollee's provider has determined a service to be medically necessary, or the enrollee has received urgent or emergency care that the provider determined was medically necessary, or the enrollee has been seen by a provider for the diagnosis or treatment of the medical condition for which the enrollee is seeking IMR. • The service has been denied, modified, or delayed by the plan or the enrollee's contracting provider based on a decision that the service was not medically necessary. • The enrollee has filed a grievance with the plan or provider and the disputed decision has been upheld or remains unresolved after 30 days.	Insurance Code section 10169(j) contains provisions substantially similar to those contained in Health and Safety Code section 1374.30(j).
Statute of Limitations	Health and Safety Code, section 1374.30(k): ▪ The enrollee may apply for IMR within six months of any of the qualifying conditions for IMR. ▪ The Director may extend the six-month application deadline if circumstances warrant. Code of Regulations, title 28, section 1300.74.30(f)(1): ▪ The six-month period within which the enrollee may apply for IMR does not begin to run until the enrollee has been properly notified in writing of the plan's resolution of the grievance.	Insurance Code, § 10169(k) contains provisions substantially similar to those contained in Health & Safety Code, § 1374.30(k).
Notice, Disclosure of IMR	Health and Safety Code, section 1374.30(i): ▪ Plans must prominently display "in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances . . . ".	Insurance Code, section 10169(i): ▪ Insurers must prominently display information concerning the right to apply for IMR in member handbooks, informational brochures, insurance contracts, evidence of coverage forms, insurer procedures for resolving grievances, insurer or provider letters of denial, and on all written responses to grievances.
Coordination with Other Agencies	Health and Safety Code, section 1374.30(g): ▪ The DMHC "may seek to integrate the quality of care and consumer protection provisions, including remedies, of the IMR system with related dispute resolution procedures of other health care agency programs, including the Medicare and Medi-Cal programs in a way that minimizes the potential for duplication, conflict, and added costs."	Insurance Code, section 10169(g): ▪ The CDI "may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare program, in a way that minimizes the potential for duplication, conflict, and added costs."

