§ 1368.015. Online grievance procedure

(a) Effective July 1, 2003, every plan with an internet website shall provide an online form through its internet website that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The internet website shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the internet website's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall be approved by the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the Department of Managed Health Care internet website, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent

Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."

The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section is exempt from these requirements until January 1, 2006.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Home page" means the first page or welcome page of an internet website that serves as a starting point for navigation of the internet website.

(2) "HTML" means Hypertext Markup Language, the authoring language used to create documents on the world wide web, which defines the structure and layout of a web document.

(3) "Hyperlink" means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another internet website or page.

(4) "Member services portal" means the first page or welcome page of an internet website that can be reached directly by the internet website's home page and that serves as a starting point for a navigation of member services available on the internet website.

(5) "Secure server" means an internet connection to an internet website that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) "URL" or "Uniform Resource Locator" means the address of an internet website or the location of a resource on the world wide web that allows a browser to locate and retrieve the internet website or the resource.

(7) "Internet website" means a site or location on the world wide web.

(f)(1) Every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, shall maintain an internet website. For a health care service plan that provides coverage for professional mental health services, the internet website shall include, but not be limited to, providing information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services as well as the information described in Section 1368.016.

(2) The provision in paragraph (1) that requires compliance with Section 1368.016 shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its internet website to an internet website operated by the specialized health care service plan, insurer, or

other entity with which it contracts, and that plan, insurer, or other entity complies with Section 1368.016.

HISTORY:

Added Stats 2002 ch 796 § 3 (AB 2085). Amended Stats 2003 ch 62 § 178 (SB 600); Stats 2008 ch 722 § 2 (SB 1553), effective January 1, 2009; Stats 2009 ch 575 § 2 (SB 296), effective January 1, 2010; Stats 2019 ch 113 § 2 (AB 1802), effective January 1, 2020; Stats 2020 ch 370 § 194 (SB 1371), effective January 1, 2021.

§ 1368.016. Establishment of Internet Web site; Link to specified information required; Updates; Applicability of section

(a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:

(1) A telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 1367.205, or instructions on how to obtain the formulary, as described in Section 1367.20.

(3) A detailed summary that describes the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services as described in Sections 1363.5 and 1367.01.

(4) Lists of providers or instructions on how to obtain the provider list, as required by Section 1367.27.

(5) A detailed summary of the enrollee grievance process as described in Sections 1368 and 1368.015.

(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

(7) Information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to Section 1374.30.

(b) Any modified material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to enrollees.

(d) The material described in subdivision (a) shall also be made available to enrollees in hard copy upon request.

(e) This article does not preclude a health care service plan from including additional information on its Internet Web site for applicants, enrollees or subscribers, or providers, including, but not limited to, the cost of procedures or services by health care providers in a plan's network.

(f) The department shall include on the department's Internet Web site a link to the Internet Web site of each health care service plan and specialized health care service plan described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE

supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(h) This section shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 10123.199 of the Insurance Code.

HISTORY:

Added Stats 2009 ch 575 § 3 (SB 296), effective January 1, 2010. Amended Stats 2014 ch 575 § 4 (SB 1052), effective January 1, 2015; Stats 2018 ch 687 § 2 (SB 910), effective January 1, 2019.

§ 1368.02. Toll-free telephone number for complaints

(a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's internet website address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's internet website address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online."

HISTORY:
Added Stats 1998 ch 377 § 3 (SB 1443), operative July 1, 1999. Amended Stats 1999 ch 525 § 103 (AB 78), operative July 1, 2000; Stats 2000 ch 857 § 34 (AB 2903); Stats 2002 ch 796 § 4 (AB 2085); Stats 2003 ch 62 § 179 (SB 600); Stats 2011 ch 552 § 3 (AB 922), effective January 1, 2012; Stats 2019 ch 113 § 3 (AB 1802), effective January 1, 2020.

§ 1368.03. Participation in plan's grievance process before complaint with department

(a) The department may require enrollees and subscribers to participate in a plan's grievance process for up to 30 days before pursuing a grievance through the department or the independent medical review system. However, the department may not impose this waiting period for expedited review cases covered by subdivision (b) of Section 1368.01 or in any other case where the department determines that an earlier review is warranted.

(b) Notwithstanding subdivision (a), the department may refer any grievance issue that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(c) This section shall become operative on January 1, 2001, and then only if Assembly Bill 55 of the 1999-2000 Regular Session is enacted.

HISTORY:
Added Stats 1999 ch 542 § 5 (SB 189), operative January 1, 2001.

§ 1368.04. Enforcement by director; Violations; Administrative penalty

(a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess administrative penalties 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. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances

when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

HISTORY:

Added Stats 1999 ch 542 § 7 (SB 189), operative January 1, 2001. Amended Stats 2000 ch 135 § 88 (AB 2539), ch 1067 § 12 (SB 2094) (ch 1067 prevails); Stats 2008 ch 607 § 6 (SB 1379), effective September 30, 2008.