



The California
**PATIENT'S
GUIDE**

**Your Health Care
Rights and Remedies**

Prepared by the
FOUNDATION FOR
TAXPAYER AND CONSUMER
RIGHTS

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This guide is intended to inform you of your rights to receive quality health care and what steps you can take if you encounter problems. It has been assembled by medical, legal and consumer experts under the supervision of a non-profit organization, The Foundation for Taxpayer and Consumer Rights, through a grant from the California Wellness Foundation.

While the authors of this guide have made every attempt to be as accurate and comprehensive as possible regarding current law, you should refer to the statutes and cases cited for the exact language used.

In recent years, state and federal legislators have responded to public concerns about threats to health care quality by enacting a number of new laws to help patients negotiate the managed health care system. This guide references state laws signed by Governor Davis and effective as of January 1, 2001.



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Acknowledgments

The Foundation for Taxpayer and Consumer Rights and the Department of Consumer Affairs wish to thank the following individuals who served as advisors to this guide:

**Sharon Arkin, Esq.
Robinson, Calcagnie &
Robinson**
620 Newport Center Dr.
Newport Beach, CA 92660

**Sherry Bahramabeygi, Esq.
Hosey & Bahramabeygi**
550 West "C" Street, Ste. 2050
San Diego, CA 92101

**Bob Ehrlenbusch
LA Coalition To End Hunger
& Homelessness**
548 South Spring St., Suite 339
Los Angeles, CA 90013

**Harvey Frey, M.D., Ph.D., J.D.
Health Administration
Responsibility Project (HARP)**
552 12th Street
Santa Monica, CA 90402-2908

**Kathleen Hamilton, Director
Department Of Consumer Affairs**
400 R Street, Suite 3000
Sacramento, CA 95814

**Catherine Hanson,
General Counsel
California Medical Association**
221 Main St. P.O. Box 7690
San Francisco, CA 94120-7690

**Steve Heimberg, J.D., M.D.
Law Offices of Steven Heimberg**
1880 Century Park East, Ste. 900
Los Angeles, CA 90067

**Carol Jimenez, Esq.,
Legal Counsel**

California Health Advocates
5182 Katella Ave., Suite 106
Los Alamitos, CA 90720

**Drew Liebert, Chief Counsel
Assembly Judiciary Committee**
1020 N St., Room 104
Sacramento, CA 95814

**Michael Lighty
California Nurses Association**
2000 Franklin St.
Oakland, CA 94612

**Michael Mattoch,
Legal Counsel
California Healthcare Association**
P.O. Box 1100
Sacramento, CA 95812-1100

**Cher McIntyre,
Director of Advocacy
Consumer Action**
523 W. 6th Street, Ste 1105
Los Angeles, CA 90014

**David Link, General Counsel
Office of Patient Advocate**
320 W. Fourth St., Suite 880
Los Angeles, CA 90013

**Don Moulds, Principal Consultant
Office of Senate Pro Tem John
Burton**
State Capitol, Room 500
Sacramento, CA 95814

**Kathy & Scott Olsen
Olsen Coalition For Patient Rights**
473 El Rancho Vista North
Chula Vista, CA 91910

Mark Rakich, Chief Counsel

**Senate Business & Professions
Committee**
State Capitol, Room 2053
Sacramento, CA 95814

**Linda Roberts-Ross, J.D.
PULSE of Southern California**
12781 Medlar Street
Yucaipa, CA 92399

**Ken Sigelman, J.D., M.D.
Kenneth M. Sigelman &
Associates**
1901 First Ave., 2nd Floor
San Diego, CA 92101

**Joanne Stern, Professor
Whittier Law School**
2766 Longwood Court
Costa Mesa, CA 92626

**Steve Thompson
Director Of Governmental Affairs
California Medical Association**
1201 K Street
Sacramento, CA 95814-3906

**Lea Ann Tratten
Consumer Attorneys Of California**
980 9th Street, Suite 200
Sacramento, CA 95814-2771

**Daniel Zingale, Director
Herb K. Shultz,
Deputy Director for External Affairs
Barbara Yonemura,
Legal Counsel
Department Of Managed
Health Care**
980 9th St., Suite 500
Sacramento, CA 95814

Introduction

How do I get copies of my medical records? What should I do if my health plan denies coverage for a particular treatment? How do I file a grievance against my health care plan? And, when can I sue my HMO? Can my health care plan exclude coverage for my preexisting condition? If I don't have insurance, what are my rights to receive emergency medical treatment? What health care programs are available if I cannot afford private insurance?

These are just some of the important questions that you will find answered in “The California Patient’s Guide: Your Health Care Rights and Remedies.”

We hope this guide will help you to learn your rights and responsibilities under your health care plan or insurance company and the laws governing them.

“My most disturbing observation throughout this entire experience was how common it was for people to refuse to connect, to relate to other people on a common level. So, every time I have communicated with a person with a regulatory agency or the health care industry, I have tried to reach that person on a personal level. I don’t know if it helped. I can’t help but to believe that it did. Regardless, I will continue to try. I do that in my mother’s memory.”

—Terry Preston

Terry Preston’s mother died a tragic and avoidable death of a ruptured abdominal aortic aneurysm (AAA) following delayed treatment at a California hospital. Preston was ultimately able to hold the HMO accountable for her mother’s death through a state regulator. Her persistent efforts resulted in a precedent setting \$1 million penalty awarded in an enforcement action against the HMO.

It is because of the persistence of Terry Preston, and others like her, that many of the rights and remedies described in this guide were enacted. While it is hoped that many of these new laws will prevent tragedies as endured by the Preston family from

occurring, her story and recommendations remain highly relevant for patients and their loved ones who may find themselves in similar circumstances:

1. *Don’t let delays by your HMO wear you down. If you believe you’re right and the cause is a worthy one, don’t give up.*
2. *People need support, especially when grieving the injury or loss of a loved one. Keep looking for support until you find it. Taking on a large HMO and the State was a daunting experience, especially without an attorney to do the work for me. Self-doubt and pure exhaustion were common. Contact the patient advocate organizations as listed throughout this guide for help and motivation.*
3. *Contact the media. If they don’t understand the significance of your story, do all within your power to convince them of its potential impact on their readers or viewers.*
4. *Try to connect with all those you encounter and believe that deep inside, most people have the desire to do what is right. Sometimes they just need encouragement.*
5. *Don’t give up.”*

Organization of the Guide

The first 8 chapters of this guide discuss your major health care rights and remedies. Each of these areas is discussed in a question and answer format. Chapter 9 provides information about government sponsored health care coverage options. The appendices provide other useful information for obtaining quality health care. Many of the rights and remedies described in this guide apply specifically to **Health Maintenance Organizations (HMOs)** and other managed care companies. Your rights and remedies in relation to health care providers in general, such as doctors and hospitals, apply regardless of what kind of health care plan you have.

The term “managed care” refers to a number of different types of health care plans that all combine the functions of payment and delivery of health care services to patients, such as HMOs and “**preferred provider organizations**” (PPOs). The terms “health care plan,” “health plan” and “HMO” are used interchangeably throughout the guide to refer to managed care plans that are regulated by California’s Department of Managed Health Care. If your health care is provided through a PPO, other than a Blue Cross or Blue Shield PPO, your rights may vary somewhat from those described in this guide. You should contact the California Department of Insurance for more specific information concerning your rights in relation to your PPO.

References to specific California and federal statutes, regulations and cases have been included in footnotes at the end of each chapter. When corresponding with a health plan, it always helps to cite to the relevant law.

Key definitions are highlighted within each chapter and terms appearing in **boldface type** are included in the Glossary at the end of the guide.

At the end of each chapter, you will find a list of “Other Resources” where you can go for additional information about a particular issue.

SOURCES OF HEALTH CARE RIGHTS AND THE RELATIONSHIP TO YOUR RIGHTS

The source of your health care coverage determines what legal rights you have in relationship to your health plan. However, your rights in relationship to doctors, hospitals and other care-givers are not affected by the source of your health coverage. The chart below helps to summarize coverage sources and the rights associated with them. If you are not sure what coverage source applies to you, ask your employer or health plan.

If Your Health Care Coverage is...

Your Rights & Remedies are Determined By...

Through **private employer that contracts with an HMO or managed care company**, but employer's health plan is not "self-funded" —it does not finance services from the employer's own funds rather than HMO or insurer's.

State laws regulating managed care companies and insurance apply. A new state HMO "right to sue" law can be used when HMO interferes with the quality of care. The federal **Employee Retirement Income Security Act** or "**ERISA**" may limit your ability to sue for damages in some instances —when the HMO claims it is not responsible under the language of its contract with you for a specific benefit (a "coverage dispute.")

Through "**self-funded**" **employer** — typically a large employer that finances treatment from its own funds and contracts with a plan to administer the employer plan. (If you are not sure whether your employer has a "self-funded" health plan, ask your plan administrator, your employer's Human Resources Director, or other person in charge of employee benefits.)

State laws do not apply to health plan. Federal ERISA law applies because "self-funded" plans can never be considered insurance companies for purposes of being regulated by the state. Legal recovery is limited to what you paid out-of-pocket for the treatment. Doctors, nurses and hospitals are still subject to state regulation.

Through **Medicare** or **Medicaid/Medi-Cal**.

State laws apply to health plans. Federal Medicare and Medicaid laws apply as well. Federal ERISA law never does. State "right to sue" laws can be used to recover damages.

Through your **own funds**.

State laws apply. Federal ERISA law never does. State "right to sue" laws can be used to recover damages.

Through **church employer**.

State laws apply. Federal ERISA law never does. State "right to sue" laws can be used to recover damages.

Through **state government**. (i.e., you are employed by a state agency that provides your health benefits.)

State laws apply. State "right to sue" laws can be used to recover damages.

Through **federal government**. (i.e., you are employed by a federal agency that provides your health benefits.)

Most state laws do not apply. Federal ERISA law never applies. The Federal Employee Health Benefits Act (FEHBA) applies and has procedures to assist you in receiving benefits that are different from state law.

CHAPTER I.

Your Rights to Continuous Care, Second Opinions, Referrals and Information

*As a general rule, a **patient/physician relationship** is established between you and a physician when the initial history and physical examination is conducted. Depending on the circumstances, however, the relationship may exist even earlier—such as when a physician agrees by telephone to see you, when you enter the physician’s examining room, or when a referral physician gives you an appointment for a consultation.*

*A **capitation payment** is a lump sum paid to physicians for each patient they treat, regardless of how much care is needed.*

SUMMARY OF YOUR RIGHTS

- **You have the right to receive uninterrupted care from your doctor and HMO and to be referred to other health care providers when necessary.**
- **You have the right to receive a second opinion when you or your doctor request one.**
- **You have the right to receive an authorization from your health plan for referral to a specialist within three days.**
- **You have the right to have your doctor freely discuss your medical treatment options and care with you, without interference or restrictions by your health plan.**

WHAT DUTIES DO MY DOCTOR AND HMO HAVE TO ENSURE THAT I WILL RECEIVE CONTINUED CARE?

Patient/Physician Relationship¹

The establishment of a patient/physician relationship creates many duties for your doctor to make sure you get the treatment you need.

Your enrollment in a managed care plan, before you have selected your particular physicians, does not establish a patient/physician relationship. However, once you have chosen a doctor or your doctor begins receiving a **capitation payment** from your plan, then a patient/physician relationship may be established.

Generally speaking, once a patient/physician relationship is established, your doctor has an ongoing responsibility to you until the relationship is terminated. This obligation includes providing “coverage” for you when he or she is ill, on vacation, or treating other patients. Such coverage is typically provided by other doctors who agree to be available to provide care in your doctor’s absence.

How can I end the patient/physician relationship?

You can end the patient/physician relationship by telling your doctor that you no longer want to be treated by him or her.

Can my doctor end the patient/physician relationship?

Yes. The patient/physician relationship can be terminated by your doctor when he or she gives you notice and a reasonable opportunity to find substitute care.

A doctor can decide whether he or she will provide services to any particular person. However, there are both legal and ethical constraints on a doctor's discretion. A doctor is not free to refuse a patient merely because a patient is a member of certain groups. It is illegal and unethical to refuse to treat a patient because of the patient's sex, race, color, religion, ancestry, national origin, or physical disability.

In addition, a doctor's ability to terminate you as a patient may also be limited by a contract between your doctor and your health care plan or hospital, which requires the doctor to see all patients.

What are my rights to continue treatment with a doctor whose contract with my health care plan is terminated?

Your health care plan must notify you **30 days in advance** when your primary care physician is terminated by the plan and provide you with instructions for choosing a new primary care physician.² If you are undergoing treatment for a serious illness or pregnancy, your plan must arrange for your doctor to continue your treatment.³ Your plan must provide you with information, in any plan **evidence of coverage** or disclosure form issued after 1999 and upon your request, as to how you may request **continuity of care**.⁴

If you have an **acute** or serious **chronic condition**, your plan must provide you with services from the terminated doctor for up to **90 days**, or however long is necessary to provide for the safe transfer to another doctor as determined by your plan in consultation with your doctor.⁵ For pregnancies, the plan shall provide you with health care service from your terminated doctor until all services related to delivery are completed, or for a longer period if needed to ensure safe transfer to another doctor.⁶

Your health plan may require your doctor to agree to the same terms and conditions regarding payment if you continue to see that doctor after the contract has been terminated. In this case, you will still be responsible for all the same co-payments, deductibles or other costs while you are under the care of the terminated doctor.⁷

If your doctor does not agree to the same contract terms while providing you continued care, your health plan will not be obligated to pay for your doctor's services after the contract is terminated. You may have to pay for the costs out of your own pocket.⁸

What are my rights to continued coverage by my current doctor when I join a new health plan?

Health care plans are required to provide you with continuity of care and referral to other providers when appropriate.⁹ Group health care plans must have a written policy on file with the Department of Managed Health Care describing how the health plan will help new

A physician has an obligation to notify you of the termination of the patient/physician relationship and allow you a reasonable time to locate another physician.

***Continuity of Care** is receiving health care services without inappropriate disruption even if your provider or plan changes.*

enrollees receive continued care for an acute condition from a doctor who is outside of the plan's **participating providers**.¹⁰ The written policy must explain how the plan reviews requests to continue services with your current doctor and must take into account the effects that a change of doctor would have on your treatment for an acute condition.¹¹ Your plan must provide notice of the policy to you at the time of enrollment and upon your request once you are enrolled in the plan.¹²

A “qualified health care professional” is a primary care physician or a specialist who has the training and expertise related to the condition for which you are requesting a second opinion.¹⁴

WHAT ARE MY RIGHTS TO OBTAIN A SECOND OPINION?

When you or your doctor request a second opinion, your health care plan must quickly provide or authorize a second opinion by a qualified health care professional.¹³

Your plan must require the second opinion health care professional to provide you and your initial doctor with a consultation report, including any recommended tests or procedures.¹⁵

Who can provide a second opinion?

If you are requesting a second opinion about care you are receiving from your primary physician, the second opinion must be provided by a qualified health care professional of your choice within the same physician organization.¹⁶

If you are requesting a second opinion from a **specialist**, then you must be provided a second opinion by any doctor of the same or equivalent specialty whom you choose from within your plan's network of doctors. You will have to pay for additional medical opinions from outside the original physician organization if not approved by your plan.¹⁷

If there is no doctor within your plan's network that meets the qualified health care professional standard, then the plan must authorize a second opinion from someone with the appropriate qualifications from outside of the plan's network, taking into account your ability to travel to the provider.¹⁸

In what situations will my plan authorize a second opinion?

Your plan should provide or authorize a second opinion if:

- you have questions about the reasonableness or necessity of a recommended surgical procedure;
- you have questions about a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function, or a serious chronic condition;
- a diagnosis is in doubt due to conflicting test results, your treating doctor is unable to diagnose your condition, or the clinical indications are complex, unclear, or confusing;
- the treatment plan in progress is not improving your condition;
- you attempted to follow a treatment plan and have serious concerns about the diagnosis or treatment plan.¹⁹

These are not the only reasons to get a second opinion, however, and your plan may authorize a second opinion for reasons other than those mentioned above.

What is the timeline for my plan authorizing a second opinion?

Generally, a second opinion must be authorized or provided upon request in an “expeditious” or speedy manner—in certain circumstances within 72 hours.²⁰

Plans are required to file their timelines for responding to requests for second opinions involving emergency needs, urgent care, and other requests with the Department of Managed Care. These timelines must be made available to the public upon request.²¹

If your health care plan approves your request for a second opinion, you are only responsible for the costs of applicable copayments for similar referrals.²²

What happens if my plan denies my request for a second opinion?

If your health plan denies your request for a second opinion, it must notify you in writing of the reasons for the denial and inform you of the right to file a grievance with the plan.²³

HOW LONG CAN MY PLAN TAKE TO AUTHORIZE MY REFERRAL TO A SPECIALIST?

When you require a **referral** to a **specialist** or **specialty care center**, your health plan must decide whether or not to authorize the referral **within three business days** of the date when you or your primary care physician made the request and submitted all necessary information and medical records. Once your health plan decides to **authorize** the referral, the company must make the referral **within four business days** of when the proposed treatment plan is submitted to the **plan medical director**.²⁴

CAN MY HMO RESTRICT WHAT MY DOCTOR TELLS ME ABOUT MY CONDITION OR TREATMENT OPTIONS?

No. Health care plans cannot impose so-called “gag-orders” on their doctors that restrict the doctors’ ability to freely discuss your medical treatment options and care with you. The intent of the Legislature in passing this law was “to guarantee that a physician and surgeon or other licensed health care provider can communicate freely with, and act as advocate for, his or her patient.”²⁵

Your health plan cannot interfere with the ability of a physician, surgeon, or other licensed health care provider to communicate with you regarding your health care. This includes, but is not limited to, discussions of your treatment options, alternative plans, or other coverage arrangements.²⁶ While your doctor should discuss all your treatment options with you, your health plan is not required to pay for those treatments discussed which are not covered benefits, as provided in your health plan or insurance contract.²⁷

*When your condition is life threatening or you are faced with a potential loss of limb or other major bodily function, your health plan must provide you with a second opinion **within 72 hours after your request when possible.***

CAN HMOS PROVIDE FINANCIAL INCENTIVES TO DOCTORS TO NOT PROVIDE CERTAIN TREATMENT OR CARE TO THEIR PATIENTS?