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Fees and Costs for IMR	Health and Safety Code, sections 1374.30 and 1374.35: ▪ An enrollee owes no fees for requesting an IMR. ▪ Health care service plans must pay for the cost of the IMR system through DMHC assessments.	Insurance Code sections 10169 and 10169.5 contains provisions substantially similar to those contained in Health and Safety Code, sections 1374.30 and 1374.35.
Required Response Time to IMR Application	Health and Safety Code, section 1374.33(c): ▪ The review organization shall complete its review and make its determination in writing within 30 days of receipt of the application and supporting documentation, or within less time as prescribed by the Director.	Insurance Code section 10169.3(c) contains provisions substantially similar to those contained in Health and Safety Code section 1374.33(c).
Expedited Review	Health and Safety Code, sections 1374.31 and 1374.33 ▪ When an IMR request involves an imminent and serious threat to the health of the enrollee: • Plans or contracting providers must provide all required medical records and other documents to the DMHC within 24 hours of the DMHC's approval of the IMR request. • IMR reviewers must complete their analyses and determinations within three days of receiving the enrollee's information. Code of Regulations, title 28, section 1300.74.30(d)(4): ▪ An enrollee's application for expedited IMR must include physician certification that an imminent and serious threat to the health of the enrollee exists.	Insurance Code sections 10169.1 and 10169.3 contain provisions substantially similar to those contained in Health and Safety Code sections 1374.31 and 1374.33. Code of Regulations, title 10 contains no similar restriction.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Standards for Conducting the IMR	Health and Safety Code, section 1374.33: ▪ In conducting an IMR, reviewers must determine whether the disputed or proposed health care service is medically necessary based on the specific medical needs of the enrollee and any of the following criteria: • Scientific and medical evidence regarding effectiveness of the service • Nationally recognized professional standards • Expert opinion • Generally accepted standards of medical practice • Treatments that are more clinically efficacious for the enrollee ▪ The reviewers' determination must state whether the disputed service is medically necessary. ▪ If more than one reviewer analyzes the case, the majority prevails. If the reviewers are evenly split concerning the disputed service, the decision must be in favor of providing the service. ▪ The DMHC must keep names of all reviewers confidential in all communications with entities outside the IMR organization. ▪ The DMHC must immediately adopt the determination of the IMR organization and promptly issue a written, binding decision to the parties. ▪ After removing the names of the parties, including but not limited to the enrollee, all medical providers, the plan and any of the insurer's employees or contractors, the DMHC must make decisions available to the public, at the department's cost.	Insurance Code section 10169.3 contains provisions substantially similar to those contained in Health and Safety Code section 1374.33.
IMR Involving Experimental or Investigational Therapies	Health and Safety Code, section 1370.4: ▪ IMR for disputes involving experimental or investigational therapies must be provided under the following criteria: • The enrollee has a life-threatening or seriously debilitating condition. • The enrollee or the enrollee's physician has recommended or requested a drug, device, procedure, or other therapy that is likely to be more beneficial to the enrollee than available standard therapies, as certified by the physician, or from medical and scientific evidence, and that recommendation or request has been denied by the plan. • The recommended or requested drug, device, procedure, or therapy would be a covered service except for the plan's determination that it is experimental or under investigation. ▪ The IMR process for disputes involving experimental or investigational therapies must be conducted as follows: • The plan must notify the enrollee in writing of the opportunity to request IMR within five days of denying the disputed service. • Reviewers must make determinations within seven days if there is a necessity for expedited review.	Insurance Code section 10145.3 contains provisions substantially similar to those contained in Health and Safety Code section 1370.4.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
	• Determinations must be written and describe the reviewers' rationale for recommending or not recommending the disputed service. Code of Regulations, title 28, section 1300.70.4: ▪ Plan notification must include information on the IMR process, an application, the DMHC toll-free number, and a physician certification form. ▪ An enrollee's application for IMR must include a copy of the written denial of the disputed therapy or service, and certification from a treating physician that includes information on the enrollee, physician, the enrollee's medical condition, and the disputed therapy or service, and copies of medical or scientific evidence relevant to the requested therapy or service. ▪ The DMHC does not require the enrollee to participate in the plan's grievance process prior to seeking an IMR involving an experimental or investigational therapy.	
Qualifications of IMR Organizations	Health and Safety Code, section 1374.32: ▪ An IMR organization that contracts with the DMHC must be independent of any health care service plan doing business in California; this provision extends to the organization's directors and employees. ▪ An IMR organization must submit and update the following information to the DMHC: • The names of all stockholders, and owners if publicly held; the names of major bond or note holders; the names of affiliated organizations; the names and background of all directors, officers and executives. • The percentage of revenue the organization earns from IMR, quality assurance and utilization reviews. • A description of the IMR process. • How the organization recruits and selects medical professionals as reviewers. ▪ Neither the IMR organization nor the expert reviewers conducting a review may have any material affiliation with: • The plan involved, or its directors or employees. • Any physician or medical group involved in the disputed or proposed health care service. • Any facility at which a disputed or proposed service would be provided. • The development or manufacture of any drug, device, procedure, or therapy disputed or proposed for the enrollee. • The enrollee or the enrollee's immediate family. ▪ The IMR organization must demonstrate it has an ongoing quality assurance mechanism ensuring appropriate reviewer credentialing and selection, quality reviews, and record confidentiality.	Insurance Code section 10169.2 contains provisions substantially similar to those contained in Health and Safety Code section 1374.32, with the exception that Insurance Code section 10169.2(f) also provides that: "The commissioner may contract with the Department of Managed Health Care to administer the independent medical review process established by this article."

