Assembly Bill No. 1869

CHAPTER 167

An act to amend Section 136000 of the Health and Safety Code, relating to health care.

[Approved by Governor July 24, 2012. Filed with Secretary of State July 24, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1869, John A. Pérez. Office of Patient Advocate: federal veterans health benefits.

Existing law requires the Office of Patient Advocate to provide assistance to, and advocate on behalf of, individuals served by health care service plans regulated by the Department of Management Health Care, insureds covered by health insurers regulated by the Department of Insurance, and individuals who receive or are eligible for other health care coverage in California. Under existing law, commencing January 1, 2013, the office is required to provide, and assist in the provision of, outreach and education about health care coverage options, including information and assistance regarding public programs such as Medi-Cal, the Healthy Families Program, and Medicare.

This bill would require the Office of Patient Advocate, commencing January 1, 2013, to also provide, and assist in the provision of, outreach and education about federal veterans health benefits.

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

SECTION 1. Section 136000 of the Health and Safety Code is amended to read:

136000. (a) (1) Effective July 1, 2012, there is hereby transferred from the Department of Managed Health Care the Office of Patient Advocate to be established within the California Health and Human Services Agency, to provide assistance to, and advocate on behalf of, individuals served by health care service plans regulated by the Department of Managed Health Care, insureds covered by health insurers regulated by the Department of Insurance, and individuals who receive or are eligible for other health care coverage in California, including coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program. The goal of the office shall be to help those individuals secure the health care services to which they are entitled or for which they are eligible under the law. Notwithstanding any provision of this division, each regulator and health

coverage program shall retain its respective authority, including its authority to resolve complaints, grievances, and appeals.

(2) The office shall be headed by a patient advocate appointed by the Governor. The patient advocate shall serve at the pleasure of the Governor.

(3) The provisions of this division affecting insureds covered by health insurers regulated by the Department of Insurance and individuals who receive or are eligible for coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program shall commence on January 1, 2013, except that for the period July 1, 2012, to January 1, 2013, the office shall continue with any duties, responsibilities, or activities of the office authorized as of July 1, 2011, which shall continue to be authorized.

(b) (1) The duties of the office shall include, but not be limited to, all of the following:

(A) Developing, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the California Health Benefit Exchange, the Department of Managed Health Care, and the Department of Insurance, educational and informational guides for consumers describing their rights and responsibilities, and informing them on effective ways to exercise their rights to secure health care coverage. The guides shall be easy to read and understand and shall be made available in English and other threshold languages, using an appropriate literacy level, and in a culturally competent manner. The informational guides shall be made available to the public by the office, including being made accessible on the office's Internet Web site and through public outreach and educational programs.

(B) Compiling an annual publication, to be made available on the office's Internet Web site, of a quality of care report card, including, but not limited to, health care service plans.

(C) Rendering assistance to consumers regarding procedures, rights, and responsibilities related to the filing of complaints, grievances, and appeals, including appeals of coverage denials and information about any external appeal process.

(D) Making referrals to the appropriate state agency regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of consumers.

(E) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsperson programs.

(2) The office shall employ necessary staff. The office may employ or contract with experts when necessary to carry out the functions of the office. The patient advocate shall make an annual budget request for the office which shall be identified in the annual Budget Act.

(3) Until January 1, 2013, the office shall have access to records of the Department of Managed Health Care, including, but not limited to, information related to health care service plan or health insurer audits, surveys, and enrollee or insured grievances.

(4) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

(5) The office shall adopt standards for the organizations with which it contracts pursuant to this section to ensure compliance with the privacy and confidentiality laws of this state, including, but not limited to, the Information Practices Act of 1977 (Chapter 1(commencing with Section 1798) of Division 3 of the Civil Code). The office shall conduct privacy trainings as necessary, and regularly verify that the organizations have measures in place to ensure compliance with this provision.

(c) In enacting this act, the Legislature recognizes that, because of the enactment of federal health care reform on March 23, 2010, and the implementation of various provisions by January 1, 2014, it is appropriate to transfer the Office of Patient Advocate and to confer new responsibilities on the Office of Patient Advocate, including assisting consumers in obtaining health care coverage and obtaining health care through health coverage that is regulated by multiple regulators, both state and federal. The new responsibilities include assisting consumers in navigating both public and private health care coverage and assisting consumers in determining which regulator regulates the health care coverage of a particular consumer. In order to assist in implementing federal health care reform in California, commencing January 1, 2013, the office, in addition to the duties set forth in subdivision (b), shall also do all of the following:

(1) Receive and respond to all inquiries, complaints, and requests for assistance from individuals concerning health care coverage available in California.

(2) Provide, and assist in the provision of, outreach and education about health care coverage options as set forth in subparagraph (A) of paragraph (1) of subdivision (b), including, but not limited to:

(A) Information regarding applying for coverage; the cost of coverage; and renewal in, and transitions between, health coverage programs.