No. It is illegal for your health plan to provide any “incentive plans” that make direct payments to doctors as an incentive to deny, reduce, limit or delay specific, medically necessary, and appropriate services to you.²⁸

It is legal, however, for health plans to have incentive plans that involve general payments not tied to specific medical conditions involving specific enrollees or groups of enrollees with similar medical conditions.²⁹ Capitation payments, for example (as defined above), are legal.

CHAPTER I. Footnotes

¹ All sections regarding the Patient/Physician Relationship are adapted from California Medical Association’s California Physician’s Legal Handbook (1999) Vol. 3.

² Health & Safety Code section 1373.65(a).

³ Health & Safety Code section 1373.96(a); see also Insurance Code section for similar requirements for disability insurers.

⁴ Health & Safety Code section 1373.96(e).

⁵ Health & Safety Code section 1373.96 (b).

⁶ Health & Safety Code section 1373.96(b).

⁷ Health & Safety Code section 1373.96(f).

⁸ Health & Safety Code section 1373.96(c).

⁹ Health & Safety Code section 1367(d).

¹⁰ Health & Safety Code section 1373.95(a); see also Insurance Code section 10133.55 for similar requirements for disability insurers.

¹¹ Health & Safety Code section 1373.95(b).

¹² Health & Safety Code section 1373.95(a).

¹³ Health & Safety Code section 1383.15(a); see also Insurance Code section 10123.68 for similar requirements for disability insurers. Plans that offer health care services through preferred provider networks do not have to comply with Health & Safety Code section 1383.15 if, subject to all other terms and conditions of the contract, access to and coverage for second opinions is not limited. (Health & Safety Code section 1383.15(k)).

¹⁴ Health & Safety Code section 1383.15(b).

¹⁵ Health & Safety Code section 1383.15(h).

¹⁶ Health & Safety Code section 1383.15(e).

¹⁷ Health & Safety Code section 1383.15(f) and see also section 1383.15(j).

¹⁸ Health & Safety Code section 1383.15(g).

¹⁹ Health & Safety Code section 1383.15(a).

²⁰ Health & Safety Code section 1383.15(c).

²¹ Health & Safety Code section 1383.15(c).

²² Health & Safety Code section 1383.15(d).

²³ Health & Safety Code section 1383.15(i).

²⁴ Health & Safety Code §1374.16.

²⁵ Business and Professions Code section 2056.1(a).

²⁶ Business and Professions Code section 2056.1(b).

²⁷ Business and Professions Code section 2056.1(c).

²⁸ Health & Safety Code section 1348.6(a).

²⁹ Health & Safety Code section 1348.6(b).

Chapter II.

Your Right to Informed Consent

SUMMARY OF YOUR RIGHTS

- **You have the right to know all the risks, benefits and treatment alternatives before consenting to any treatment.**
- **You have the right to refuse treatment by withholding your consent.**

WHAT IS INFORMED CONSENT?

Informed consent is more than merely your agreement to a particular treatment or procedure. Informed consent is your agreement to a proposed course of treatment based on receiving clear, understandable information about the treatment's potential benefits and risks.¹ You must also be informed about all treatments available for your health condition, and the risks of receiving no treatment.

WHY IS INFORMED CONSENT IMPORTANT TO ME?

You must take an active role in order to receive high quality health care. The first step is having the appropriate information about your medical condition. Once you know about all the risks, benefits and treatment alternatives, you may decide the risks are too great or the benefits too few to justify undergoing the treatment. With this kind of information, you may choose to refuse the treatment by withholding your consent.

IS MY INFORMED CONSENT ALWAYS REQUIRED FOR ALL MEDICAL TESTS OR PROCEDURES ?

Most of the time, yes. While your informed consent is usually required, there are two exceptions where your doctor does not need to have your informed consent before beginning treatment:

Simple and Common Exception

The first occurs when a “simple and common” procedure, such as a typical blood screening is performed. When risks from such procedures are commonly understood to be remote, your doctor need not discuss the risks, benefits or alternatives to the procedure with you.² You must still agree to the procedure, however, before it is done.

Emergency Exception

The second situation is in a life-threatening emergency. This is known as the Emergency Exception.³

An “**emergency**” is defined for purposes of this exception as a situation requiring immediate treatment of a medical condition that would otherwise lead to serious disability or death.⁴

*The decision to accept (consent to) or reject (refuse to consent to) a treatment, therapy or medication is ultimately yours to make—not your doctor's or other **health care provider's**.*

If you are incapable of giving informed consent, the law presumes that you would consent to life-saving treatment, and the physician is authorized by law to provide it.⁵

There are two specific limitations on the Emergency Exception:

- If the patient is unable to give consent, the physician must make a reasonable effort to locate a family member or legally authorized representative who can give informed consent on behalf of the patient before treatment.⁶
- No treatment can be given if the doctor knows or has reason to know that the patient has previously executed a **Durable Power of Attorney for Health Care** or a **Declaration under the Natural Death Act** that expressly refuses life saving treatment.

IS THE DOCTOR REQUIRED TO TAKE THE TIME TO TALK TO ME ABOUT INFORMED CONSENT?

Yes. Your doctor has a duty to **fully inform you about all of the risks and benefits of suggested treatments in terms you can understand.**

HOW DO I GIVE THE DOCTOR INFORMED CONSENT?

Informally

Often, your informed consent comes informally in the course of discussion with your doctor during a routine office visit or similar situation.

Formally

Informed consent can also be given formally, by signing a document that states your doctor has fully discussed a treatment or procedure with you and that you have acknowledged and agreed to the risks. In a formal consent, you are usually asked to sign a form titled “Informed Consent to Treatment,” or something similar. This is especially true in situations involving hospitalization, surgery or invasive testing.

California law requires that your consent be obtained *in writing* for several specific procedures and treatments for specific types of conditions, including:

- sterilizations,⁷
- hysterectomy,⁸
- breast cancer,⁹
- prostate cancer,¹⁰
- gynecological cancers,¹¹
- psychosurgery,¹² and
- electroconvulsive therapy.¹³

If a physician has a personal interest in treating you, either financial or research-related, then he or she must disclose those interests to you. Because any such interest might influence your physician’s judgment about treatment decisions, he or she is required to tell you about that interest before a procedure is performed and obtain your informed consent when you participate in a medical research study.¹⁴

Another circumstance in which specific disclosures by physicians to you are mandated by law is the area of human experimentation and research.¹⁵ Federal law has established extensive regulations governing federally-funded biomedical and behavioral research.¹⁶

WHEN SHOULD MY DOCTOR DISCUSS THE RISKS AND BENEFITS OF A PROPOSED COURSE OF TREATMENT AND ANY TREATMENT ALTERNATIVES WITH ME?

Any discussion of the risks and benefits of a particular treatment must take place **before** the treatment is given.¹⁷

You are sometimes asked, as a routine part of filling out medical history and personal information forms, to sign an informed consent document. This sometimes happens before you see the doctor or care provider and before you have had the treatment and/or any alternatives explained and before there has been any chance to ask any questions.

Never sign any such document until after there has been a full opportunity to have all of your questions answered and concerns discussed.

WHAT KINDS OF QUESTIONS SHOULD I ASK SO I CAN GIVE “INFORMED CONSENT?”

The key here is to ask for the *information* you need to decide whether or not you want to agree to treatment. Below are some examples of questions that will help you. This is not intended to be a complete list, as appropriate questions will differ depending on the medical condition or treatment being considered. These questions will help begin a discussion with your physician or care provider in order for you to make a truly “informed” decision about your body and health care:

- What is the condition, disease, or problem called?

- How do you recommend treating it?
- What are the risks of this type of treatment?
- What are the benefits?
- What is the complication (**morbidity**) rate for this treatment?
- What is the mortality (death) rate for patients in my condition using this treatment?
- What other treatments are available? Why are those not recommended?
- What will happen if I don't do anything?
- How many patients have you cared for with this problem? How many patients have you performed this surgery or this test on?
- What is your success rate in treating this problem?
- If I undergo this treatment, will it prevent me from using an alternative treatment if needed?
- Are you board certified in the specialty that treats this disease or condition?
- What can I expect if I undergo this treatment?
 - Will I be able to work and/or care for myself?
 - Will my activities be restricted?
 - How much pain or discomfort will I be in?
 - Will this treatment cause other problems?
 - What kind of side effects should I expect?
 - What should I do if I experience side effects?
 - Will you personally perform the surgery, test, or procedure?¹⁸
 - Is anesthesia necessary?
 - Who will be the anesthesiologist?
- What can I expect if I don't undergo this treatment?
- What are the alternatives to this treatment?
- What are the potential risks, complications or side effects associated with the alternative treatment?

Doctors are not required by law to disclose their own record of complications or outcomes with you to obtain informed consent. Therefore, you should always ask questions to determine the competency of your doctor in performing a particular procedure or caring for a particular disease or condition. You should always investigate the doctor with the

appropriate licensing or regulatory board before receiving medical services. (See list at the end of this chapter.)

IS THE DOCTOR LIMITED BY MY INFORMED CONSENT?

Yes. The doctor is limited by the **scope** of your informed consent. This means that the doctor cannot perform any procedure or treatment other than those discussed with you to which you agree.¹⁹

This is also true under the Emergency Exception previously discussed.²⁰ Your doctor may only do what is necessary to stabilize you and eliminate the emergency situation. If a procedure can safely be postponed until informed consent is obtained, then it must be postponed. ***If the doctor does not postpone the procedure when it is safe to do so, you may sue for battery if you would have refused to give consent.***

WHAT ARE MY RIGHTS IF THE DOCTOR DOESN'T GET MY CONSENT, OR PERFORMS SERVICES BEYOND THE SCOPE OF MY INFORMED CONSENT?

You may be able to sue the doctor for battery and recover **damages** for any injury to you caused by the doctor's failure to get your informed consent, or by the doctor's performance of procedures or treatments beyond those to which you agreed.²¹

If your physician fails to get **proper** informed consent, this is considered **negligence**, and may be the basis for a **medical malpractice** lawsuit. If you think that this has happened to you, immediately consult an attorney who specializes in medical malpractice. The **statute of limitations** (the time within which the law allows lawsuits to be filed) for medical malpractice is one year from the time you knew or should have known that malpractice had been committed.²²

WHERE CAN I GO FOR HELP?

You should report any health care provider who fails to get your informed consent for treatment to the appropriate regulatory agency. These agencies will conduct an investigation that may result in disciplinary action against the physician, care provider, or medical organization.

- **Medical Board of California**
<http://www.medbd.ca.gov>
Central Complaint Unit
1426 Howe Ave., Suite 54
Sacramento, CA 95825-3236
Phone: (800) 633-2322
- **Osteopathic Medical Board of California**
<http://www.docboard.org/cx>
2720 Gateway Oaks Dr., Suite 350
Sacramento, CA 95833
Phone: (916) 263-3100 or (916) 263-3117
- **Board of Registered Nursing**
<http://www.rn.ca.gov>
400 R Street, Suite 4030
P.O. Box 944210
Sacramento, CA 94244-2100
Phone: (916) 322-3350
Fax: (916) 327-4402
TDY: (916) 322-1700
- **Department of Managed Health Care**
<http://www.dmhc.ca.gov>
email: helpline@dmhc.ca.gov
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Phone: (888) HMO-2219 or (800) 400-0815
Fax: (916) 229-0465
TDD: (877) 688-9891
- **Acupuncture Board**
<http://www.dca.ca.gov/acup>
1424 Howe Ave., Suite 37
Sacramento, CA 95825-3233
Phone: (916) 263-2680
Fax: (916) 263-2654
Ca Relay Service
TT/TDD (800) 735-2929
/ DCA TDD (916) 322-1700
- **Board of Dental Examiners**
<http://www.dbc.ca.gov>
1432 Howe Ave., Ste. 85-B
Sacramento, CA 95825
Phone: (916) 263-2300
- **The Committee on Dental Auxiliaries**
<http://www.comda.ca.gov/>
1428 Howe Ave., Suite 58
Sacramento, CA 95825
Phone: (916) 263-2595
Fax: (916) 263-2709
- **Board of Psychology**
<http://www.dca.ca.gov/psych>
1422 Howe Avenue, Suite 22
Sacramento, CA 95825-3200
Phone: (916) 263-2699
- **Physician Assistant Committee,
Medical Board of California**
<http://www.physicianassistant.ca.gov>
E-mail: pacommittee@medbd.ca.gov
1424 Howe Avenue, Suite 35
Sacramento, CA 95825-3237
Phone: (916) 263-2323 or (800) 555-8038
Fax: (916) 263-2671
- **Board of Podiatric Medicine**
<http://www.dca.ca.gov/bpm>
1420 Howe Avenue, Suite 8
Sacramento, CA 95825-3229
Phone: (916) 263-2647
Fax: (916) 263-2651

CHAPTER II. Footnotes

¹ While a statutory definition of “Informed Consent” has never been written into California law, it has been extensively discussed in case law and is well understood within the medical and legal communities to mean that a patient “receive sufficient information to make a meaningful decision” regarding their own healthcare. *Cobbs v. Grant* (1972) 8 3d 229

² *Cobbs v. Grant* (1972) 8 3d 229.

³ Business & Professions Code § 2397(a)(2).

⁴ California Business & Professions Code § 2397(c)(2) and (c)(3).

⁵ *Cobbs v. Grant* (1972) 8 3d 229, 243-244.

⁶ Business & Professions Code § 2397(a).

⁷ Admin. Code §§ 51305.1 – 51305.4.

⁸ Health & Safety Code § 1690.

⁹ Health & Safety Code § 109275.

¹⁰ Health & Safety Code § 109280 and § 109282.

¹¹ Health & Safety Code § 109278.

¹² Welfare & Institutions Code § 5326.6.

¹³ Welfare & Institutions Code § 5326.5.

¹⁴ *Moore v. Regents of the University of California* (1990) 51 3d 120.

¹⁵ Health & Safety Code § 24173 & § 24175.

¹⁶ See 45 C.F.R. Part 46.

¹⁷ *Cobbs v. Grant* (1972) 8 3d 229.

¹⁸ If a physician obtains consent for treatment based on a particular condition and the physician fails to fulfill that condition, then the physician may be liable for battery; for example the patient consents to surgery if it is performed by a particular surgeon, and another surgeon performs the procedure, *Ashcroft v. King* (1991) 228 App.3d 604.

¹⁹ *Ashcroft v. King* (1991) 228 App.3d 604.

²⁰ California Business & Professions Code § 2397.

²¹ If a doctor obtains consent for a treatment based on a particular condition and the doctor fails to fulfill that condition, then the doctor may still be liable for battery. For example, if you consent to surgery to be performed by a particular surgeon, but another surgeon performs the procedure, you may be able to sue the original surgeon for battery. *Ashcroft v. King* (1991) 228 App.3d 604.

²² California Code of Civil Procedure § 340.5.

CHAPTER III.

Your Rights to Medical Records and Confidentiality¹

WHAT INFORMATION IS SUBJECT TO PROTECTIONS CONCERNING MEDICAL RECORD CONFIDENTIALITY?

Any information about you, whether in electronic or physical form regarding your medical history, mental or physical condition, or treatment, is subject to California laws protecting your medical record confidentiality.

You have the right to provide a health care provider with a written statement of up to 250 words regarding any information contained in your medical records that you believe to be incorrect or incomplete. This statement will become part of your medical record and must be included whenever your medical records are disclosed by your health care provider to a third party.

SUMMARY OF YOUR RIGHTS

- ***You have the right to obtain complete information about your medical condition and care.***
- ***You have the right to inspect your medical records within five days of making a written request.***
- ***You have the right to have your medical records kept confidential unless you provide written consent, except in limited circumstances.***
- ***You have the right to sue any person who unlawfully releases your medical information without your consent.***

HOW CAN I OBTAIN MY OWN MEDICAL RECORDS?

You have a right under California law to access complete information about your medical condition and the care provided to you.²

From Health Care Providers

Health care providers, such as doctors, HMOs, and hospitals, must permit you to inspect your medical records during business hours ***within five working days*** after receiving a written request from you. You are required to pay reasonable clerical costs associated with locating the records and making the records available for your inspection.³

Your health care provider must provide copies of the records for not more than \$.25 per page, or \$.50 per page for records copied from microfilm.⁴ Your health care provider does not have to give you copies of X-rays if they provide them to another health care provider upon your written request within 15 days after receipt of the request, specifying the name and address of the health care provider to whom the records are to be delivered.⁵

From Corporations that Maintain Medical Information

Any corporation that maintains medical records for the purpose of making them available to patients or health care providers must provide you, ***at no charge***, with a copy of your records.

DO DOCTORS AND HMOS NEED TO OBTAIN MY CONSENT BEFORE RELEASING MY MEDICAL RECORDS ?

Most of the time, yes, your written consent is required before your medical records can be released to anyone. Under California's Confidentiality of Medical Information Act,⁶ health care providers, HMOs

and certain **health care contractors** must obtain your written authorization before disclosing your medical information, with some exceptions.⁷

Your doctor, HMO and other health care contractors must establish procedures to ensure the confidentiality of your medical record information in their possession and that they properly dispose of any medical record information in a way that preserves your confidentiality.⁹ A new California law signed by Governor Davis effective January 1, 2001 requires that all businesses, including HMOs, must dispose of records that are no longer needed by 1) shredding, 2) erasing, or 3) otherwise modifying the personal information in those records to make it unreadable or undecipherable through any means.¹⁰ If any business fails to properly destroy your records and you suffer harm because of it, you can sue that business.¹¹

WHAT DOES AN AUTHORIZATION FORM FOR RELEASE OF MY MEDICAL RECORDS HAVE TO INCLUDE TO BE VALID?

To be valid, an authorization form used by health care providers, HMOs and health care contractors must:

- Be handwritten by you (or your authorized representative signing the authorization form) or be typewritten in no smaller than 8 point type. (This is 8 point type.)
- Be clearly separate from any other language on the same page and have a line for your signature that serves no purpose other than to authorize the release of your information.
- Be signed by one of the following:
 - you, the patient,
 - your legal representative if you are a minor or incompetent,
 - the beneficiary or personal representative of a deceased patient,or,
 - your spouse or person financially responsible for you for the sole purpose of processing an application for health care insurance or enrollment in a health care service plan or employee benefit plan when you are to be an enrolled spouse or dependent under the policy or plan.
- Specify the uses and limitations on the types of medical information to be disclosed.
- Specify the name or functions of the health care provider that may disclose the information.
- State the name or functions of the persons or entities authorized to receive the medical information.
- State the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information.
- State a specific date after which the health care provider is no longer authorized to disclose your medical record information.
- State that you have a right to receive a copy of the authorization.¹²

*Unless provided by law, or authorized by you, your doctor, HMO, or other medical provider, may not disclose, sell, or otherwise use your medical information for any purpose other than as is necessary for providing direct health care services to you.*⁸

CAN MY DOCTOR OR HMO RELEASE MY MEDICAL RECORDS WITHOUT MY CONSENT?