APPENDIX C: COMPARISON OF DISCLOSURES

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Comparative Benefit Matrix	Health and Safety Code sections 1363.06, 1363.07(a), 1363.07(b), and 1363.07(c): ▪ The DMHC and CDI must compile two benefit matrices. The first matrix will compare benefits for the MRMIB graduate product. The second matrix will compare HIPAA Plans and Individual Conversion Plans. ▪ Plans must send copies of the matrix when updated, or at least annually (pursuant to section 1363.06), to contracting solicitors, solicitor firms, and employers. ▪ Plans must require representatives to provide information about plan products when presenting a benefits package. ▪ If the plan maintains a website, a current updated matrix must be downloadable.	Insurance Code sections 10127.14 and 10113.8 contain provisions substantially similar to those contained in Health and Safety Code sections 1363.06, 1363.07(a), 1363.07(b), and 1363.07(c). Insurers must maintain a website with an updated matrix, and each health insurer must require its representatives to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.
Disclosure Form	Health and Safety Code section 1363(a): ▪ The DMHC Director shall require each plan to use disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the Director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner.	Insurance Code sections 10603 and 10604 contain provisions substantially similar to Health and Safety Code section 1363(a); however, the Health and Safety Code requires significantly more to be disclosed in the Disclosure Form.
Supplemental Disclosure Information	Health and Safety Code section 1364: ▪ Where the DMHC Director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by a plan for the purpose of influencing persons to become members of a plan shall contain such supplemental disclosure information as the Director may require.	Insurance Code section 10606 contains a substantially similar provision to Health and Safety Code section 1364.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Infertility Coverage	Health and Safety Code §§ 1374.55(a-c) ▪ Every health care service plan contract that covers hospital, medical, or surgical expenses on a group basis, shall offer coverage for the treatment of infertility, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contract-holders and to all prospective group contract-holders with whom they are negotiating.	Insurance Code § 10119.6 contains a substantially similar provision to Health and Safety Code §§ 1374.55(a-c).
Economic Profiling	Health and Safety Code § 1367.2(b) ▪ Every health care service plan shall file with the department a description of any policies and procedures related to economic profiling utilized by the plan and its medical groups and individual practice associations. ▪ The director shall make each plan's filing available to the public upon request. The director shall not publicly disclose any information submitted pursuant to this section that is determined by the director to be confidential pursuant to state law.	Insurance Code § 10123.36 contains a substantially similar provision to Health and Safety Code § 1367.2(b).
Alcoholism	Health and Safety Code § 1367.2(a) ▪ Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan. Every plan shall communicate the availability of such coverage to all group subscribers and to all prospective group subscribers with whom they are negotiating.	Insurance Code § 10123.6 contains a substantially similar provision to Health and Safety Code § 1367.2(a).
Comprehensive Care of Children 16 Years or Under	Health and Safety Code § 1367.35(a) ▪ Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contract-holders and to all prospective group contract-holders with whom they are negotiating.	Insurance Code § 10123.5 contains a substantially similar provision to Health and Safety Code § 1367.35(a).