(B) Information and assistance regarding public programs, such as Medi-Cal, the Healthy Families Program, federal veterans health benefits, and Medicare; and private coverage, including employer-sponsored coverage, Exchange coverage; and other sources of care if the consumer is not eligible for coverage, such as county services, community clinics, discounted hospital care, or charity care.

(3) Coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform.

(4) Render assistance to, and advocate on behalf of, consumers with problems related to health care services, including care and service problems and claims or payment problems.

(5) Refer consumers to the appropriate regulator of their health coverage programs for filing complaints, grievances, or claims, or for payment problems.

(d) (1) Commencing January 1, 2013, the office shall track and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, source of coverage, regulator, and resolution of complaints, including timeliness of resolution.

(2) The Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, the Managed Risk Medical Insurance Board, the California Health Benefit Exchange, and other public coverage programs shall provide to the office data in the aggregate concerning consumer complaints and grievances. For the purpose of publicly reporting information about the problems faced by consumers in obtaining care and coverage, the office shall analyze data on consumer complaints and grievances resolved by these agencies, including demographic data, source of coverage, insurer or plan, resolution of complaints and other information intended to improve health care and coverage for consumers. The office shall develop and provide comprehensive and timely data and analysis based on the information provided by other agencies.

(3) The office shall collect and report data to the United States Secretary of Health and Human Services on complaints and consumer assistance as required to comply with requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(e) Commencing in January 1, 2013, in order to assist consumers in understanding the impact of federal health care reform as well as navigating and resolving questions and problems with health care coverage and programs, the office shall ensure that either the office or a state agency contracting with the office shall do the following:

(1) Operate a toll-free telephone hotline number that can route callers to the proper regulating body or public program for their question, their health plan, or the consumer assistance program in their area.

(2) Operate a Internet Web site, other social media, and up-to-date communication systems to give information regarding the consumer assistance programs.

(f) (1) The office may contract with community-based consumer assistance organizations to assist in any or all of the duties of subdivision (c) in accordance with Section 19130 of the Government Code or provide grants to community-based consumer assistance organizations for portions of these purposes.

(2) Commencing on January 1, 2013, any local community-based nonprofit consumer assistance program with which the office contracts shall include in its mission the assistance of, and duty to, health care consumers. Contracting consumer assistance programs shall have experience in the following areas:

(A) Assisting consumers in navigating the local health care system.

(B) Advising consumers regarding their health care coverage options and helping consumers enroll in and retain health care coverage.

(C) Assisting consumers with problems in accessing health care services.

(D) Serving consumers with special needs, including, but not limited to, consumers with limited-English language proficiency, consumers requiring culturally competent services, low-income consumers, consumers with disabilities, consumers with low literacy rates, and consumers with multiple health conditions, including behavioral health.

(E) Collecting and reporting data, including demographic data, source of coverage, regulator, and resolution of complaints, including timeliness of resolution.

(3) Commencing on January 1, 2013, the office shall develop protocols, procedures, and training modules for organizations with which it contracts.

(4) Commencing on January 1, 2013, the office shall adopt standards for organizations with which it contracts regarding confidentiality and conduct.

(5) Commencing on January 1, 2013, the office may contract with consumer assistance programs to develop a series of appropriate literacy level and culturally and linguistically appropriate educational materials in all threshold languages for consumers regarding health care coverage options and how to resolve problems.

(g) (1) Commencing on January 1, 2013, the office shall develop protocols and procedures for assisting in the resolution of consumer complaints, including both of the following:

(1) A procedure for referral of complaints and grievances to the appropriate regulator or health coverage program for resolution by the relevant regulator or public program.

(2) A protocol or procedure for reporting to the appropriate regulator and health coverage program regarding complaints and grievances relevant to that agency that the office received and was able to resolve without further action or referral.

(h) For purposes of this section, the following definitions shall apply:

(1) "Consumer" or "individual" includes the individual or his or her parent, guardian, conservator, or authorized representative.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(3) "Health care" includes behavioral health, including both mental health and substance abuse treatment.

(4) "Health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345. Health care service plan includes "specialized health care service plans," including behavioral health plans.

(5) "Health coverage program" includes the Medi-Cal program, Healthy Families Program, tax subsidies and premium credits under the Exchange, the Basic Health Program, if enacted, county health coverage programs, and the Access for Infants and Mothers Program.

(6) "Health insurance" has the same meaning as set forth in Section 106 of the Insurance Code.

(7) "Health insurer" means an insurer that issues policies of health insurance.

(8) "Office" means the Office of Patient Advocate.
(9) "Threshold languages" shall have the same meaning as for Medi-Cal managed care.

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