Yes, but only in certain limited situations when necessary to provide you with appropriate health care. Your doctor or HMO is **required** to release your medical record information, even without your written authorization, to the following:

- A court pursuant to a court order.
- A board, commission, or administrative agency for purposes of resolving a dispute pursuant to its lawful authority.
- A party to a proceeding before a court or administrative agency pursuant to an investigative subpoena.
- An arbitrator or arbitration panel, when arbitration is lawfully requested by either party pursuant to a subpoena.
- A government law enforcement agency pursuant to a search warrant.¹³

Your health care provider and HMO may also, **in their discretion**, release medical information about you **without your written authorization** to the following entities in the following limited circumstances:

- Billing, claims management, medical data processing or other administrative services for the health care provider or HMO.¹⁴
- Organizations or professional societies that review the competence or qualifications of health care professionals.¹⁵
- Any private or public body responsible for licensing or accrediting health care providers or HMOs for review at the premises of the health care provider or HMO.¹⁶
- County coroner in the course of an investigation by the coroner's office.¹⁷
- Agencies, investigators, and educational and research organizations engaged in bona fide research projects provided that the recipient does not further disclose your identity.¹⁸
- Your employer who has paid for employment-related health care services in connection with a lawsuit or arbitration dispute where you have placed your medical condition in issue, provided that information is disclosed only in connection to the proceeding, or when used to determine your entitlement to leave from work for medical reasons or physical limitations that prevent you from performing your job.¹⁹

- The sponsor, insurer, or administrator of your group or individual health plan for the purpose of evaluating the application for coverage of benefits.²⁰
- Your health care plan for the purpose of transferring to other providers in the plan.²¹
- Probate officers or domestic relations investigators for the purposes of determining the need for a **conservatorship** or **guardianship**.²²
- Organ procurement organization or tissue bank for purpose of aiding a transplant.²³
- The Federal Food and Drug Administration when medical information relates to problems with drug products or medical devices.²⁴
- Disaster relief organizations for the purpose of responding to disaster welfare inquiries, but only basic information including your name, city of residence, age, sex and general condition may be disclosed.²⁵
- Third parties for purposes of encoding, encrypting, or otherwise making information anonymous.²⁶
- **Disease management organizations** that provide services to patients in order to improve their overall health in accordance with certain practice guidelines to which your doctor may refer you.²⁷

WHEN CAN MY EMPLOYER OBTAIN AND USE OR DISCLOSE MY MEDICAL RECORDS WITHOUT MY CONSENT?

Your employer must establish appropriate procedures to ensure the confidentiality of your medical information and to protect it from unauthorized use and disclosure. Your employer cannot use or disclose your medical information unless you sign an authorization, except in the following instances:

- When compelled by a judicial or administrative process.
- When relevant to a lawsuit, arbitration or other claim when you have first raised your medical history, condition or treatment as an issue in the case.
- For the purpose of administering and maintaining employee benefit plans, including plans providing for disability and workers' compensation, and for determining eligibility for paid and unpaid leave from work for medical reasons.

- To aid your health care provider in diagnosis or treatment when you or someone designated by you is unable to authorize disclosure.²⁸

If you refuse to sign an authorization, your employer cannot discriminate against you in terms or conditions of employment. Your employer can take such actions as are necessary in the absence of medical information due to your refusal to sign an authorization (such as when all employees of a certain job are required to undergo a medical examination necessary to determine fitness to perform that job).²⁹

WHEN CAN AN INSURANCE COMPANY OBTAIN ACCESS TO MY MEDICAL RECORDS WITHOUT MY CONSENT?

In addition to the limited purposes described above, your doctor or HMO can disclose your medical information to private insurance companies and their agents that have complied with all the requirements for obtaining your information under the Insurance Information & Privacy Protection Act.³⁰ This Act imposes similar requirements on private insurance companies and their agents as those imposed on doctors and HMOs by the Confidentiality of Medical Information Act. The insurance company must have a valid written authorization form from you that permits disclosure of your medical records to the insurance company or its agents. To be valid, the authorization form must:

- Be written in plain language and dated.
- Specify the persons authorized to disclose information about you.
- Specify the nature of the information authorized to be disclosed.
- Name the insurance institution or agent and identify representatives of the insurance institution to whom the individual is authorizing information to be disclosed.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid, which shall be no longer than:
 1. For authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for a change in policy benefits:

- a) thirty months from the date the authorization is signed if the application or request involves life, health, or disability insurance; or

- b) one year from the date the authorization is signed if the application or request involves property or casualty insurance.

2. For authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy

- a) the term of coverage of the policy if the claim is for a health insurance benefit, or

- b) the duration of the claim if the claim is not for a health insurance benefit, or

- c) the duration of all claims processing activity performed in connection with all claims for benefits made by any person entitled to benefits under a nonprofit hospital service contract.

- Advise you or the person authorized to act on your behalf of your or your authorized representative's right to receive a copy of the authorization form.³¹

WHAT CAN I DO TO PROTECT MY MEDICAL RECORD INFORMATION FROM BEING DISCLOSED WITHOUT MY CONSENT?

- **Carefully read any and all forms you are asked to sign allowing the release of your medical information.** Under California law, most disclosures of your medical information require your written consent and must be limited to the specific purposes you authorize. You should carefully read any form disclosures that you may be given to sign by your doctor, HMO, other health care provider or employer. Pay particular attention to the purposes for which the medical record information may be released, and only sign if you agree to these uses. Do not be talked into signing a general release that authorizes your medical records to be released for "all legally valid purposes." If you do not understand any of the terms of the authorization, ask your doctor, health care provider, or employer providing you with the authorization form to thoroughly explain its terms.
- **Prepare a written statement to give your doctor or other health care provider if you want to have a particular visit or treatment kept confidential.** If you do not want a particular treatment or condition to be disclosed to your insurance company or employer, write a statement to bring to your doctor or HMO. The

statement should direct that you do not consent to release of your medical record information for that particular visit. Since insurers and employers may be entitled to certain medical information related to health care services that they are paying for, you may want to personally pay for those services for which you do not want any information disclosed.

- **Be careful when asked to provide medical history information to entities other than your doctor, HMO or insurance company.** It is wise to limit the information you give out about your medical history to only those who need it for treatment of an illness or payment of a claim for health benefits. With the proliferation of Web-based health information sites, there are an increasing number of avenues through which third parties can gain access to your medical information.

WHAT IS THE MEDICAL INFORMATION BUREAU?

The **Medical Information Bureau (MIB)** is a company that keeps a database of medical record information on individuals as provided to them by insurance companies that subscribe to their services. Insurance companies use information obtained from MIB to make decisions regarding your eligibility for coverage at the time of application for insurance benefits. According to MIB, about 1 or 2 in 10 people have a record with MIB. Insurance companies may only report information to MIB with your written consent, and are supposed to only report information if you have a condition that is significant to health or longevity. MIB reports are kept for seven years. For information on how to access and correct any misinformation that MIB may have about you, access MIB's Web site at www.mib.com or write to:

MIB, Inc.
P.O. Box 105
Essex Station
Boston, MA 02112
Tel. 617-426-3660
FAX 781-461-2453

There is an \$8.50 charge for obtaining a copy of your MIB report.

WHAT REMEDIES DO I HAVE IF SOMEONE ILLEGALLY OBTAINS OR DISCLOSES MY MEDICAL RECORDS?

Anyone who illegally obtains or discloses your medical information that causes you economic loss or personal injury may be guilty of a misdemeanor under California law.

You may also bring an action against any person or entity that negligently releases confidential information or records in violation of California law for:

- Nominal damages of one thousand dollars (\$1,000). (Damages awarded when you are unable to prove that the violation caused you monetary loss).
- Actual damages sustained by you.

The Attorney General, any district attorney, city attorney, or city prosecutor may bring an action in the name of the people of California to recover a civil penalty. Licensing agencies or certifying boards may impose an administrative fine against individuals or entities that illegally obtain or disclose your medical record information.

OTHER RESOURCES:

- **Privacy Rights Clearinghouse**
Provides a consumer help line and educational materials on a wide range of privacy issues. Visit their Web site at <http://www.privacyrights.org>; see Fact Sheet #8: *How Private Is My Medical Information?* or call (619) 298-3396.
- **California Medical Association**
Visit their Web site at <http://www.cmanet.org> or send a fax request to (800) 592-4CMA to obtain CMA ON-CALL Document #1101: *Confidentiality: CMLA and HIPPA*.

CHAPTER III. Footnotes

¹ The information contained in this chapter is based on California law. The federal Health Insurance Portability and Accountability Act passed by Congress in 1996 required that Congress pass regulations to protect patients/medical record privacy. The U.S. Department of Health and Human Services adopted the final rule officially published December 28, 2000. For more information on the new federal rule, go to <http://aspe.os.dhhs.gov/>

² Health & Safety Code § 123100.

³ Health & Safety Code § 123110(a).

⁴ Health & Safety Code § 123110(b).

⁵ Health & Safety Code § 123110(c).

⁶ Civil Code § 56 *et seq.*

⁷ Civil Code § 56.10(a).

⁸ Civil Code § 56.10(d) (italics added).

⁹ Civil Code § 56.101.

¹⁰ Civil Code § 1798.81.

¹¹ Civil Code § 1798.82.

¹² Civil Code § 56.11.

¹³ Civil Code § 56.10(b).

¹⁴ Civil Code § 56.10(c)(3).

¹⁵ Civil Code § 56.10(c)(4).

¹⁶ Civil Code § 56.10(c)(5).

¹⁷ Civil Code § 56.10(c)(6).

¹⁸ Civil Code § 56.10(c)(7).

¹⁹ Civil Code § 56.10(c)(8).

²⁰ Civil Code § 56.10(c)(9).

²¹ Civil Code § 56.10(c)(10).

²² Civil Code § 56.10(c)(12).

²³ Civil Code § 56.10(c)(13).

²⁴ Civil Code § 56.10(c)(14).

²⁵ Civil Code § 56.10(c)(15).

²⁶ Civil Code § 56.10(c)(16).

²⁷ Civil Code § 56.10(c)(17).

²⁸ Civil Code § 56.20(c).

²⁹ Civil Code § 56.20(b).

³⁰ Insurance Code § 791 *et seq.*

³¹ Ins. Code § 791.06.

CHAPTER IV.

Your Right to Emergency Medical Care

SUMMARY OF YOUR RIGHTS

- **You have the right to receive emergency care at any licensed facility with an emergency room.**
- **You have the right to be treated until your emergency medical condition is stabilized when you go to a hospital emergency room.**
- **You have the right to be informed by the hospital of your right to receive emergency services, without regard to your ability to pay, prior to being transferred or discharged.**
- **You have the right not to be transferred from an emergency care facility against your will.**

*California and federal laws define an “**emergency medical condition**” similarly as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.³*

You have important rights when you go to a hospital’s emergency room, regardless of your insurance status. California law severely restricts and regulates the ability of all licensed health care facilities with emergency departments to **transfer** and **discharge** emergency patients.¹ These laws expand upon the important protections in the federal **Emergency Medical Treatment and Active Labor Act** (“EMTALA”).² The federal protections under EMTALA and its regulations apply to all hospitals that participate in the Medicare program and apply to all patients that go to those hospitals, not just to Medicare patients.

WHAT IS CONSIDERED AN “EMERGENCY MEDICAL CONDITION” THAT REQUIRES EMERGENCY MEDICAL CARE?

Your condition is a medical emergency when your life, body parts or bodily functions are at risk of damage or loss unless immediate medical care is received.

The federal regulations that apply to Medicare hospitals expand upon this definition to expressly include **psychiatric disturbances** and symptoms of **substance abuse** to the extent that such conditions meet the definition of an emergency medical condition (i.e., where the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, etc.)⁴

DOES A WOMAN IN LABOR HAVE AN EMERGENCY MEDICAL CONDITION?

Any pregnant woman who is having contractions has an emergency medical condition if there is inadequate time before delivery of the baby to have her safely transferred to another hospital, or if such a transfer may pose a threat to the health or safety of the woman or unborn child.⁵ Federal regulations at Medicare hospitals clarify that a

pregnant woman experiencing contractions is not in “true labor” if, after a reasonable time of observation, the doctor certifies that the woman is in “false labor.”⁶

WHAT ARE MY RIGHTS TO EMERGENCY CARE?

When you have an emergency medical condition, you have the right to emergency care at any licensed health facility operating an emergency department when that facility has the proper facilities and personnel to provide you the care.⁸

A hospital must inform you of your right to receive emergency services and care, prior to transferring or discharging you, and **without regard to your ability to pay**:

- Hospitals must tell you, both orally and in writing, any reasons for transferring you or refusing to provide you services.
- The hospital must post a sign in the emergency room informing you of these rights. Both the sign and written notice must inform you of the government agency you may file a complaint with, if necessary.
- Notification is not necessary where it is not possible because of your physical or mental condition and the hospital has been unable to locate your representative after reasonable efforts.⁹

Federal law also requires that hospitals post a sign informing you of your rights with respect to the examination and treatment of emergency medical conditions, and whether the hospital participates in a state Medicaid program.¹⁰

WHAT DOES IT MEAN TO HAVE MY MEDICAL CONDITION SCREENED?

When you go to a hospital’s emergency department, you must be examined by a doctor, or other appropriate personnel under the doctor’s supervision, in order to determine whether you have an “emergency medical condition,” or are in “active labor,” in a pregnant woman’s case as discussed above. ***THIS REQUIRED SCREENING MUST BE PERFORMED BEFORE THE HOSPITAL ASKS YOU ABOUT YOUR ABILITY TO PAY.***¹¹ If no doctor is available, only another appropriate individual, approved under the law and supervised by the doctor, may screen you.¹²

Your medical screening must be done by medical staff who are qualified under hospital bylaws or rules.¹³ Emergency services must also be supervised by qualified members of the medical staff, and there must be adequate medical and nursing staff who are qualified in emergency care to carry out written emergency procedures and meet the needs anticipated by the hospital.¹⁴

WHAT DOES IT MEAN TO HAVE MY CONDITION STABILIZED?

Your condition has been “**stabilized**” only when you have been provided the necessary medical treatment to assure, within reasonable medical probability (likelihood), that no material deterioration (worsening) of your condition is likely to result from, or occur during, your

When you go to a medical facility’s emergency department, you have the right to:

- a) be informed of your rights,*
- b) have your condition screened,*
- c) be treated until your emergency medical condition is stabilized,*
- d) only be transferred if the hospital meets certain requirements, and*
- e) be accepted if you are transferred from another hospital.*⁷

transfer from the facility.¹⁵ A pregnant woman in labor is considered stabilized once the child and the placenta have been delivered.¹⁶

WHEN CAN I BE TRANSFERRED TO ANOTHER HOSPITAL?

You can only be transferred to another hospital's emergency department if you are stabilized **and** all other requirements under the California law are met (as listed below) or if an exception applies. (e.g., if you need services not available at that hospital)

Requirements for Transfer

You cannot be transferred to another hospital for any **non-medical** reasons (such as your inability to pay) unless all of the following conditions are met:

- You are examined and evaluated by a doctor and surgeon;
- You have been provided with appropriate emergency medical services to ensure that you will not be harmed by the transfer;
- The doctor and surgeon have arranged with the new hospital for the appropriate resources and doctors to treat you;
- Your medical records (including a "Transfer Summary" that gives all relevant transfer information and is signed by the transferring doctor) are transferred with you; and
- The hospital complies with all relevant state regulations related to transfers.¹⁷

These requirements do not affect a hospital's ability to transfer you for medical reasons or when you have specifically requested to be transferred and give your informed consent.

Federal law places the following additional requirements on hospitals that accept Medicare patients:

- The transferring hospital must provide you with medical treatment that minimizes the risk to your health;
- The receiving hospital must have adequate space and staff to attend to you;
- The receiving hospital must have agreed to accept the transfer;
- The transfer is done with qualified medical staff and transportation equipment, including

the use of necessary and appropriate life support measures;

- The transferring hospital must send all of your medical records related to your emergency condition with you.¹⁸

Can I Ever Be Transferred Against My Will?

No. Whether you are stabilized or not, you have a constitutional right to control your body and medical treatment. If you are forcibly transferred to another facility over your objection you may have a claim of battery, false imprisonment or other claims against the hospital or doctor.

Can I Be Transferred at My Request Before I Have Been Stabilized And Against Medical Advice?

Yes. Hospitals can transfer or discharge you if **you** request a transfer or discharge against medical advice and provide informed consent to receive such a transfer or discharge.¹⁹

WHAT ARE MY LEGAL RIGHTS IF I AM HARMED WHILE RECEIVING EMERGENCY CARE?

California law permits you to sue a transferring or receiving hospital that harms you as a result of violation of these laws or regulations. You may recover **damages** (money to compensate you for your losses), reasonable attorneys' fees, and other appropriate relief. You may also seek an injunction against the hospital, or administrative or medical personnel. An **injunction** is a court order directing that a particular illegal action be stopped, such as a transfer to another hospital when the benefits would not outweigh the risks. If the injunction is granted, you must be granted attorneys' fees.

WHAT ARE MY HEALTH CARE PLAN'S OBLIGATIONS WITH REGARD TO PAYING FOR EMERGENCY SERVICES I RECEIVE?

Under California law, your health plan must reimburse any doctor who performs **any emergency services that you receive to stabilize you**.²⁰ The only time that a plan is not required to pay for your emergency health care services is when it determines that you did not require emergency services, and you should have known that an emergency did not exist. Your plan must provide 24-hour access for you and doctors to obtain authorization for care once your condition has been stabilized.

WHERE CAN I GO FOR HELP WITH QUESTIONS OR COMPLAINTS REGARDING A HOSPITAL'S EMERGENCY SERVICES?