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Comprehensive Care of Children 17 and 18 Years Old	Health and Safety Code § 1367.3(a) ▪ Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in paragraph (4) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contract-holders and to all prospective group contract-holders with whom they are negotiating.	Insurance Code § 10123.55 contains a substantially similar provision to Health and Safety Code § 1367.3(a).
Orthotic and Prosthetic Devices and Services	Health and Safety Code § 1367.18 ▪ Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under such terms and conditions as may be agreed upon between the group contract holder and the plan.	Insurance Code **§** 10123.7 contains a substantially similar provision to Health and Safety Code § 1367.18.
Specialized Footwear	Health and Safety Code § 1367.19 ▪ Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under such terms and conditions as may be agreed upon between the group contract holder and the plan. As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability. § 1367.19	Insurance Code § 10123.41 contains a substantially similar provision to Health and Safety Code § 1367.19.
Prenatal Genetic Testing	Health and Safety Code § 1367.7 ▪ Every health care service plan contract that covers hospital, medical, or surgical expenses on a group basis, and which offers maternity coverage in such groups, shall also offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. Every health care service plan shall communicate the availability of such coverage to all group contract holders and to all groups with whom they are negotiating. § 1367.7	Insurance Code **§** 10123.9 contains a substantially similar provision to Health and Safety Code § 1367.7.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Effect of Participation in Plan	Health and Safety Code §§ 1367.10(a), (b) ▪ Plans must include in disclosure and evidence of coverage forms how plan participation may affect choice of physician, hospital or other health care providers, basic method of reimbursement, whether financial bonuses/incentives are used, and that additional information on bonus/incentive arrangements can be obtained from plan, provider, medical group or independent practice association. ▪ If plan, provider, medical group or independent practice association uses financial incentives, they must provide written summary of financial incentive arrangements upon request.	Insurance Code **§** 10123.12 contains a substantially similar provision to Health and Safety Code §§ 1367.10(a), (b), but does not require disclosure of basic method of reimbursement, or whether financial bonuses/incentives are used.
Process for Review of Requests by Health Care Service Providers	Health and Safety Code § 1363.5 ▪ Plans using utilization management/ utilization review shall disclose to the Director of DMHC, network providers, enrollees, or the public upon request, the process used to authorize, delay, modify or deny health care services requests including requests for sub acute, transitional inpatient or skilled nursing facility care.	Insurance Code **§** 10123.135(f) contains a substantially similar provision to Health and Safety Code § 1363.5.
Rejection of Health Care Claims	Health and Safety Code § 1399.55 ▪ Plans must disclose specific rationale for rejecting claim to provider or patient upon demand.	Insurance Code § 790.03(h)(13) ▪ Prohibits knowingly or general business practice of failing to provide prompt reasonable explanation of basis for denial of claim or for the offer of a compromise settlement. Fair Claims Practices Regulations 2695.7(b)(1) (3) ▪ Requires insurer to provide a written explanation of the reason for a denial of the claim in whole or in part. Must cite specific statute or policy language that supports denial. This notification must also include a notice that the insured may have the matter reviewed by CDI including the address and phone number for complaint handling unit.
Prescription Drug Information	Health and Safety Code § 1363.03 ▪ Plans that cover prescription drug benefits and issue cards to enrollees for claims processing purposes shall issue a card containing uniform prescription drug information.	Insurance Code § 10123.194 contains a substantially similar provision to Health and Safety Code § 1363.03.
Prescription Drugs: Formularies	Health and Safety Code § 1363.01 and § 1367.20 ▪ Every Plan that covers prescription drug benefits shall provide notice to enrollees in evidence of coverage and disclosure forms of whether Plan uses a formulary. Whether certain drug is on the formulary shall be provided to public upon request. ▪ Plans w/ drug formularies to provide formulary list or lists to public upon request.	No comparable Insurance Code provision because insurers do not provide health services and do not restrict insured's ability to obtain prescription drugs.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Mental or Nervous Disorders	Health and Safety Code § 1373(h)(1) ▪ A health care service plan that offers outpatient mental health services but does not cover these services in all of its group contracts shall communicate to prospective group contract-holders as to the availability of outpatient coverage for the treatment of mental or nervous disorders.	Insurance Code §§ 10125 and 10127 contain substantially similar provisions to Health and Safety Code § 1373(h)(1).
Disclosure of California Continuation Benefits (Cal-COBRA)	Health and Safety Code § 1366.24(e) ▪ Every plan disclosure form for a group benefit plan shall provide a notice that the enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.	Insurance Code §10128.54 contains a substantially similar provision to Health and Safety Code § 1366.24(e).
List of Contracted Providers	Health and Safety Code § 1367.26 ▪ Health plans must provide, upon request, a list of contracting providers, medical groups, IPAs, and hospitals within enrollee's general geographic area.	Insurance Code § 10133.1 contains a substantially similar provision to Health and Safety Code § 1367.26.
Reproductive Health Services Information	Health and Safety Code § 1363.02 ▪ Plans that cover hospital, medical and surgical benefits shall include statement in provider directory that some providers don't provide some or all covered reproductive health services, unless none limit these services.	Insurance Code § 10604.1 contains a substantially similar provision to Health and Safety Code § 1363.02.
Contract for Compliance with Quality Improvement or Utilization Management Programs	Health and Safety Code § 1375.7(b)(3) ▪ No contract between a health plan and a provider may contain a provision requiring compliance with quality improvement or utilization management programs or procedures of a plan, unless the requirement is disclosed to the provider at least 15 business days prior to execution of contract by provider.	Insurance Code § 10133.65(b)(2) contains a substantially similar provision to Health and Safety Code § 1375.7(b)(3).
New or Modified Plan Contract	Health and Safety Code § 1352.1 ▪ A plan that meets the requirements of Section 1352.1(b) is required to file a new or modified plan contract, or disclosure form or evidence of coverage (EOC), within 10 days of entering the contract or publishing or distributing the disclosure form or EOC. A plan that does not meet the requirements for this "use and file" exception, must file the documents at least 30 days before use and may implement the documents if the DMHC has not provided notice of objections to the documents within 30 days of filing. If the DMHC does not provide objections within 30 days of a plan filing an amendment, Rule 1300.52.4(c) provides for limitations on enforcement or disciplinary action, but confirms that the DMHC may require the plan to make changes necessary to comply with the Act and the rules adopted pursuant to the Act.	Insurance Code §§ 10192.7; 2219; 10270.9; 10290; and 10291 ▪ Medicare Supplement policies or certificates shall not be advertised solicited or issued for delivery unless they comply with Insurance Code. § 10192.7 ▪ All individual disability policy forms shall be submitted to the Commissioner for approval. § 2219; 10290. ▪ All group disability policy forms shall be filed with the Commissioner for approval. § 10270.9 ▪ A disability policy shall not be issued or delivered to any person in this state unless it is filed with commissioner and the commissioner does not approve it within 30 days. § 10290 ▪ After the Commissioner disapproves a form in writing issuing form is unlawful. § 10291

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Solicitation and Enrollment	Health and Safety Code § 1363 ▪ DHMC director must require plan disclosure forms that are full, fair and easy to understand and clearly organized.	Insurance Code § 10291.5(b)(1) ▪ CDI will disapprove any disability policy containing provisions that are uncertain, ambiguous, abstruse or likely to mislead.
Binding Arbitration as Contract Term	Health and Safety Code § 1363.1 ▪ Specifies disclosure requirements for plans that require binding arbitration to settle disputes. §1363.1, including a provision that enrollee is waiving right to a jury trial.	Insurance Code § 10123.19 contains a similar provision. Any disability insurance policy that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trail shall include a clear disclosure that meets specified conditions contained in 10123.19.
Plan Contract; Arbitration	Health and Safety Code §§ 1373(i), 1373.20(c) ▪ Plans that use arbitration must set forth type of disputes subject to arbitration, the process used, and how it is initiated. ▪ EOC must disclose a provision for the assumption of all or part of enrollee's share of arbitration fees in cases of extreme hardship.	No comparable Insurance Code provisions.
911 Emergency Response Use	Health and Safety Code §§1363 and 1363.2 ▪ Disclosure form required by §1363 shall include statement that enrollees are encouraged to use 911 for medical conditions that require emergency response.	No comparable Insurance Code provision because insurers do not provide direct health services and does not restrict use of emergency services.
Patient's Rights Information	Health and Safety Code §§ 1262.5 and 1367.5 ▪ Plans shall not prohibit or restrict health facilities' compliance with Health and Safety Code § 1262.5, which requires that hospitals have a written discharge policy and that a transfer summary regarding continuing health care requirements be communicated to patients.	No comparable Insurance Code provision because insurers do not provide direct health services.
Plan Contract; Commencement of Benefits	Health and Safety Code § 1373(j) ▪ Plan contracts that provide benefits that start after a period of confinement in health care facility must specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requisite to the commencement of benefits.	Insurance Code Sections 10127.2 and 10123 contain similar provisions to Health and Safety Code Section 1373.95.
Continuity of Care	Health and Safety Code §§ 1373.95, 1373.96 and 1363(a)(15) ▪ A health care service plan, including a health care service plan that offers professional mental health services on an employer–sponsored basis, shall file a written continuity of care policy and shall provide to all new enrollees notice of its written continuity of care policy and information regarding the process for an enrollee to request review under the policy, and shall provide upon request, a copy of the policy to the enrollee. Disclosure of these rights must be included in the EOC and Disclosure Forms.	Insurance Code §§ 10133.55 and 10133.56 contain substantially similar provisions.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Second Medical Opinion	Health and Safety Code § 1383.1 ▪ Plans must file policy with DMHC on how it determines if a second medical opinion is medically necessary and appropriate. Notice of the policy shall be provided in the evidence of coverage.	Insurance Code § 10123.67 contains a substantially similar provision.