For complaints about California-licensed hospitals:

California Department of Health Services

714 P Street, Room 1350
Sacramento, CA 95814

Licensing & Certification/ Hospitals/Nursing Homes

Phone: (916) 657-3064 (general info.)
Fax: (916) 657-0240

<http://www.dhs.ca.gov/>

For complaints about emergency services received at your HMO's facilities:

California Department of Managed Health Care

Department of Managed Health Care
California HMO Help Center

980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

Phone: (888) HMO-2219 or
(800) 400-0815 or

TDD: (877) 688-9891

Fax: (916) 229-0465

<http://www.dmhc.ca.gov>

For complaints about hospitals that accept Medicare patients:

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.
Washington, D.C. 20201

Phone: (202) 619-0257
Toll Free: 1-877-696-6775

<http://www.os.dhhs.gov>

CHAPTER IV. Footnotes

¹ Health & Safety Code §§1317 et seq.

² 42 U.S.Code (U.S.C.) §1395dd.

³ Health & Safety Code §1317.1(b)] [42 U.S.C. §1395dd(e)(1).

⁴ 42 Code Of Federal Regulations § 489.24.

⁵ 42 U.S.C. §1395dd(e)(1)(B) and Health & Safety Code § 1317.1(c).

⁶ 42 Code Of Federal Regulations §489.24(b).

⁷ 42 U.S.C.§1395dd and Health & Safety Code §1317 et seq.

⁸ Health & Safety Code §1317(a).

⁹ Health & Safety Code § 1317.3(d).

¹⁰ 42 U.S.C. § 1395cc(a)(1)(N)(iii) and (iv).

¹¹ Health & Safety Code §1317(d).

¹² 42 U.S.C. §1395dd(a) and Health & Safety Code §1317.1(a).

¹³ 42 Code Of Federal Regulations §489.24(a).

¹⁴ 42 Code Of Federal Regulations §482.55.

¹⁵ 42 U.S.C.§1395dd(e)(3)(A) and Code of Federal Regulations 489.24(b); Health & Safety Code §1317.1(j).

¹⁶ 42 U.S.C.§1395dd(e)(3)(B) and 42 Code Of Federal Regulations §489.24(b)(ii)(B).

¹⁷ Health & Safety Code §1317.2.

¹⁸ 42 U.S.C.§1395dd(c)(2).

¹⁹ Health & Safety Code § 1317.2(i); 42 U.S.C. § 1395dd(b)(2) and (3) and 42 Code Of Federal Regulations §489.24(c)(2).

²⁰ Health & Safety Code §1371.4.

CHAPTER V.

Your Rights to Coverage of Preexisting Conditions

When you are otherwise eligible for health care services under an employee benefit plan, you cannot be completely excluded from the plan (except in the case when you enrolled after the enrollment deadline) on the basis of any of the following:

- health status
- medical condition including both physical and mental illnesses
- claims history
- medical history
- genetic information
- disability or evidence of insurability, including conditions arising out of acts of domestic violence.²

SUMMARY OF YOUR RIGHTS

- ***If you are joining a group health plan, you have the right to not be denied coverage on the basis of your health status, medical condition or history, genetic information, disability or insurability.***
- ***You have the right to receive coverage for preexisting conditions in most cases within 12 months (or, in some instances, six months) of enrolling in a group health care plan.***
- ***If you are enrolling in an individual plan, you have the right not to be denied coverage if you have had 18 months of continuous coverage previously and meet certain other requirements.***
- ***You have the right to be credited for time enrolled in a previous plan against any preexisting condition waiting period.***

In 1996, Congress passed a law known as the **Health Insurance Portability and Accountability Act or HIPAA (also known as the Kassebaum-Kennedy Act)**, which went into effect on July 1, 1997. HIPAA was designed to allow employees to move freely from one job to another without the risk of becoming uninsured for their most serious health problems. HIPAA also has protections for individuals who move from a group plan to an individual health plan. In California, there are additional protections for members of group health plans that go beyond the requirements of HIPAA.

WHAT IS A “PREEXISTING CONDITION”?

A **preexisting condition** generally refers to any health condition that you have had prior to enrolling in your current health plan.

Under HIPAA and California laws, a “preexisting condition,” is more narrowly defined as a condition for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received ***during the six months immediately preceding the enrollment date in a new plan or effective date of coverage.***¹

CAN MY HEALTH PLAN DENY COVERAGE FOR TREATMENT OF MY PREEXISTING CONDITION?

Group Health Plans

Yes, but only for those conditions you had in the previous six months and only for a specific period of time allowed by law.

Both HIPAA and California law prohibit **group health plans** (health insurance usually sponsored by an employer, union or professional association that covers two or more employees) from discriminating against you or your dependents by establishing rules for eligibility based on your health status.

Health care plans are also prohibited from denying enrollment because of a family history of breast cancer or one or more diagnostic tests for the disease when there has been no development or diagnosis of the disease.³

How long can a group health plan exclude coverage for a preexisting condition?

Both federal and California law limit the amount of time that a group health plan can exclude coverage for your preexisting condition.

If you are under a federally-regulated health plan, **twelve months** is the longest period of time that your plan can exclude coverage for your preexisting condition. (Ask your employer if you are not sure whether your plan is subject to the federal law.) For most other group health plans, the more protective California law applies, and your preexisting condition can only be excluded for up to **six months**. (See sidebar at right for more detailed explanation of the federal and state standards.)

If your health plan contract does not contain a preexisting condition exclusion provision, it can require an “affiliation” or waiting period of not more than 60 days before any coverage becomes effective. Although the plan does not have to provide you coverage for any health care services during the waiting period, you also cannot be charged a premium during this time.⁷

Exceptions to Preexisting Condition Exclusions

A health care service plan issuing group coverage may not exclude coverage for a preexisting condition for any of the following:

- A newborn who has applied for coverage through an employer-sponsored plan within 30 days of birth;
- A child who is adopted or placed for adoption prior to age 18 who, within the 30 days beginning with the date of adoption or placement for adoption, is covered by another plan.
- A condition relating to benefits for pregnancy or maternity care.⁸

Credit for Previous Health Care Coverage

The length of any preexisting condition exclusion period will be shortened by giving you credit for time that you were previously covered under certain prior health care plans. Specifically, **if you are eligible to begin coverage under a new employee group health plan within 62 days of having been terminated from prior coverage** under another individual or group health plan, Medicare, Medicaid, or other publicly-sponsored medical care program, **then your new health plan must credit any time that you were previously covered towards the preexisting exclusion period.**⁹

EXAMPLE 1: Patient Mrs. Smith is treated for a medical condition seven months before the enrollment date in Employer ABC’s group health plan. As part of such treatment, Mrs. Smith’s doctor recom-

*Under federal law, the period for which a group plan with two or more enrollees can deny you coverage for your preexisting condition is up to **twelve months**. (Or eighteen months for late enrollees.)⁴*

*Under the more protective California law, a small employer-sponsored (2-50 employees) group health plan and any health care service plan contract that covers three or more enrollees (whether employer-sponsored or not) can only deny coverage for a preexisting condition for up to **six months** following the effective date of your coverage under the plan.⁵ The twelve-month exclusion period may be applied, however, if you enrolled after the enrollment deadline, or if your plan covers only one or two individuals and is not an **employer-sponsored plan**.⁶*

mends that a follow-up examination be given 2 months later. Despite this recommendation, Mrs. Smith does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to or received by Mrs. Smith during the six-month period ending on Mrs. Smith's enrollment date in Employer ABC's plan. In this example, Employer ABC's plan may not impose a preexisting condition exclusion period with respect to the condition for which Mrs. Smith received treatment seven months prior to the enrollment date.

EXAMPLE 2: Mrs. Smith works for Employer XYZ and has creditable coverage under Employer XYZ's plan for 18 months before Mrs. Smith's employment terminates. Mrs. Smith is hired by Employer ABC and enrolls in Employer ABC's group health plan 64 days after the last date of coverage under Employer XYZ's plan. Employer ABC has a six-month preexisting condition exclusion period. In this Example, because Mrs. Smith had a break in coverage of 63 days, Employer ABC may disregard Mrs. Smith's prior coverage and subject her to a six-month preexisting condition exclusion.

EXAMPLE 3: Same facts as Example 2, except that Mrs. Smith is hired by Employer ABC and enrolls in Employer ABC's plan on the 63rd day after the last date of coverage under Employer XYZ's plan. In this example, because Mrs. Smith did not have a significant break in coverage (more than 62 days), Employer ABC must count Mrs. Smith's prior creditable coverage towards reducing the plan's preexisting condition exclusion period as it applies to Mrs. Smith. Because Mrs. Smith had 18 months of creditable coverage through her plan with Employer XYZ, this would completely eliminate the six-month preexisting exclusion period under Employer ABC's plan, which would have to provide coverage for Mrs. Smith's condition upon enrollment.

Special Standards for Individual Health Plans

In general, when you are buying an **individual health plan** (insurance sold outside the employer group market), ***you cannot be denied health coverage nor be subject to an exclusion period for a preexisting condition if you meet all the following conditions:***

- You must have had a total of 18 months of continuous "creditable coverage" which means health insurance coverage without a break of 63 or more consecutive days under any of the

following: a group health plan; an individual health plan; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees and dependents); Federal Employees Health Benefits Program (FEHBP); Indian Health Service; Peace Corps; or a state health insurance high risk pool. *The most recent period of prior coverage must have been under a group health plan, governmental plan, or church plan;*

- You must have used up any **COBRA** or state continuation coverage available to you;
- You must not be eligible for **Medicare, Medicaid**, a state program, or a group health plan;
- You must not have other health insurance; and
- You must apply for individual health insurance **within 63 days** of losing your prior creditable coverage.¹⁰

If you do not meet these conditions, however, you may be eligible for a state-sponsored program specifically designed to meet the needs of individuals who are denied coverage due to preexisting conditions. California's program is known as the **Major Risk Medical Insurance Program (MRMIP)** as described further below.

WHAT CAN I DO IF I AM DENIED COVERAGE?

File grievances with your health plan and the Department of Managed Health Care

If you feel that your health plan wrongly denied coverage for treatment of your preexisting condition, you may want to file a grievance with your plan and/or the Department of Managed Health Care **(888) HMO-2219 or (877) 688-9891 (TDD)**.

You may also have the right to obtain a review of your plan's decision through an independent review process. The standards and timelines that apply to these grievance and review processes are further explained in chapters VI and VII of this guide.

Sue your health plan

While a health plan may deny you coverage as part of its overall restrictions on certain benefits as they are applied to all enrollees, it may not deny coverage of your preexisting condition in violation of the governing federal and state statutes.

Obtain alternative coverage

If you are unable to obtain coverage on the open market due to a serious health condition, you may be eligible for coverage under the California **Major**

Risk Medical Insurance Program (MRMIP).

Health care is provided to qualifying Californians through contracts with various health plans. Participants in the program are responsible for the cost of program premiums. The program supplements those premiums to cover the cost of care.

To be eligible to participate in the program, you must:

- Be a California resident.
- Not be eligible for **both** Part A and Part B of Medicare, unless eligible solely because of end-stage renal disease.
- Not be eligible to purchase any health insurance continuation of benefits under COBRA or CalCOBRA.
- Not be able to secure adequate coverage as evidenced by one of the following:
 - A letter from a health insurance carrier, health plan, or HMO denying individual coverage within the last 12 months;
 - A letter from a health insurance carrier, health plan, HMO, or employer indicating involuntary termination of health care coverage for reasons other than nonpayment of premium or fraud;
 - A letter indicating that an offer of individual plan coverage by a health insurance carrier, health plan, or HMO is in excess of the Major Risk Medical Insurance Program premium for the individual's first choice of participating program; or the premium for the individual and/or their dependents is in excess of the MRMIP rate for the individual and/or their dependents; or
 - A letter indicating that a member of a group of two or less has been denied coverage by a health insurance carrier, health plan, or HMO within the last 12 months.

There are other specific eligibility requirements if you know you are not currently eligible but will be in the future. You can apply for deferred enrollment. Additional information and application materials can be obtained by writing to:

Managed Risk Medical Insurance Board

1000 G Street, Suite 450
Sacramento, CA 95814

or by calling: (916) 324-4695,

or by visiting their Web site at:
<http://www.mrmib.ca.gov>

WHERE CAN I GO FOR HELP?

- For questions or complaints about a group health plan, call the **California Department of Managed Health Care** at (888) HMO-2219, or (877) 688-9891 (TDD).
- For questions about HIPAA and individual coverage, call the **U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA)** at (415) 744-3600. Answers to commonly asked questions about HIPAA can be found on the HCFA Web site at <http://www.hcfa.gov>.

CHAPTER V. Footnotes

- ¹ 26 United States Code Annotated (U.S.C.A.) section 9801(a)(1) and Health & Safety Code section 1357.51.
- ² 26 U.S.C.A. section 9802; Health & Safety Code section 1357.52.
- ³ Health & Safety Code section 1367.6(b).
- ⁴ 26 U.S.C.A. section 9801(a).
- ⁵ Health & Safety Code sections 1357.06 and 1357.51(a).
- ⁶ Health & Safety Code section 1357.51(f) and 1357.50(b) (late enrollees); Health & Safety Code section 1357.51(b) (plans with only one or two enrollees).
- ⁷ 26 U.S.C.A. section 9801(c)(2)(C); Health & Safety Code sections 1357.06 and 1357.51.
- ⁸ 26 U.S.C.A. section 9801(d); Health & Safety Code section 1357.51.
- ⁹ 26 U.S.C.A. section 9801(c)(1)-(3) and 29 C.F.R. section 2590.701-4; Health & Safety Code sections 1357.06 and 1357.51.
- ¹⁰ 42 U.S.C.A. section 300gg-41; Health & Safety Code section 1366.35(a) and (b).

CHAPTER VI.

Your Right to File Grievances with your Health Plan and the Department of Managed Health Care

SUMMARY OF YOUR RIGHTS

- **You have the right to file a grievance with your health plan for any decision that you believe has adversely affected your health care.**
- **You have the right to have your grievance resolved by your plan within 30 days, when possible.**
- **You have the right to submit your grievance to the Department of Managed Health Care, after participating in your plan's grievance process for 30 days.**
- **You have the right to have DMHC resolve your grievance within 30 days.**

When there is no other reasonable alternative, get needed treatment first— then deal with resolving any problems you may have with your health plan.

If you are dissatisfied with any decision made by your health plan, medical group or doctor, you have the right to file a complaint, or “**grievance**,” with your health plan and with California’s regulator of managed care plans, the **Department of Managed Health Care (DMHC)**. Both the health plan and the DMHC must follow particular standards and timelines when reviewing and resolving your grievance.

WHEN SHOULD I FILE A GRIEVANCE WITH MY PLAN?

You should file a grievance when:

- your doctor, medical group or health plan denies or unnecessarily delays treatment that you believe should be covered.
- you feel the treatment or medication that has been authorized for you is not the best course of treatment, after receiving a second opinion.
- your health plan is denying payment for the treatment you have already received.
- the treatment you think is necessary and covered has been denied or delayed because it is considered to be **experimental, investigational** or not medically necessary.

WHAT ARE MY RIGHTS TO FILE A GRIEVANCE AGAINST MY HEALTH PLAN?

If you are denied access to medical services or specialists, or experience any other action by your health plan that you believe negatively affects your ability to receive quality health care, you have the right to file a grievance with your plan. Under California law, health plans must have in place a grievance system under which you can submit a grievance to the plan.¹ Each plan must adequately consider each grievance and remedy the situation when needed. You must be informed by the plan when you enroll and once a year after that about how and where to file such a grievance.²

Medi-Cal and Medicare laws also require managed health care plans to have a grievance process and to inform members of their rights.

WHAT STEPS SHOULD I TAKE BEFORE I FILE A GRIEVANCE?

Before filing a grievance with your health plan, make sure you know the answers to the following questions:

- *Does my health plan cover the care I am seeking?*

Make sure the medical care or services you are trying to get approved are covered benefits by your health plan. Check your “**Evidence of Coverage**” booklet, **plan contract** or any other pertinent plan information to determine: 1) your covered benefits, and 2) any exclusions or limitations that are specifically not covered.

- *Who has made the decision to deny me coverage?*

When you are denied medical care or services, determine who has made the decision. If your doctor is the source of the denial, discussing it may straighten things out. You may want to request a change of doctors, or seek out a second opinion from another doctor. You must make sure you know the reasoning behind your doctor’s decision to deny, so ask for an explanation in terms you can easily understand.

If the decision came from your health plan, contact the plan’s customer service department. Request an explanation for the denial from the plan’s representative **in writing**. If the representative is unresponsive, demand to talk to a supervisor. Always move up the plan’s chain of command when you meet resistance.

- *Why was my coverage denied?*

It is important for you to find out **why** your care was denied. Be sure to get the reason for the denial in writing. If your health plan claims the care is not a covered benefit, you should explain to them in writing why you disagree with the decision. If you understand that the treatment is not covered, you may want to talk to your employer about changing your benefit coverage.

If another treatment has been suggested or your requested treatment has been deemed not “**medically necessary**,” you will need to advocate aggressively for the desired treatment. You should research your condition and treatment options on your own so that you have strong explanations for why your requested treatment is necessary.

Consider the situation of Harry Christie who fought a successful battle to force his HMO to pay for his daughter’s cancer surgery. Harry’s daughter, Carley, was stricken with a rare cancer called Wilms tumor. Harry’s HMO would not approve a surgeon who had previously performed the tumor removal procedure. The Christies decided on the spot to have the care rendered and worry about payment later. The family’s initial decision to make certain that Carley received the care she needed without waiting for the HMO’s approval was a wise strategic choice to put her health above the HMO’s rules. Today, as a result, Carley is living a healthy life.

Harry’s strategy was to go through every step of the process and get all the allies he could to ensure HMO payment for Carley’s care and a fine for the unlawful denial. Harry’s calm and deliberate demeanor led to the state of California ultimately fining his HMO — \$500,000 for its failure to approve the proper surgeon.

According to Harry:

“I thought I had approval the night before the surgery. Then they back-pedalled and said we didn’t seek pre-approval. That is a falsehood. Then it took eleven months to recover payment of the medical bills. Next time I would go directly to the medical group. I thought I had to do all my dealings through the managed care plan. What I didn’t know was that the medical group held its own set of cards. If you know in your heart of hearts what you are being told is not right, follow your instincts and do what needs to be done and fight it afterwards.”

In an emergency case, you do not have to participate in the plan's grievance process, but rather, you can submit your grievance directly to the Department of Managed Health Care.

*The Department of Managed Health Care has **30 days from when it receives your request for review to issue its final decision**, unless the Director decides that additional time is needed.¹⁰*

WHAT IS MY HEALTH PLAN'S TIMELINE FOR RESOLVING MY GRIEVANCE?