APPENDIX D: COMPARISON OF ARBITRATION LAWS

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Arbitration Code and Regulations	Knox-Keene Health Care Service Plan Act, Health & Safety Code, §§ 1363.1, 1373, 1373.19, 1373.20, 1373.21 CCR Title 28 §§ 1300.63.1, 1300.63.2, 1300.73.21	California Insurance Code, § 10123.19. Does not require CDI to draft regulations. Code specifies contents of disclosure.
Disclosure of Arbitration Provisions	Health & Safety Code, § 1363.1 Disclosure: ▪ Is required when the plan includes terms that require arbitration to settle disputes and that restrict or waive the right to a jury trial. ▪ Must be in clear, understandable language. ▪ Must specifically state whether binding arbitration is used to settle medical malpractice claims. ▪ Must appear separately in subscriber agreement and be prominently displayed on the enrollment form. ▪ The disclosure regarding the waiving of a right to a jury trial must be substantially expressed as in CCP § 1295(a). ▪ Must be displayed immediately before the signature line for enrollee.	Insurance Code, § 10123.19 Provision is similar to Health & Safety Code § 1363.1
	Health & Safety Code, § 1363 provides that if the health plan uses arbitration to settle disputes, the disclosure form must provide a statement of that fact.	No similar Insurance Code provision.
	<u>Regulation:</u> CCR Title 28 §§ 1300.63.1, 1300.63.2: ▪ The Evidence of Coverage and Disclosure form are required to contain disclosures of any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.	No similar CDI regulation.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Selection of Arbitrator	Health and Safety Code, section 1373.19 and 1373.20(a): ▪ Plans that require binding arbitration for cases for which the total amount of damages is *$200,000* or less must permit the parties to select a single neutral arbitrator. ▪ If parties are unable to agree on an arbitrator, the method provided in Code of Civil Procedure section 1281.6 *may be* utilized. ▪ Parties may also use a tripartite arbitration panel that includes two party-appointed arbitrators, or three neutral arbitrators, or another multiple arbitrator system agreed to by the parties. ▪ If the parties agree to waive the requirement to use a single neutral arbitrator, the enrollee has three days to rescind the agreement, if his/her counsel hasn't signed the agreement. ▪ If a plan does not use an independent professional dispute resolution organization, independent of the plan for arbitration: • The method of selection provided in Code of Civil Procedure section 1281.6 *may be* utilized, if the party seeking arbitration and the plan are unable to select a neutral arbitrator within 30 days after service of written demand. • Section 1281.6 selection method may also be utilized if party arbitrators are unable to agree on designation of the neutral arbitrator on a tripartite arbitration panel.	Insurance Code, section 10123.19: There are no similar restrictions for consumers; however, policies may include language that permits binding arbitration in cases of medical malpractice in which the total amount is $50,000 or less. If parties are unable to agree on selection of arbitrator, the method provided in Code of Civil Procedure section 1281.6 *must be* utilized.
Penalties for Dilatory Conduct	Health and Safety Code section 1373.20(b): ▪ The court may issue an order awarding reasonable costs, including attorney fees, incurred in filing a petition if a party has engaged in dilatory conduct intended to cause delay.	There are no comparable Insurance Code provisions. Consumers may sue their insurance companies.
Extreme Hardship Cases	Health and Safety Code section 1373.20(c): ▪ Plan contracts must include a provision for assuming all or a portion of an enrollee's share of the fees and expenses of a neutral arbitrator in cases of extreme hardship. This provision must be disclosed to enrollees in the evidence of coverage. ▪ Approval or denial of an enrollee application for extreme hardship relief must be determined by either an independent professional dispute resolution organization or a neutral arbitrator other than the arbitrator assigned to hear the underlying dispute.	There are no comparable Insurance Code provisions. Consumers may sue their insurance companies.

Issue/Variable	Department of Managed Health Care	California Department of Insurance
Written Arbitration Decisions	Health and Safety Code section 1373.21 and Code of Regulations, title 28, section 1300.73.21: ▪ Plans that use arbitration must require that a written decision accompany the arbitration award to the parties, indicating the prevailing party, amount, terms, and the rationale for the award. ▪ Plans must provide a copy of the complete written arbitration decision to the DMHC within 30 days of receiving the decision for purposes of administrating the provisions of the Knox-Keene Act. ▪ Redacted copies of all written arbitration decisions must be provided to the DMHC quarterly to make available for public inspection on the DMHC web page. The plan must redact the decisions, to include the terms, amount and rationale for the award and the names of arbitrators, but to exclude the names of the enrollee, witnesses, the plan, attorneys, providers, plan employees, and health facilities.	There are no comparable Insurance Code provisions.

APPENDIX E: SB 1913

BILL NUMBER: SB 1913 CHAPTERED
BILL TEXT

CHAPTER 793
FILED WITH SECRETARY OF STATE SEPTEMBER 22, 2002
APPROVED BY GOVERNOR SEPTEMBER 22, 2002
PASSED THE SENATE AUGUST 22, 2002
PASSED THE ASSEMBLY AUGUST 15, 2002
AMENDED IN ASSEMBLY JUNE 4, 2002
AMENDED IN SENATE APRIL 16, 2002

INTRODUCED BY Committee on Insurance (Senators Speier (Chair), Escutia, Figueroa, Johnson, Scott, and Soto)

FEBRUARY 22, 2002

An act to add Section 1342.4 to the Health and Safety Code, and to add Section 12923.5 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1913, Committee on Insurance. Department of Managed Health Care and Department of Insurance: joint working group.

Existing law requires the Director of Managed Health Care in the Department of Managed Health Care to consult with the Insurance Commissioner in the Department of Insurance to ensure consistency of regulations relating to health care.

This bill would require the Department of Managed Health Care and the Department of Insurance to maintain a joint senior level working group to ensure clarity in enforcement and consistency in regulations. The bill would require the joint working group to review and examine certain procedures in the departments and to report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care to submit to the Legislature by January 1 of every year for 5 years.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1342.4 is added to the Health and Safety Code, to read:

1342.4. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

SEC. 2. Section 12923.5 is added to the Insurance Code, to read:

12923.5. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

[DoI1]Changed order of agencies to DMHC first and CDI second
[DoI2]Added A
[DoI3]Added comma
[DoI4]Added privacy requirement contained in ICS 10169.3 (g).
[DoI5]Made must regular text instead of bold.
[DoI6]Added additional requirement from ICS 10113.8 (c).
[DoI7]Added additional clarifying language from ICS 790.03(h)(13)
[DoI8]Added additional reference for requirement.
[DoI9]Insurance Code Section 10123.9 does require disclosure of waiver to a jury trail if contained in a disability policy
[DoI10]These insurance code sections contain similar provisions.
[DoI11]Insurance Code Section 10123.19 does require disclosure to policyholder that he/she is waiving right to a jury trial.