Your health plan must resolve your grievance **within 30 days whenever possible**.³ Medi-Cal and Medicare rules also require that grievances be resolved within 30 days. Your plan must also provide you with a written statement regarding the status of the grievance no later than 3 days from when the company receives the grievance.⁴

WHAT IS THE TIMELINE FOR RESOLVING MY GRIEVANCE IN AN EMERGENCY CASE OR WHERE A SERIOUS THREAT TO MY HEALTH IS INVOLVED?

Your health plan must have a quicker grievance process for emergency cases or when a serious or imminent threat to your health exists, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.⁵ When your plan is told that your case requires a speedier review, your plan must immediately inform you in writing of your right to contact the Department of Managed Health Care about your grievance. Your plan must also notify you and the Department **within three days** from when it received your grievance of its decision or the pending status of your grievance.⁶ Medicare rules similarly require that grievances be resolved within 72 hours when there is a serious threat to life or health.

WHEN MAY I SUBMIT A GRIEVANCE TO THE DEPARTMENT OF MANAGED CARE (DMHC)?

After you have either completed your plan's grievance process or been in the process for 30 days without resolution, **you have the right to submit your grievance to the Department of Managed Health Care for review by completing a "Consumer Complaint Form."**⁷ (A copy is included as Appendix A on page 57) **Your plan must inform you of this right. The DMHC may require that you participate in your health plan's grievance process for 30 days**, unless your case involves a serious threat to your health or some other circumstance where the DMHC determines that an earlier review is needed.⁸

WHAT IS THE DEPARTMENT OF MANAGED HEALTH CARE'S TIMELINE FOR RESOLVING MY GRIEVANCE?

Generally 30 days. The Department of Managed Health Care must review the written documents you submit along with your DMHC "Consumer Complaint Form." The DMHC may ask for additional materials from you and may hold meetings with the parties involved, including your doctors.⁹ The DMHC must then send you, whoever is assisting you, and your health plan, a written notice of the Department's final decision on your grievance, along with reasons for the decision.

If your grievance has remained unresolved for 30 days, you may call the Department of Managed Health Care for assistance at (888) HMO-2219 or TDD (877) 688-9891.

Remember: You can use your health plan's and the Department of Managed Health Care's grievance review processes *in addition to any other dispute resolution procedures that may be available to you*. You can still pursue other legal remedies that may be available to you without having to complete your plan's grievance process.

CAN THE DEPARTMENT OF MANAGED HEALTH CARE PENALIZE MY HEALTH PLAN FOR NOT COMPLYING WITH THE GRIEVANCE STANDARDS?

Yes. The Director of the DMHC may impose a penalty on your plan when your plan has repeatedly failed to follow the grievance standards. The Director must periodically evaluate patient complaints to find out whether the plans are complying with the grievance standards, and must then notify the plan and provide an opportunity for a hearing before fining the plan.¹¹

WHERE CAN I GO FOR HELP?

- If you are a Medi-Cal member, contact the **Department of Health Services' Medi-Cal Managed Care Ombudsman at (888) 452-8609** for help with your grievance.
- If you are a Medicare member, contact **HICAP (Health Insurance Counseling & Advocacy Program) at 1-800-824-0780** for more information about your rights to file grievances.
- For assistance with the **Department of Managed Health Care's** grievance review process, call **1-800-HMO-2219 or TDD (877) 688-9891**. A copy of the Department's "Consumer Complaint" form is included as Appendix A in this guide or you can fill it out online at: <http://www.dmhc.ca.gov/gethelp/complaint.asp>.

CHAPTER VI. Footnotes

¹ Health & Safety Code §1368(a)(1).

² Health & Safety Code §1368(a)(2).

³ Health & Safety Code §1368.01(a).

⁴ Health & Safety Code §1368.01(b).

⁵ Health & Safety Code § 1368.01(b).

⁶ Health & Safety Code § 1368.01(b).

⁷ Health & Safety Code § 1368(b)(1)(A).

⁸ Health & Safety Code §1368.03.

⁹ Health & Safety Code §1368(b)(3).

¹⁰ Health & Safety Code §1368(b)(5).

¹¹ Health & Safety Code §1368.04.

CHAPTER VII.

Your Rights to Have your HMO's Decisions Independently Reviewed and to Sue Your HMO

SUMMARY OF YOUR RIGHTS

- ***You have the right to have denials of treatment by your health plan or physician's group reviewed by an external, independent medical review organization.***
- ***You have the right to sue your health plan in some circumstances — when a health plan interferes with the quality of care you receive and you are injured by the delay or refusal of the health plan to provide the care.***

This chapter first overviews the workings of the independent review process, which is available to review some denials of care. The second part discusses what limitations you may face in bringing a lawsuit against your health plan (referred to generically throughout this chapter as “HMO”) if you have health coverage through a private employer. The remainder of the chapter explains your right to sue under a new California law and its relationship to the independent review process.

WHAT ARE MY RIGHTS TO AN INDEPENDENT REVIEW OF AN HMO DENIAL?

The independent review process is designed to get HMO treatment denials based on **medical necessity** (where HMOs say that you do not medically need a treatment) reviewed quickly and resolved informally with the goal of getting you care in as prompt a manner as possible. The independent review process is intended to be “independent” of the HMO and is administered through and supervised by the Department of Managed Health Care. If the independent review concludes that the health care service should be provided, the HMO is **required** to provide the service or reimburse you if the service was obtained out of plan and paid for by you.¹

IS THERE A DIFFERENCE BETWEEN FILING A GENERAL GRIEVANCE WITH THE DEPARTMENT OF MANAGED CARE AND SEEKING AN INDEPENDENT REVIEW?

It is important to note that there are *two* separate and distinct review processes conducted under the jurisdiction of the Department of Managed Health Care:

- The first is a general **grievance review process** that applies to any type of dispute you may have with your health plan, including coverage disputes.² (See chapter VI for further information about your health plan's internal grievance process and the Department of

Managed Health Care’s review of those grievances.) Coverage disputes are based on whether you are entitled to a specific benefit under the language of the HMO contract.

- The second is the more formal - but narrower - **independent review process**.³ This process is designed to help get you care when an HMO claims treatment is *not medically necessary*.

WHAT HMO DECISIONS ARE SUBJECT TO INDEPENDENT REVIEW?

Independent review applies when:

The requested health care service is “eligible” for coverage under the plan.⁴

For example, if the requested service is for proton beam therapy, you will only qualify for independent review if proton beam therapy is eligible for coverage under the plan.

If there is no provision in your plan excluding coverage for proton beam therapy and yet your HMO denies the treatment as “experimental” and therefore not covered, you may be able to have the denial independently reviewed if you have a life-threatening or serious condition. This is explained in more detail below.

The request for the health care service has been denied, modified or delayed.⁵

If the plan denies you treatment outright, if there has been a delay that amounts to a denial, or if the plan has approved only a different type of treatment, the review process applies.

You can use the independent review process, for example, when your doctor is recommending a hysterectomy for treatment of recurrent cervical cancer, but the HMO will only approve cervical cryosurgery. Similarly, when the doctor recommends proton beam radiation for treatment of prostate cancer, but the HMO only approves surgery, you can also use the independent review process.

The denial is based, in whole or in part, on a finding that the health care service is not medically necessary.⁶

This is where the biggest divergence between the liability statute and the independent review statute occurs. The liability statute is not limited to HMO decisions that are based on medical necessity – when HMOs say you do not medically need a service.

The denial, delay or modification is by the HMO or one of its contracting providers.⁷

This requirement will be very easy to show. Whether the treatment decision comes from the doctor, the medical group, a utilization review service or the HMO itself, the fact that the entity was given the power to make a treatment decision will show there is a contract of one form or another between the HMO and that entity. This provision was added for the purpose of protecting patients from claims by the HMO that it did not make the decision, but that the medical group or some other entity did.

The requested health care service has been recommended by a medical provider as medically necessary.⁸

Before the independent review process can be used, the requested treatment must be recommended by a health care provider as being medically necessary, but the provider need not be an in-plan provider. The recommending doctor can be an out-of-plan doctor.

You have filed a grievance with the plan and the disputed decision must have been upheld by the plan, or the decision must have been unresolved after 30 days.⁹

This is a very important provision. Once the HMO issues its initial decision, you **must** file a grievance with the plan or its contracting provider pursuant to Health & Safety Code section 1368. (See chapter VI for more information on the grievance process.) ***In non-emergency cases, the independent medical review system can be initiated only if the denial is upheld by the plan, or the grievance has not been resolved within 30 days.*** The plan's internal grievance process must be used before the independent review process is initiated. In turn, in most cases, the independent review process must itself be used before litigation can be filed.

IS THERE AN "EMERGENCY REVIEW"?

Yes. Expedited review is required in "cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function."¹⁰

Where a grievance requires expedited or emergency review, you are required to participate in the plan's grievance process for ***no more than three days*** before the review process can be initiated.¹¹

IS THERE A SPECIAL REVIEW PROCESS FOR EXPERIMENTAL TREATMENTS?

Yes. As of January 1, 2001, every health care plan must have an external, independent review process that can review the plan's coverage decisions regarding experimental or investigational therapies.¹² To be eligible for this independent review process, you must meet all of the following criteria:

1. Have a **life-threatening** or **seriously debilitating** condition;
2. Your doctor certifies that standard therapies have not been effective, would not be appropriate for you, or that there is no more beneficial therapy for your condition that is covered under your plan;
3. Either (a) your doctor who is under contract with or employed by the plan has recommended a therapy that he or she certifies in writing is likely to be more beneficial to you than any standard available therapy, or (b) you or your doctor, who is a board-

"Life threatening" means either that you have a condition that has a high likelihood of death, or that you could die from your illness unless you receive proper treatment.

"Seriously debilitating" refers to conditions that cause major irreversible health problems.

certified specialist, has requested a therapy that, based on two documents from scientific and medical evidence, is likely to be more beneficial to you than any standard treatment;

4. You have been denied coverage by your plan of the recommended therapy, drug or procedure; and
5. The drug, device, procedure, or therapy would be a covered service, except for the determination by your plan that it is experimental. (i.e., the recommended treatment would not be excluded under any other terms of your health plan.)

When you meet these criteria, you can use the independent review process. There are some additional requirements for review of experimental treatments as follows:

- Your plan must notify you of the opportunity to request the external independent review within **five business days** of its decision denying you coverage.¹³
- If your doctor determines that you need the therapy immediately in order to benefit from it, then the independent review panel must issue their recommendations **within seven days of the request for expedited review.**¹⁴
- Each expert on the independent review panel must provide a written statement of the reasons why the recommended therapy is or is not likely to be more beneficial than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the plan.¹⁵
- Coverage for services required under this review process must be provided to you under the same terms and conditions that apply to other benefits under the plan contract.¹⁶

HOW DOES THE INDEPENDENT REVIEW PROCESS WORK?

Who decides if the treatment decision is one that is subject to independent review?

The Department of Managed Health Care makes the determination of whether the claim is subject to the independent review process or the separate general grievance process.¹⁷

How is the claim of a minor or incompetent person submitted to the independent review process?

If a minor or incompetent person's claim needs to be reviewed, the request for review can be submitted by the parent, guardian, conservator, relative or other designee of the patient as the agent of the patient.¹⁸ "Relative" is defined as a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle or aunt of the patient.¹⁹

Is there a time limit on requesting independent review?

Yes, you must request independent review within 6 months of any of the following:

- *The recommendation by a health care provider for the treatment, or the receipt of emergency treatment that was deemed medically necessary by a health care provider;*
- *The health plan decision denying, modifying or delaying a treatment based in whole or in part on the assertion that the treatment is not medically necessary, or,*
- *A health plan decision is issued in the grievance process upholding the plan's previous decision or where the grievance remains unresolved after 30 days.*

The Department of Managed Health Care Director, however, can extend the application deadline beyond 6 months if the circumstances of a case warrant the extension.²²

Can anyone help a patient who is not a minor or an incompetent?

Yes, the provider (e.g., doctor) can assist with the submission of the claim to the independent review process and may advocate on behalf of the patient.²⁰

Does the independent review process apply to Medi-Cal members?

Yes.²¹ Medi-Cal members can choose to use the independent review process instead of the review process under the Medi-Cal program, known as the Medi-Cal “fair hearing process.” For information on the Medi-Cal fair hearing process and to obtain a fair hearing form, contact the **Department of Social Services** at: 1-(800)952-5253 or 1-(800)952-8349 (TDD). Medi-Cal members should also contact the **Department of Managed Health Care** at (888) HMO-2219 or (877) 688-9891 (TDD) to determine which process would be most appropriate in their particular case.

Does the independent review process apply to Medicare members?

In most cases, probably not. Medicare has its own grievance and appeal system established by the U.S. Department of Health and Human Services. The independent review process for Medicare members is administered by the **Center for Health Dispute Resolution (CHDR)**. For more information, contact CHDR at (716) 586-1770 and/or download information and forms on their Web site at: <http://www.healthappeal.com/medicare.htm>.

Is there an application or processing fee?

Not for the patient.²³

Where do I get an application form for seeking independent review?

The plan must provide you with an application form and an addressed envelope as part of its notification to you regarding the decision made on your grievance.²⁴

Additionally, as part of that form, the health plan must provide any information required by DMHC, such as your diagnosis or condition, the disputed health care service sought, a means to identify the case (such as a file or record number), and any other relevant information. The form must also include notice that a decision not to participate may cause loss of the right to sue, a consent form to obtain any necessary medical records, and notice of your right to provide information or documentation.

What documents or information can you submit to DMHC for the purposes of the review?

- A doctor's recommendation indicating that the treatment is medically necessary;
- Medical information or justification that the treatment is medically necessary; and
- Information supporting your position that the service is medically necessary, including information submitted to the plan as well as any additional material that you believe is relevant.²⁵

What documents, if any, is the plan required to supply?

- A copy of all relevant medical records in the plan's or its contracting providers' possession. Both the plan and the contracting providers have an ongoing duty to continue to supply updated records.²⁶
- A copy of all information provided to you by the plan or its contracting providers regarding the decision, and a copy of any materials submitted to the plan or its contracting providers by you or your doctor in support of the request for the disputed health care service, including the plan's written response to the request for the service.²⁷
- A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether the services should have been provided.²⁸ The plan is also required to provide this same information to you unless the Director of the DMHC finds that they include "legally privileged" information. Communications between the plan and its legal counsel, for example, could be "privileged" information that the plan is not required to disclose.
- Any statements by the plan and its contracting providers explaining the reasons for the decision.²⁹ The plan is also required to provide this same information to you unless the Director finds that they include "legally privileged" information.

Is there any way to avoid the HMO's internal grievance process before initiating the independent review?

Yes, but only in an extraordinary and compelling case where the Director finds that you have acted reasonably and where there is "an imminent and serious threat" to your health.³⁰ That, in turn, occurs when there is "serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration" of your health.³¹

Can the independent review process be expedited and, if so, in what circumstances?

Yes. The independent review process can be expedited when there is "an imminent and serious threat" to your health.³²

Who conducts the independent review?

The independent review is conducted by one or more independent medical review organizations that contract with the Department of Managed Health Care.³³ The review organizations must be independent of any health care service plan doing business in this state and there are conflict provisions in the statute that preclude the review organization from having any material professional, familial, or financial affiliation with:

- the plan;
- a physician or medical group or practice association involved in the dispute;
- the facility at which the proposed treatment would be provided;
- the development or manufacture of any drug, device, procedure or other therapy in dispute; or
- you or your immediate family.

DMHC ensures that the review organization and the review process used are free from conflicts of interest.³⁴

Can the reviewers request other information over and above that already submitted to them?

Yes. But if they request any further information, a copy of the request and the response must be given to all of the parties.

What do the reviewers base their decision on?

The reviewer or reviewers must determine whether the disputed health care service was medically necessary based upon your specific medical needs.³⁵ The reviewer or reviewers may also consider any of the following:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the service;
- Nationally recognized professional standards;
- Generally accepted standards of medical practice; and
- Treatments that are likely to provide a benefit to the patient for conditions for which other treatments are not clinically effective.

For reviews relating to experimental therapies, the reviewers must base their determinations on relevant medical and scientific evidence.³⁶

How is the decision made? Must it be issued in writing?

The decision must be issued in writing and set forth in layperson's terms to the maximum extent practicable.³⁷ The determination must state whether the disputed service is medically necessary and must cite the medical condition and the relevant documents and findings associated with the information relied on to support the determination.³⁸

If more than one reviewer is assigned to the review, the recommendation of the majority shall prevail. If the reviewers are evenly split, the decision shall be in favor of providing the service.

Do I get a copy of the decision?

Yes. You, your plan, and your doctor must receive a copy of the analysis done by each reviewer, if there was more than one. You will also receive a description of the qualifications of the medical professionals who reviewed the case. The names of the reviewers are kept confidential, unless the reviewers are called to testify or in response to court orders.³⁹

Once the reviewers' determinations are provided to the Director, he or she must immediately issue a written decision to the parties.

If the decision is in my favor, does my plan have to provide the treatment?

Yes. The decision of the Director of the DMHC is binding on the plan.⁴⁰ Since the independent review process applies only to medical necessity determinations, however, it is only binding in that respect. If the plan denied the procedure on another basis as well, the plan may argue that the Director's determination cannot force the plan to provide the service, but only resolves the issue of medical necessity.

Are the decisions available to the public?

Once a decision has been issued, the Director must make the decision public, upon request, and at the Department of Managed Health Care's expense, after removing the names of all parties.⁴¹

What recourse is there if the plan delays the review process or delays in implementing the decision rendered?

If your plan delays the review process, it is subject to fines, penalties or other remedies that can be imposed by the Director. If the plan delays in implementing the decision, it will be subject to a penalty of not less than \$5000 per day for each day that the decision is not implemented.⁴²

If the review relates to the plan's denial of payment for urgent or emergency services obtained out of the plan network that were denied by the plan, can the plan be required to reimburse me for the costs of those services?

Yes, so long as the Director finds that the enrollee's decision to secure the services outside of the network and without using the grievance or review process first, was reasonable under the circumstances and the disputed services were a covered benefit under the plan.⁴³

Who pays for the independent review?

Independent review costs are paid by the health care service plans through a fee assessment system.

What is the timeline for the review process and can the timeline be expedited?

The following are the timelines for a basic review, and for an expedited review based on a finding that there is an "imminent and serious threat" to your health.

WHAT IS THE RELATIONSHIP BETWEEN SUING AN HMO & APPEALING DENIALS OF CARE THROUGH MY PLAN'S INTERNAL GRIEVANCE PROCESS OR THROUGH THE INDEPENDENT REVIEW PROCESS?

With respect to claims that fall under the general grievance review procedures (see chapter VI), but not the independent review procedures, you may still bring a lawsuit against your HMO without completing the HMO's internal grievance process.⁴⁴

The California "right to sue" law requires you to go through the *independent review* process before bringing suit - with the exception of certain situations discussed below.

For a checklist that summarizes the steps to take as they relate to the grievance process, independent review, and filing a lawsuit, see Appendix B at the end of this guide.

TIMELINE FOR BASIC REVIEW

EVENT	RESPONSE	TIME DEADLINE FOR RESPONSE
Decision denying, delaying or modifying the requested service	File a grievance pursuant to the plan's terms.	No statutory time stated; check plan terms for time limits.
Grievance decision by plan upholding decision denying, delaying or modifying the requested service.	File a request for independent review, if the denial is based in whole or in part on the determination by the plan that the treatment is not medically necessary. (Mandatory in order to preserve the right to sue the HMO, if none of the exceptions apply.) File a request for review of the grievance decision by the DMHC if the decision is not based in whole or in part on the determination that the treatment is not medically necessary. (Voluntary)	Six months from the grievance decision by the HMO.
Thirty days have passed from the filing of the grievance with the plan without a decision on the grievance.	File a request for independent review or for a review of the grievance decision, as above.	Six months from the expiration of the 30 days the claim was submitted to the grievance process.
Notice from the DMHC to the plan that a request for independent review has been filed.	The plan must supply the information required by the statute to the independent review organization.	Three business days from receipt of the notice.
Receipt of application for review and supporting documents by reviewing organization.	Issuance of decision.	30 days from receipt of materials - but may be extended by the director for up to 3 days in extraordinary circumstances or for good cause.
Receipt by plan of decision.	Implement decision.	Immediately.

TIMELINE FOR EXPEDITED REVIEW

Expedited review provisions apply when there is an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function or in any other case in which the Department of Managed Health Care determines that an earlier review is warranted.

EVENT	RESPONSE	TIME DEADLINE FOR RESPONSE
Decision denying, delaying or modifying the requested service.	File a grievance pursuant to the plan's terms.	The requirement to pursue a grievance through the plan's own system is waived for a review subject only to the grievance process, and not independent review. If the grievance relates to a claim that must be submitted to independent review, the grievance process must still be utilized. If the decision is not rendered in three days, however, the independent review application can be filed.
Three days have passed from the filing of the grievance with the plan without a decision on the grievance.	File a request for independent review.	Immediately.
Receipt of request for expedited review.	Director of Department of Managed Care determines if expedited review is appropriate. Director notifies plan if expedited review is approved.	"Expeditiously" and "immediately."
Notice from the Department of Managed Care to the plan that a request for expedited independent review has been approved.	The plan must supply the information required by the statute to the independent review organization.	Within 24 hours of approval of the request for review.
Receipt of application for review and supporting documents by reviewing organization.	Issuance of decision.	Three days from receipt of materials - but may be extended by the director for up to 3 days in extraordinary circumstances or for good cause.
Receipt by plan of decision.	Implement decision.	Immediately.

*“Substantial harm” is defined as “loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.”*⁴⁶

*A new California “right to sue” law attempts to avoid the impact of ERISA’s limitations on your ability to recover damages for harm caused by your HMO. The law provides that an HMO has a **duty of ordinary care** to arrange for the provision of **medically necessary health care services** to its subscribers. The health plan or other managed care entity is liable when:*

- (1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.
- (2) The subscriber or enrollee suffered substantial harm.⁵⁰

ARE THERE ANY EXCEPTIONS TO THE REQUIREMENT THAT I USE THE INDEPENDENT REVIEW PROCESS BEFORE FILING A LAWSUIT?

Yes. The independent review process need not be used where: “Substantial harm” has occurred prior to the completion of the applicable review; **OR** “Substantial harm” will imminently occur prior to the completion of the applicable review.⁴⁵

If you have been, or are in danger of being substantially harmed by your HMO’s actions, you do not have to use the independent review process. For example, if you need immediate surgery for which your HMO has denied coverage and you may die or be seriously harmed if you do not receive the surgery, then you can go ahead with the surgery and do not have to use the independent review process before filing a lawsuit to recover what you had to pay for the surgery.

WHAT ARE THE LIMITS ON MY ABILITY TO SUE AN HMO?

If you choose to bring a lawsuit against your HMO, and you have health coverage through a private employer, any monetary award (or “damages”) you may receive to compensate you for your injuries may be severely limited by a federal law known as **ERISA (Employee Retirement Income Security Act)**, 29 U.S.C. section 1001, et seq.) Although originally enacted to prevent pension plan abuses, ERISA also applies to all employee benefit “plans,” including health care coverage benefits, even when there is no formal “plan” established by the employer and even when the health care benefits are provided through the purchase of a group insurance policy.⁴⁷

WHO IS NOT LIMITED BY ERISA IN THEIR RIGHT TO RECOVER DAMAGES?

There are two major classes of persons with employer-paid health care who are not subject to ERISA’s limitations: (1) Employees of a government agency (federal,⁴⁸ state, county, or municipal); and, (2) Employees of a church or any of its related businesses or organizations (for example, a church-run hospital, clinic or school. If you are self-employed and not an employee of another, your health care plan will not be covered by ERISA, unless you are an employer and have employees on the plan— then you **are** covered by ERISA.

HOW DOES ERISA LIMIT THE ABILITY OF PRIVATE SECTOR-EMPLOYEES TO RECOVER DAMAGES IN A LAWSUIT?

ERISA can take away your ability to recover damages over and above the actual benefits that are owed to you. For example, if you need a bone marrow transplant and the HMO illegally refuses to pay for it, (see sidebar next page) **California law** might allow you to recover for the cost of the transplant, other medical care expenses, certain losses and the emotional distress you suffered as the result of the HMO’s misconduct. **Under ERISA**, however, all you would be able to recover

would be the cost of the treatment itself and, if the court chooses to award it, reasonable attorney's fees.

As another example, if your spouse or child needed lifesaving treatment that the HMO refused to provide and your loved one died, **under California law** if you met the criteria necessary to bring a lawsuit (see sidebar on this page), you would be able to sue the HMO for your losses resulting from the death of your loved one. **Under ERISA** you cannot.

WHAT ARE MY RIGHTS UNDER CALIFORNIA LAW TO SUE MY HMO?

A new law in California, effective January 1, 2001, allows lawsuits against an HMO, even in most cases, when brought by a private sector employee who is subject to ERISA.⁴⁹ The law states that where the HMO's conduct results in the denial, delay or modification of the recommended treatment, the HMO can be **liable** (held legally responsible for its wrongful acts). Basically, the California statute is intended to make the HMO responsible for injury caused when it makes health care and/or treatment decisions under the guise of "cost management."

NOTE: This law will be referred to throughout the remainder of this chapter as the "liability statute."

WHEN DOES THE RIGHT TO SUE MY HMO TAKE EFFECT?

The liability statute applies only to "services rendered on or after January 1, 2001." There is some ambiguity here, of course, because if the HMO *denies a request* for services, there are, in fact, no "services rendered." The intent of the statute, however, was clearly to apply to HMO treatment decisions made on or after January 1, 2001.

UNDER WHAT CIRCUMSTANCES CAN I SUE MY HMO?

In most cases, before you sue your HMO, you must use (or "exhaust") the independent review process set forth in Health & Safety Code section 1374.30.⁵¹ See the sidebar at left for all the conditions that must be met before you can sue your HMO.

WHERE CAN I SUE?

While you have the right to "sue" your HMO, you may still be limited as to **where** you can bring your action. Most health plan contracts require you to **arbitrate** your disputes rather than filing a lawsuit in a court of law. **Arbitration** is the legal process of resolving disputes out of court through the use of a private, neutral decision-maker who will apply the liability standards as set forth above. Plans that require binding arbitration must clearly disclose that fact to you in clear and understandable language in your plan contract or enrollment agreement directly above the signature line.⁵²

If you are only seeking to stop a plan practice that has harmed you and others, but not damages, however, you may be able to bring a lawsuit in court without going through the arbitration process.⁵³ Also, if your health care plan unfairly administers its arbitration program, such as by

In order to bring a lawsuit, under the new California law you must show the following:

- *The plan breached its duty of ordinary care in arranging for the provision of medically necessary services, and that those services are provided as a benefit under the plan;*
- *The failure to exercise ordinary care resulted in the denial, delay or modification of services to you;*
- *You suffered substantial harm, meaning loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic pain or significant financial loss;*
- *The services were recommended by a health care practitioner; and,*
- *The independent review process was utilized ("exhausted") or was not required to be used.*

delaying consideration of your claim, you may be able to bring a lawsuit in court against your health plan for fraud.⁵⁴

Every health plan that uses arbitration to settle disputes with its members must file a copy of any written arbitration decision with the Department of Managed Health Care. The filed copy must include the amount of the award, the reasons for the award and the names of the arbitrators. By law, the names of the plan, member, witnesses, attorneys, provider, plan employees and plan facilities are deleted from the copy filed with the Department. These redacted copies of the decisions are filed each quarter and available to the public.⁵⁵ You can find them online at <http://www.hmohelp.ca.gov/library/arbitrations>.

CHAPTER VII. Footnotes

¹ Health & Safety Code section 1368(b)(6); Health & Safety Code section 1374.33(f).

² Health & Safety Code section 1368.

³ Health & Safety Code section 1374.30

⁴ Health & Safety Code section 1374.30(b).

⁵ Health & Safety Code section 1374.30(b).

⁶ Health & Safety Code section 1374.30(b).

⁷ Health & Safety Code section 1374.30(b).

⁸ Health & Safety Code section 1374.30(j)(1).

⁹ Health & Safety Code section 1374.30(j)(3).

¹⁰ Health & Safety Code section 1368.01.

¹¹ Health & Safety Code section 1374.30(j)(3).

¹² Health & Safety Code section 1370.4(a).

¹³ Health & Safety Code section 1370.4(c)(1).

¹⁴ Health & Safety Code section 1370.4(c)(2).

¹⁵ Health & Safety Code section 1370.4(c)(3).

¹⁶ Health & Safety Code section 1370.4(c)(4).

¹⁷ Health & Safety Code section 1374.30(d)(2) and (3).

¹⁸ Health & Safety Code section 1374.30(e); Health & Safety Code section 1368(b)(2).

¹⁹ Health & Safety Code section 1368(b)(2).

²⁰ Health & Safety Code sections 1368(b)(2) and 1374.30(e).

²¹ Health & Safety Code section 1374.30(f).

²² Health & Safety Code section 1374.30(k).

²³ Health & Safety Code section 1374.30(l).

²⁴ Health & Safety Code section 1374.30(m).

²⁵ Health & Safety Code section 1374.30(m)(3).

²⁶ Health & Safety Code section 1374.30(n)(1).

²⁷ Health & Safety Code section 1374.30(n)(2).

²⁸ Health & Safety Code section 1374.30(n)(3).

²⁹ Health & Safety Code section 1374.30(n)(3).

³⁰ Health & Safety Code section 1374.31.

³¹ Health & Safety Code section 1374.33(c).

³² Health & Safety Code section 1374.31.

³³ Health & Safety Code section 1374.32.

³⁴ Health & Safety Code § 1374.32.

³⁵ Health & Safety Code section 1374.33(b).

³⁶ Health & Safety Code section 1370.4(b)

³⁷ Health & Safety Code section 1374.33(c).

³⁸ Health & Safety Code section 1374.33(d).

³⁹ Health & Safety Code section 1374.33(e).

⁴⁰ Health & Safety Code section 1374.30(f).

⁴¹ Health & Safety Code section 1374.33(g).

⁴² Health & Safety Code section 1374.34(b).

⁴³ Health & Safety Code section 1374.34(c).

⁴⁴ Health & Safety Code section 1368(d).

⁴⁵ Civil Code section 3428(k)(2).

⁴⁶ Civil Code section 3428(b).

⁴⁷ *Pilot Life Ins. Co. v. Dedeaux* (1987) 81 U.S. 41, 107 S.Ct. 1549.

⁴⁸ Federal employees are subject to the Federal Employee Health Benefits Act (FEHBA) which may restrict your ability to use state law in other ways.

⁴⁹ If your employer “self-funds” its health plan, you will be restricted by ERISA in your ability to sue under this law. See chapter VII of this guide for your rights to sue under ERISA.

⁵⁰ Civil Code section 3428(a).

⁵¹ Civil Code section 3428(k).

⁵² Health & Safety Code § 1363.1.

⁵³ *Broughton v. Cigna Healthplans of California* (1999) 90 Rptr.2nd 334.

⁵⁴ See *Engalla v. Permanente Medical Group, Inc.* (1997) 64 Rptr.2nd 843.

⁵⁵ Health & Safety Code section 1368.04.

* All code sections refer to California law.

CHAPTER VIII.

Your Right to Appeal and Litigate Benefit Denials Under ERISA

This chapter provides an overview of what your rights and remedies are under the “**Employee Retirement Income Security Act of 1974**” (**ERISA**), the federal law that governs most group health plans provided through *private* employers. Because some of your rights under state law could be superseded, or “pre-empted” by ERISA, you will need to understand how to bring an action for denials of coverage under ERISA. This should be considered in addition to any remedies through your plan, external review processes and state law as discussed in other chapters of this guide.

Only those patients who are in “self-funded” ERISA plans – where their employer funds the cost of health coverage without using an HMO or insurer to finance the treatment – are fully restricted from utilizing California law, and are limited to ERISA’s remedies. Large national companies traditionally self-fund their health plans. Other patients with employer-paid health coverage (from smaller employers) can avail themselves of at least some of California’s consumer protection laws. ***Using California law may be easier and preferable to seeking relief under ERISA, which only allows for recovery of the cost of benefits denied you.***

NOTE: At the time of publication, Congress was poised to expand remedies under ERISA, so please check with your Congressperson about such changes. *The following is only a general guide for pursuing claims under ERISA:*

DOES ERISA APPLY TO MY HEALTH PLAN?

Almost all health benefits plans offered through *private employers* are governed by ERISA. This law restricts your ability to challenge a denial of benefits by your health plan under state law, and requires instead that you bring a legal claim under the procedures and remedies established by ERISA. However, ***California’s appeal process and “right to sue” laws (see chapter VII of this guide) should still be applicable to most patients, except those in self-funded ERISA plans.***

A health or disability benefit plan that meets the following four criteria will be governed by ERISA, 29 U.S.C. §1001, *et seq.*:

- It is a “plan, fund or program”;
- Established or maintained” by an employer (or an employee organization);
- For the purpose of providing medical, surgical, hospital care, sickness, accident, disability, or other enumerated benefits;
- To participants or beneficiaries.¹

ERISA does not govern if:

- Your insurance is unconnected with your employment, or
- The covered person is self-employed,² or is a partner in a professional partnership,³ or

- The insurance IS connected with your employment, but your employer
 - is an agency of any level of government, or
 - is a religious organization,⁴ or
 - is minimally involved, i.e.: The employer makes no contributions toward the premiums; participation is completely voluntary for the employees; the employer doesn't "endorse" the program; the employer does no more than allow the insurer to publicize it to the employees, collect premiums through the payroll deduction, and remit them to the insurer; and the employer gets no compensation except for its administrative services.⁵

HOW LONG DOES MY HEALTH PLAN HAVE TO MAKE A DECISION ON MY INITIAL CLAIM FOR BENEFITS?

Currently, your health plan must make a decision on your initial request for a plan benefit **within 90 days** (or 180 days if your plan notifies you in writing of special circumstances that require an extension of time for processing your claim).⁶

Under new federal rules that, at the time of publication, are set to apply to claims **filed on or after January 1, 2002**, the 90-day deadline will be replaced by a new set of standards:

- Claims for urgently needed care must be ruled on "as soon as possible," and in no event more than 72 hours after the claim is filed.
- Claims for pre-approval of benefits must be decided upon within 15 days.
- Claims for reimbursement when you have already received care must be ruled on within 30 days.

WHAT ARE MY RIGHTS UNDER ERISA PERTAINING TO REVIEW OF BENEFIT DENIALS?

ERISA requires that your health plan provide you with the specific reasons for a denial of benefits and that you be given the opportunity for "full and fair review" of the denial by your plan's administrator.⁷ The denial notice must include: 1) the specific reason(s) for the denial, 2) specific reference to pertinent plan provisions on which a denial is based, 3) a description of any additional material or information necessary for you to make your claim, and an explanation of why such material or information is necessary, and 4) information on the steps to be taken if you wish to submit your claim for review.⁸

You have **at least 60 days** (your plan may provide a longer time) to submit your claim for review (called an "appeal"). If you haven't received a decision from your plan within 60 days, the plan must notify you in writing of the reason for the delay. Under new rules set to take effect January 1, 2002, you will have 180 days to file your appeal. For more information on how to file an appeal under ERISA, consult with your employer's benefits manager, the **U.S. Department of Labor** (contact information provided below), or visit the **Patient Advocate Foundation's** Web site at <http://www.patientadvocate.org/appeals>.

In most cases, a decision on your appeal must be made **within 60 days** “unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.”⁹ Under new rules effective January 1, 2002, the deadline will be 72 hours for “urgent care,” 30 days for claims seeking advance approval of care, and 60 days for claims seeking payment after care is provided.

WHAT CAN I DO IF MY APPEAL IS DENIED?

If your appeal is denied, you may have a right to file a lawsuit under ERISA. ERISA provides for the right to bring a civil action against your plan “to recover benefits due to [you] under the terms of [your] plan, to enforce [your] rights under the terms of the plan, or to clarify [your] rights to future benefits under the terms of the plan.”¹⁰

You may find that by enlisting the support of others who have some technical expertise on the administration of health plans, you are able to obtain the care you need without resorting to legal action. Following are some of the sources you may want to consult:

- **Your Employer**—Find out from your employer if there is someone who serves as a **liaison** between your employer and your health care plan, such as a benefits manager, that may be able to help intervene on your behalf.
- **Regulators**—For assistance with your rights and remedies under ERISA, you may wish to contact the **U.S. Department of Labor** at (202)219-8776, or at Pension and Welfare Benefits Administration, Office of Participant Assistance and Communications, 200 Constitution Ave., N.W., Room N-5619, Washington D.C. 20210. You can find general information about ERISA and the steps in filing a claim for benefits online at the DOL Web site:
<http://www.dol.gov/dol/pwba>
Contact the **Department of Managed Health Care** at (888) HMO-2219, or (877) 688-9891 (TDD), concerning denials of care by HMOs. (see chapter VI for information on DMHC’s grievance process)
- **Patient Advocates**—The following organizations may provide you with technical assistance and/or referrals to free legal assistance:

Patient Advocate Foundation

Phone: (800) 532-5274

<http://www.patientadvocate.org>

Health Care For All

Phone: (415) 695-7891

<http://www.healthcareforall.org>

Center for Health Care Rights

Phone: (213) 383-4519

<http://www.healthcarerights.org>

WHAT SHOULD I DO BEFORE PREPARING A LAWSUIT?

1. **Consult with an attorney.**

Bringing a case under ERISA for denial of benefits by your health plan can be a complex and lengthy endeavor. This type of case is generally not the kind that one should undertake without legal representation. If you do decide to represent yourself, you should obtain an attorney as your legal “coach.” There are many useful legal reference sources available in your local law library and on the Internet to help you understand the litigation process. Here are some Internet Web sites you may wish to consult.

Representing Yourself in Court

<http://www.legalfreedom.com/prc/>

<http://www.halt.org>

ERISA Litigation, Statutes and Regulations

<http://www.harp.org/pro-se.htm>

<http://personal.riverusers.com/~searcher/help/sue.html>

<http://www4.law.cornell.edu/uscode/29/ch18.html>

http://www.dol.gov/dol/allcfr/PWBA/Title_29/Chapter_XXV.htm

Rules of Procedure, Court Rules and Evidence

<http://www.law.cornell.edu/rules/frcp/overview.htm>

<http://www.ca5.uscourts.gov/docs/frap-iop.htm>

<http://www.ilrg.com/codes.html>

www.law.cornell.edu/rules/fre/overview.html

Sample Pleadings

<http://www.harp.org/bard.htm>

2. **Exhaust internal plan remedies.**

Before filing a lawsuit under ERISA, you must first participate in, or “**exhaust**,” any internal review or administrative appeal remedies offered by the plan, as outlined above. ***If you fail to exhaust your administrative remedies, the court may not consider the merits of your claim. However, if treatment is needed before the plan remedies can be exhausted, you may file suit to seek emergency relief pending exhaustion of plan remedies. First, you will want to request that your plan speed up its review process, if possible. (See the sample letter to request expedited review from your health plan included as Appendix C at the end of this guide.)***

3. **Obtain copies of all relevant documents from the plan administrator.**

The administrator must furnish copies of plan documents and relevant claims information requested by you within thirty (30) days of your request.¹¹ If he or she doesn’t produce the records,

that in itself is evidence of an unfair claims review process.¹² You will want to keep copies of all correspondence between you and your plan concerning your request(s) to obtain documents from your plan. Even if the judge decides you have no valid claim for benefits, you may nevertheless be entitled to penalties for the plan's failure to give you the documents.¹³

4. *Communicate with your treating physician.*

Your treating physician's opinion is often the key to coverage. Your treating physician often will be your strongest ally. Many courts put great stock in the treating physician's definition of medical necessity or give great deference to the treating physician's opinion.¹⁴

When reviewing ERISA benefits claims, the court is supposed to limit review to the **administrative record**, giving deference to the decision-maker in the administrative proceeding. Often the administrator or a reviewing doctor has contradicted the findings of the treating doctor. In other kinds of cases, such as Social Security claims, the court is guided by the well-established "treating physician rule," whereby the opinions of treating physicians must be given great weight.¹⁵ For the same practical reasons found in social security cases, the treating physician rule can be advanced in appropriate ERISA cases. Of course, where the treating physician has a financial interest in the outcome, his opinions may not be entitled to as much weight.¹⁶ In other cases, however, the court should give substantial weight to the opinions of the treating physician.

5. *Communicate with the treating institution.*

You may have been referred by your doctor to another treating institution, such as a regional cancer treatment center or teaching hospital. The physicians at these centers tend to be nationally-recognized experts in their fields. Like the treating physicians, they will usually be your allies. The centers usually have admissions coordinators who are accustomed to dealing with insurance carriers. It can help tremendously to develop a close, working relationship with these admissions personnel.

6. *Survey the medical literature and find out how many times the medical procedure has been done in the past.*

The medical center furnishing treatment, or perhaps the treating physicians, usually will be able to refer you to medical literature and unpublished studies supporting the efficacy of the treatment at issue which should be available at a public library or on the Internet. Copies of any relevant studies or literature should be submitted as part of the record.

Following are some useful Internet Web sites to consult for medical literature:

Medline Plus

<http://www.nlm.nih.gov/medlineplus/>

National Medical Guidelines

http://www.guidelines.gov/body_home_nf.asp?view=home

Merck Manual

<http://www.merck.com/pubs/mmanual>

MedHelp

<http://www.medhelp.org>

PubMed

<http://www4.ncbi.nlm.nih.gov/PubMed/>

7. Find out what other health plans offer coverage for the procedure.

Health plans do not make coverage decisions uniformly. It often helps to furnish a list of other insurance carriers that have allowed coverage for the procedure. The medical center furnishing treatment to your client often can help with this.

8. Find out if the procedure is done at other notable institutions.

Your own doctor may know doctors at other reputable medical centers that have performed the procedure. Ask him for referrals, or contact the other medical centers directly through their general information phone lines to inquire as to whether records are kept of the number of times the procedure has been performed there.

9. “Humanize” the record.

Never underestimate the importance of the **administrative record**. Courts have said that, in many cases, the *only* evidence that a court can review is the “administrative record” which includes all documents such as your case file, letters between you and your plan, and any other information that was before the plan administrator at the time the decision to deny benefits was made. If the court decides this in your case, you cannot present new evidence or cross-examine adverse witnesses once you file suit. Therefore, *it is important to maintain a record with any information that might be helpful to your case before suit is filed*. Submit photographs of you and your family. Include statements from friends, neighbors, pastors and children.

If the administrative record at the time of the benefit denial contained insufficient evidence to allow the court to adequately review your claim, the court may send it back to the plan administrator for reconsideration after getting more evidence.¹⁷

CHAPTER VIII. FOOTNOTES

¹ *Donovan v. Dillingham* (11th Cir. 1982) 688 F.2d 1367, 1371.

² 29 Code of Federal Regulations section 2510.3-3(b).

³ 29 Code of Federal Regulations section 2510.3-3(c).

⁴ 29 United States Code section 1002(l).

⁵ 29 Code of Federal Regulations section 2510.3-1(j).

⁶ 29 Code of Federal Regulations § 2560.503-1(e).

⁷ 29 United States Code section 1133.

⁸ 29 Code of Federal Regulations section 2560.503-1(f).

⁹ 29 Code of Federal Regulations section 2560.503-1(h).

¹⁰ 29 United States Code section 1132 (a)(1)(B).

¹¹ 29 United States Code section 1132(c)(1).

¹² Department of Labor regulations at 29 C.F.R. § 2560.503-1(g)(ii).

¹³ *Daughtry v. Honeywell, Inc.* (11th Cir. 1993) 3 F.3d 488.

¹⁴ See *Marker v. Union Fidelity Life Ins. Co.* (M.D.N.C. 1989) 125 F.R.D. 121, aff'd per curiam, 907 F.2d 1138.

¹⁵ *Coffman v. Bowen* (4th Cir. 1987) 829 F.2d 514, 517.

¹⁶ See, e.g., *Salley v. E.I. DuPont de Nemours & Co.* (5th Cir. 1992) 966 F.2d 1011, 1016.

¹⁷ *Bernstein v. CapitalCare, Inc.* (4th Cir. 1995) 70 F.2d 783.

CHAPTER IX.

Your Health Care Coverage Options

MEDICARE

Medicare is a federal health insurance program that provides benefits for eligible individuals. There are three parts to the program: “Part A” is hospital insurance and “Part B” is medical insurance. Part “C,” Medicare+Choice, is a program created by the Balanced Budget Act of 1997 that was designed to give individuals new options in the way they receive health care, cut government spending, increase competition among Medicare providers, and provide new patient protections.

To find out if your are eligible, contact:

Health Insurance Counseling & Advocacy Program (HICAP)

1-800-824-0780 or 1-800-434-0222

<http://www.aging.state.ca.us/internet/programs/hicap.htm>

Other Resources:

- “It’s Your Choice: Are Medicare HMOs Right for You?” is a 27-page booklet that advises people currently in Medicare on the changes taking place in Medicare and what they mean. You can access this guide online at <http://www.consumer-action.org>.
- Access the Health Care Financing Administration Web site at: <http://www.hcfa.gov/medicare/mcarcnsm.htm>.

MEDI-CAL

Medi-Cal is California’s program to pay for medical care for some people receiving public assistance or who have a low income and meet other requirements. It is funded in large part with federal Medicaid funds.

Pregnant women should apply for Medi-Cal because it may be free for them. If they have more income than Medi-Cal allows, a program called **AIM (Access for Infants and Mothers)** may help. Call them at 1-800-433-2611.

To find out if you are eligible and to receive information on how to apply for Medi-Cal, call: 1-877-597-4777

You can obtain a Medi-Cal application from the county welfare office or another site in the community such as a clinic.

Other Resources:

Health Care Options

(800) 430-4263 (English and other languages)

(800) 430-3003 (Spanish)

(800) 430-7077 (TDD line for hearing impaired)

Medi-Cal Managed Care Education Project

(213) 532-3919

HEALTHY FAMILIES PROGRAM

Healthy Families is a state and federally-funded program that provides low-cost health insurance for many low-income children. With Healthy Families a family pays a small amount each month to receive health care for their children.

To be eligible for this program the applicants must:

- be low-income, uninsured California resident children ages 1 through 18 who are not eligible for Medi-Cal without a share of cost and who have no other health insurance.
- have too much income for the child to qualify for “free” Medi-

The child cannot have had any private insurance coverage during the three months before they apply to the Healthy Families program (there are a few exceptions).

The child stays eligible for 12 months continuously once it is decided that he or she is eligible, even if the parents’ income changes.

To apply: Call 1-800-880-5305 for a packet. Many community groups are assisting with applications. See <http://healthyfamilies.ca.gov/> for more information.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) AND CALIFORNIA CHILDREN SERVICES (CCS)

CHDP provides early and regular health exams for many low-income children up to 19 years of age; Medi-Cal eligible children up to 21 years of age; and Head Start and State preschool children. CHDP offers services including physical exams, immunizations, vision and hearing testing, lead poisoning testing, nutritional check, teeth and gum check, and some lab tests including sickle cell.

For more information and to find out if your child qualifies call 1-800-993-CHDP (1-800-933-2437).

Other Resources:

To obtain the **L.A. Coalition to End Hunger and Homelessness** pamphlet: “The People’s Guide to Welfare, Health and Other Services,” go to:

<http://www.peoplesguide.org> on the Internet, or write to:

LACEHH, Attn: Editor
548 S. Spring Street, Ste. 339,
Los Angeles, CA 90013
(\$0.50 per copy)

For more information on Medi-Cal for children, Healthy Families and other insurance options for kids who may not qualify for these programs, access the *Healthy Kids, Healthy Schools* Web site at:

<http://www.healthykidsproject.org>

Consumers Union

Healthy Kids, Healthy Schools Project Staff
1535 Mission Street
San Francisco, CA 94103-2512
(415) 431-6747
admin@healthykidsproject.org

CHAPTER IX. Footnote

¹ Excerpts reprinted with the permission of the Los Angeles Coalition to End Hunger and Homelessness from “The People’s Guide to Welfare & Other Services—How to Get Food & Money,” 2000 by the L.A. Coalition to End Hunger and Homelessness.

Appendix A

DEPARTMENT OF MANAGED HEALTH CARE'S CONSUMER COMPLAINT FORM

Complete, sign and fax or mail this form to the address below.

This form is also available online at: <http://www.dmhc.ca.gov/gethelp/complaint.asp>

DMHC use only _____

Call Ref.# _____

Complete this form if you have completed the complaint process with your health plan and are not satisfied with the resolution or if your health plan did not resolve your complaint within 30 days. However, if your complaint involves an imminent and serious threat to the health of the patient, immediately contact the Consumer Help Line toll free at (888) HMO-2219; or TDD (877) 688-9891. You may also call these phone numbers if you have any questions or need assistance completing this form.

*Upon completion, you may either fax this form to: (916) 229-0465
or mail it to:*

Department of Managed Health Care
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

1. Complainant's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Daytime: _____ Telephone Evening: _____

Cell Phone: _____ E-mail address: _____

2. *(Patient information—fill out only if different from Complainant)*

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

A P P E N D I X A

3. Health Plan Name: _____
Medical Group Name: _____
Medical Group number: _____ Patient's ID number _____
(or Membership number)

4. Are you a Medi-Cal Beneficiary? Yes ___ No ___
Are you a Medicare Beneficiary? Yes ___ No ___

5. Have you previously written to your health plan regarding this complaint? Yes _____ No _____
If YES, fill out the information below
Date(s) of contact: _____
Person(s) contacted: _____ Phone number: _____

If NO, you must first complete the complaint process with your health plan (see Consumer Complaint Process chapter VI, "How Does the Complaint Process Work?").

6. Please fully explain the essential facts of this complaint. What health plan service did you not receive? What was wrong with the service received? What billing issues do you have? Explain who, what, where, when, and how.
Please attach photocopies of any correspondence you received from the plan and any other documents that you believe support your complaint. Attach additional paper, if more space is needed.

7. Have you reported this to any other government agency? Yes ___ No ___
Agency _____ File number (if known): _____

8. Is there a lawsuit pending? Yes ___ No ___
If yes, attach a photocopy of the court documents and provide:
County where filed: _____ Case No. _____ Dated Filed: _____
Representing Attorney: _____ Telephone No.: _____

I understand that providing the information is not mandatory, but failure to do so may delay or even prevent further consideration of a resolution to my complaint. I understand that a copy of this complaint may be sent to my health plan.

Signature: _____ Date: _____

A P P E N D I X A

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Person Authorizing Release: _____ on behalf of (Patient): _____

hereby authorizes (Health Plan): _____ to release to the Department of Managed Health Care (Department) the medical record(s) in the custody and/or control of the Health Plan, including applicable mental health records, concerning care provided to the patient relating to the Complaint filed with the Department.

This authorization for release of information may be revoked or withdrawn at any time and revocation or withdrawal will apply to all information not previously released to the Department. This authorization will expire one year following the date indicated below and the expiration will apply to all information not previously released to the Department. Your medical records will only be obtained if it is determined to be necessary in order to complete a review of your Complaint. This information will be kept confidential.

THIS MEDICAL AUTHORIZATION IS NOT MANDATORY. HOWEVER, FAILURE TO SIGN THIS RELEASE MAY PREVENT FURTHER ASSISTANCE ON YOUR COMPLAINT.

Signature: _____ Date: _____

Please sign the Complaint Form and the Authorization for Release of Medical Records. Attach photocopies of all relevant documents and records as originals cannot be returned.

Fax these documents to: (916) 229-0465

or Mail to:

Department of Managed Health Care,
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT OF 1977

(California Civil Code Section 1798.17)

- a. The HMO Help Center of the Department of Managed Health Care of the State of California requests the information solicited by the forms attached to this Notice.
- b. The Chief Administrative Officer, 980 9th Street, Sacramento, CA 95814-2725, telephone number (916) 327-7659, is responsible for the system of records and shall, upon request, inform individuals regarding the location of the Department of Managed Health Care's records and the categories of persons who use the information in the Department of Managed Health Care's records.
- c. The Department of Managed Health Care's records are maintained pursuant to one or more of the following statutes: Health & Safety Code Sections 1344, 1351, 1351.1, 1352, 1353, 1368(b), 1368.02 and 1384.
- d. The submission of all items of information is voluntary.
- e. Failure to provide all or any part of the information requested by the attached form may preclude the HMO Help Center of the Department of Managed Health Care from reviewing your complaint.
- f. The principal purposes within the Department of Managed Health Care for which the information is to be used is as part of the process to determine: (1) whether a license, qualification, registration or other authority should be granted, denied, revoked or limited in any way; (2) whether business entities or individuals licensed or regulated by the Department of Managed Health Care are conducting themselves in accordance with the applicable laws; and/or (3) whether laws administered by the Department of Managed Health Care are being or have been violated and whether administrative action, civil action, or referral to appropriate federal, state or local law enforcement or regulatory agencies is appropriate.
- g. Any known or foreseeable disclosures of the information pursuant to subdivision (e) or (f) of Civil Code Section 1798.24 may include transfers to other federal, state, or local law enforcement or regulatory agencies.
- h. Subject to certain exceptions or exemptions, the Information Practices Act grants an individual a right of access to personal information concerning the requesting individual which is maintained by the Department of Managed Health Care. However, Government Code Section 6254 provides that records of complaints to or investigations conducted by the Department of Managed Health Care are exempt from disclosure except as required by law. Additionally, Evidence Code Section 1040 provides a privilege against disclosure of official information where a court determines that the necessity for confidentiality outweighs the public interest in disclosure.

Appendix B

VITAL STEPS TO RECEIVING THE HEALTH CARE YOU NEED—A CHECKLIST

- 1. Find out the reason that your health care plan is refusing to provide payment for a certain health care service or treatment. Get a copy of the denial letter and a copy of your current health plan booklet that contains a summary of your benefits and procedures to follow for payment.**

- ✓ **Is your health plan refusing to authorize a referral to a specialist?**

Remember that your health plan is required to make a decision as to whether to authorize a referral to a specialist within **3 business days** of when the request is made by you or your doctor and all necessary paperwork has been submitted to the plan.

- ✓ **Is the denial for a procedure that has already been performed and you are receiving bills from the health care provider that your plan has not paid?**

First, make sure that your doctor or the health care facility where you received treatment submitted any necessary paperwork to your health care plan. Call the doctor or service provider to get copies of any paperwork submitted. In this case, there could be a misunderstanding as to whether the doctor or facility where you received health care services is outside of the network of providers that your plan will provide full payment for. Or, perhaps your plan requires you to obtain authorization in advance for certain procedures. Did you or your doctor get the necessary authorization in advance from your health plan?

- ✓ **Is the service or treatment considered a “covered benefit?”**

Check your health plan’s “Evidence of Coverage” information that should be included in a document you received when you enrolled in the plan. Call your plan administrator to obtain a current copy if you don’t have one.

- ✓ **Is the care you need medically necessary?**

If so, you may have a right to have a denial of care by your health plan reviewed independently by an outside medical review organization approved by the Department of Managed Health Care. (See chapter VII of this guide).

- ✓ **Is the treatment you are seeking considered experimental or investigational?**

If so, there is a separate independent, external review process that you should follow. (See chapter VII of this guide)

- 2. Find out who the appropriate contact person is at your health care plan and at your doctor’s office or other treatment facility who handles questions regarding payment for health care services received.**

If your health care coverage is through your employer or your spouse’s employer, find out who the benefits manager is and talk to that person about how to get the denial of care by the health plan resolved.

3. If, after speaking with your doctor and the appropriate contacts with your health care plan, and/or employer, you still are unable to receive a satisfactory resolution, file a grievance with your health care plan and/or the Department of Managed Care.

- √ Your health plan must resolve your grievance within 30 days, in most cases.
- √ If you receive no resolution of a grievance filed with your health plan after 30 days, you may file a grievance with the Department of Managed Health Care. The Department should provide you with its decision within 30 days, unless it determines more time is needed.
- √ If there is a serious threat to your health if you do not receive treatment immediately, then you can submit a grievance directly to the Department of Managed Care without first having to go through your health plan's grievance procedure. (See chapter VI of this guide)

4. If your plan's denial of care was based on a decision that the particular treatment was not "medically necessary," and you do not receive a satisfactory resolution through your health plan's internal grievance process, ask for an independent review of your plan's decision.

- √ If you meet all the criteria as more fully outlined in chapter VII of this guide, you may be eligible to submit your dispute to an independent medical review process that is available through the Department of Managed Health Care. This decision as to whether your dispute is eligible for the independent review process is made by the Department of Managed Health Care.

5. If, after using the independent review process, you are still unable to obtain a satisfactory resolution, you may be able to file a lawsuit in state court to hold your health care plan responsible for its denials of care that resulted in harm to you.

- √ If your plan's decision to deny you care is based on a reason other than that the care was not medically necessary, then you may be able to file a lawsuit immediately without first having to go through the grievance process. (See chapter VII of this guide for more information on California's "right to sue" law.)

Appendix C

SAMPLE LETTER TO REQUEST EXPEDITED REVIEW OF A DENIAL OF COVERAGE

COVER LETTER BY FAX TO *
ORIGINAL WITH ALL
ENCLOSURES TO FOLLOW BY
FEDERAL EXPRESS

NOTE: This is a SAMPLE letter that should be used as a guide ONLY where emergency action on administrative review of a denial of care is needed. Where time permits, you should notify the administrator of the appeal and request copies of plan documents and the administrative record relied upon in the initial coverage denial.

12/19/00

Appeals Committee
HardRock Insurance Company
Outer Mellotopia, NY

Employer (Included since named as Plan Administrator)

Re: EMERGENCY REQUEST FOR EXPEDITED ADMINISTRATIVE REVIEW

Member Name: Sally Patient

Member I.D.: _____

Date of Denial of Service: 12/10/96

Greetings:

HardRock has denied coverage for an urgently needed procedure involving the use of High Dose Chemotherapy for Sally Patient's ovarian cancer, supported by Peripheral Stem Cell Rescue (HDC/PSCR). Because the treatment must begin immediately, we ask that her administrative appeal be addressed on an expedited basis.

SALLY PATIENT'S MEDICAL CONDITION

Your records show that Sally Patient suffers from Stage IV ovarian cancer involving a high grade tumor. She has undergone a hysterectomy and surgery, followed by rounds of conventional chemotherapy. Ms. Patient's physicians have successfully obtained a period of remission. However, given the severity of her cancer, the remission will not last long. She needs high-dose chemotherapy if she is to live. As you know, however, high dosages of chemotherapy cannot be administered unless supported by peripheral stem cell or bone marrow transplantation. Ms. Patient's physician's therefore have prescribed HDC/PSCR

If HDC/PSCR is to be effective, treatment must begin **immediately**, while Ms. Patient is enjoying this narrow window of remission. Stage IV ovarian cancer, particularly involving a high grade tumor, cannot be controlled over time using conventional dosages of chemotherapy. The period of remission that Ms. Patient now is enjoying will be very short. Once there is a recurrence, obtaining remission

again will be extremely difficult, if not impossible. It is for this reason that it is so urgent to begin treatment immediately.

Unless HardRock allows pre-certification of coverage for Ms. Patient's treatment, she will not be able to pay the cost. Without treatment, she will die. Your benefits plan calls for four levels of appeal and administrative review before Ms. Patient can file suit under ERISA. There is no practical way for Sally Patient to pursue her claim through these four levels of appeal with the time frames established by your plan if she is to live. I therefore ask that you review this matter on an expedited basis. Unless the plan can allow coverage immediately, we will file a civil action, seeking a temporary restraining order to halt further administrative action and a preliminary injunction to allow a court to decide this case.

MERITS OF SALLY PATIENT'S CLAIM

In Sally Patient's case, HDC/PSCR gives her the only true hope of long-term survival. Its efficacy as a treatment regime is well established. Her treating Oncologist, Dr. Really Good, is a highly respected physician who has given you information strongly supporting the use of the HDC/PSCR protocol in Ms. Patient's case. Thus, there is no reasonable medical basis for HardRock to deny coverage. The treatment requested is medically necessary and certainly would not be considered experimental under these conditions. To support Sally Patient's claim, I am enclosing the following documents:

1. Melphalan, Etoposide and Carboplatinum for the Treatment of Resistant Malignancy: A Phase II Trial, by R.A. Brown, J. Mortimer, J. DiPersio, *Washington University/Barnes Hospital BMT protocol #94-0077*.
2. Combination of Bone Marrow Transplant and High-Dose Chemotherapy Improves Survival in Ovarian Cancer, Research Report presented at the 18th Annual San Antonio Breast Cancer Symposium.
3. Role of Chemotherapy Dose Intensification in the Treatment of Advanced Ovarian Cancer, by David Fennelly, MB, MRCPI, Jeffrey Schneider, MD, *Oncology, October 1995*.
4. The Role of High-dose Chemotherapy in the Management of Advanced Ovarian Cancer, by David Fennelly, MB, FRCPI, *Rapid Science Publishers, 1996*.
5. Dose Escalation of Paclitaxel with High-Dose Cyclophosphamide, with Analysis of Progenitor-Cell Mobilization and Hematologic Support of Advanced Ovarian Cancer Patients Receiving Rapidly Sequenced High-Dose Carboplatin/Cyclophosphamide Courses, by D. Fennelly, J. Schneider, D. Spriggs, C. Bengala, T. Hakes, L. Reich, R. Barakat, J. Curtin, M.A.S. Moore, W. Hoskins, L. Norton, and J. Crown, *Journal of Clinical Oncology, Vol 13, No 5 (May), 1995: pp 1160-1166*.
6. Consolidation and Secondary Therapies for Ovarian Cancer, by Mace L. Rothenberg, Division of Medical Oncology, University of Texas Health Science Center, San Antonio, Texas 78284-7884.
7. Chemotherapeutic Dose Intensity in Ovarian Cancer, by Robert F. Ozols, MD, PhD., *Advances in Oncology, Vol 11, No 3*.
8. High-Dose Chemotherapy and Hematopoietic Progenitor Cell Support for Patients with Epithelial Ovarian Cancer, by Kenneth W. Kotz and Russell J. Schilder, *Seminars in Oncology, Vol 22, No 3 (June), 1995: pp 250-262*.

9. Chemotherapeutic Dose Intensity in Ovarian Cancer, by Robert F. Ozols, MD, PhD, *Advances in Oncology, Vol 11, No 3*.
10. Report from GOG #164
11. Report from GOG #9501 , and what additional information is needed to support the appeal.
12. "Office Personnel Management Policy" regarding coverage of HDC/PSCR for ovarian cancer under Federal Employees Health Benefits Programs.
13. State of Florida Policy regarding coverage of HCD for ovarian cancer.
14. High-Dose Chemotherapy with Autologous Hematopoietic Cell Support (AHCS) for the Treatment of Epithelial Ovarian Cancer.
15. Future Strategies for the Treatment of Advanced Epithelial Ovarian Cancer Using High-Dose Chemotherapy and Autologous Bone Marrow Support.
16. High-Doses of Melphalan and Autologous Marrow Rescue in Advanced Common Epithelial Ovarian Carcinomas: A Retrospective Analysis in 35 patients.
17. High-dose Chemotherapy with Autologous Bone Marrow Transplantation in Patients with Refractory Ovarian Cancer.
18. High-Dose Alkylating Agent Chemotherapy with Autologous Bone Marrow Support in Patients with Stage III/IV Epithelial Ovarian Cancer.
19. "Cancer Literature Medical Abstracts"
20. *Mary Jo FENIO*, Plaintiff, v. *MUTUAL OF OMAHA INSURANCE COMPANY*, Defendant. No. 94-1040 CIV.

Dr. Good has written to you under separate cover, but an additional copy of his letter is enclosed for your review as well.

ACTION REQUESTED

We genuinely hope that HardRock will allow coverage without the necessity of further action on our part. We want to cooperate with your plan as much as we can in the next few days, but we cannot compromise Ms. Patient's treatment needs in the process. So that we can move forward as quickly as possible, we ask that you do this:

1. If your plan will be retaining counsel, please have your attorney contact me immediately so that we can establish a clear line of communication for a rapid exchange of information.
2. If your plan is not retaining counsel at this point, please give me the name of a responsible party with whom I can communicate, and to whom pleadings can be directed if it becomes necessary to seek an emergency restraining order.
3. Please respond to this letter by the close of business on Monday, December 23. If we do not hear from you by that date, then it may be necessary to seek an emergency restraining order.

Thank you for your attention to this claim. I look forward to hearing from you or your counsel immediately.

Yours sincerely,

Enclosures (with original letter)

A P P E N D I X C

Appendix D

STRATEGIC ADVICE FOR PATIENTS: TACTICS TO USE AND UNDERSTAND

The patient denied treatment often faces an adversarial system. Your tactics must be those of negotiation.

Everything is negotiable—with the HMO, the HMO doctor, the HMO hospital. In a negotiation, establishing what is reasonable is the goal.

- What should a reasonable person have to do in order to document his or her need for treatment?
- What should a reasonable corporation have to provide and how long should it take?
- Is the company living up to the letter and spirit of state and/or federal law?

These are the types of standards someone negotiating with his or her HMO or HMO doctor must fight for.

Often HMOs do not concede expensive treatment without constant and repeated demands. Enough delays will equal a denial for a patient in need of critical care.

Reasonableness always includes a reasonable timetable. When will a decision be made to approve the care? Who is the decision-maker? How long will it take to schedule the procedure? What is the longest it will take before this doctor sees me?

The tactics of getting care from an HMO or HMO doctor may be no different than those involved in any other struggle against bureaucratic power. The major difference is that the patient is typically not in any condition to fight. That is why others close to them must take on that role. Patients themselves should make such contingency plans.

There are also some general rules one can always follow in dealing with HMOs, but these are no panacea, simply precautionary measures.

- **Write everything down.** Bring a notepad and pencil to all medical facilities and take notes on what your doctor tells you. This may feel uncomfortable, but it will help to keep track of your care, catch any errors, and provide a record should there be a question of inappropriate treatment. Also, write down the name of anyone you speak to on the phone, date the conversation occurred, and the outcome.
- **If you are denied care, ask for the denial in writing.** You will need a record of the denial if you want to dispute it. Write down all conversations if it becomes apparent that you are not receiving cooperation. Leaving a “paper trail” often helps to get results.
- **Find out the timelines.** There are many state regulations establishing the timeframe within which a treatment or coverage decision must be made (see chapters VI and VII of this guide.) Make sure everyone you deal with at the medical group or the HMO know that you know what those timelines are and make sure they stick to them. Also, as part of their marketing, most HMOs are accredited by non-government groups such as National Committee for Quality Assurance [www.ncqa.org], American Accreditation HealthCare Commission/URAC. (www.urac.org) and the Joint Commission on Accreditation of Health Care Organizations (www.jcaho.org). These organizations often have timeline requirements even more stringent than the state requirements. Find out if your HMO is a member of any of these organizations and if it is, find out that organization’s timeline requirements for the health plan’s decision-making process. Again, make sure the HMO knows that you know those timelines and that you expect them to be followed.
- **Complain to the accrediting organization.** Because HMOs rely so strongly on their accreditation by the non-governmental organizations (NCQA, URAC and JCAHO) in their marketing to employers and unions, they dislike having

complaints documented to those groups even less than they like having complaints on file with government regulators. In addition to copying your documentation to the state regulators, copy it to the accrediting organization or organizations that your HMO is a member of.

- **Find allies in the medical profession.** When medical experts advocate care, HMOs find it harder to deny treatment. Insist on a second or third opinion—from a qualified professional outside the HMO network, if necessary. If your HMO won't pay for a second opinion, pay out of your own pocket. It could save your life.
- **Ask how your doctor is paid.** Medicare recipients are entitled to see a summary of their physician's contract with their HMO, which details any financial incentives to withhold treatment. Doctors should increasingly provide such information to all patients. File a complaint with your state's medical board if you believe your doctor is withholding treatment for his or her own pecuniary gain.
- **Never take "no" for an answer.** Always ask if there are treatment options available for you other than those the HMO recommends. If you have a problem, take it up the ladder—fast. Enlist the help of your employer's personnel department if you get your health care through your work.
- **Never stay in a hospital by yourself.** Have a spouse, loved one or friend present at all times when you are in the hospital, even if that means sleeping in a chair. Having an advocate present to monitor what is happening around you, to make sure you get the treatment you need, is essential. If something goes wrong, he or she can act quickly to secure assistance.
- **Do not be intimidated.** Do not permit yourself to be intimidated by someone else's uniform, occupation, credentials and stature. You're paying the bills, not only as a consumer, but also as a taxpayer who helps fund the medical system. Write and call everyone you can think of in the HMO—the CEO, the Medical Director, the President of Marketing, the Board of Directors and the Ombudsman. Contact your elected

representatives for help. Write the newspapers. Enlist your doctor as an advocate for you whenever possible (good doctors will put aside any conflicts of interest to protect your health). Enlist your employer if you get your health care through your work.

But always maintain a reasonable, professional and calm demeanor, both in person and in writing—no matter how hard that is to do sometimes. If you lose control, make threats of violence or use foul language, you will simply be dismissed as a "crank," "flake," or "weirdo," and you will not accomplish your goal.

- **Get a lawyer if you need one.** Lawsuits are no fun. They can take years, involve endless and grueling maneuvering. Most who go through the process say they underestimated how hard it would be, especially to relive the medical trauma. And then, of course, there is the possibility that you have a legitimate case but will be unable get it into court, or prove it once you're there. Nevertheless, it may be necessary to consult an attorney regarding your legal options.

PATIENT ADVOCATE PRIMER: PERSUADE, PLAN, PASSION, PIN

To be an effective advocate for yourself or someone else, there are a host of principles you can follow and many excellent books on the methods of advocacy. But here is a primer.

Persuade

The most effective advocate is the most persuasive. Persuasion is the goal of all advocacy.

Persuasion is the goal of the written word, the spoken word, unspoken messages. The right words or action from the right person or people to the key decision-makers at the appropriate time is the equation for success in advocating any position.

A series of small victories at being persuasive equals a successful campaign.

Get the right doctors on your side who will then write to the correct medical director with the appropriate language and you are more likely to get care.

Perhaps one doctor is a stumbling block to you getting appropriate treatment. This physician may have a financial incentive (capitation) not to refer you to a specialist or for a test, because the money for these procedures comes out of the doctor's own pocket. Ironically, in this case, the HMO could be one important ally. If the HMO is not paying for the treatment, since the risk is shouldered by the doctor, the HMO has no disincentive to helping you compel the doctor to provide appropriate care.

Plan

Being persuasive starts with forming a strategy.

Who is the right decision-maker? What words will most influence them and from whom? How much time should I give them to reply? These questions must be asked before mapping a strategy for action.

Effective advocates do not make a first move without forming a strategy. The first formation of a strategy is a clear identification of your goal and your obstacles. The goal should be as specific as possible, but it may require many smaller goals to achieve a large one.

For instance, receiving a specific course of high-cost treatment may be your goal.

1. To achieve this you will have to map out much smaller goals.
2. Each of these smaller goals should have a timeline attached to them, leading up to the large goal.
3. Identify potential allies as well as obstacles.

MAIN GOAL: Proton-beam therapy to start by January—referral from medical group for out-of-network treatment.

OBSTACLE: Primary Care Doctor X and His Medical Group Do Not Want To Make Referral Because They Are Responsible For Treatment's Costs But No Qualified Specialist Exists Within Medical Group

ALLIES: Government regulators; the HMO (it is not paying for the treatment because it passed full risk to the medical group, so it might as well help you get the care); the specialists out-of-network who will provide the care.

SUB-GOALS — MAP OF GOALS

First Goal: Letter From Specialist Physician To Medical Group Medical Director Asking For Treatment, Noting No Qualified Specialist Exists In Medical Group

Timeline: By Tuesday

Second Goal: Official Letter From Patient To Medical Group Asking For Treatment And Requesting A Response By Next Monday

Time Line: Today

Third Goal: File Preliminary Complaint with Regulatory Agency

Timeline: By Wednesday

Fourth Goal: Specialist Physician To Follow-up On Letter With Phone Call To Medical Group Medical Director

Timeline: By End Of Week

Fifth Goal: File Complaint with HMO's Customer Service Department

Timeline: By Wednesday

Sixth Goal: Have HMO Officer Call Medical Group About Treatment

Timeline: By End of Week

By creating a work plan and mapping your strategy, you can chart the advancement or stalling of your strategy and react appropriately. Your strategy map is a formula for what is reasonable. When it runs astray, you should react proportionately.

Passion

Passion is essential to any effective advocacy effort. When a loved one's life and death is at stake, passion tends to enter the equation. But your goals must always be to establish what is reasonable and not let your anger fog the vision of what needs to be done or keep potential allies from helping you. That is not to say that you should not communicate the urgency of the situation with every contact you make. You should. But you must be under control and maintain good human relationships. You should cultivate allies, rather than simply making enemies. Keep your dignity and composure even as you communicate a sense of urgency about the life and death stakes of the situation.

In dealing with a difficult medical situation, a balance of passion and reason is essential. It will also help keep key decision-makers to deadlines.

It is your job as a patient's advocate to set those deadlines for the key decision-makers.

Patient Advocate: We sent you the medical records Thursday, I am just following up to make sure you received them so you can issue the approval for my sister's treatment. As you probably know, she is in much pain and, as the letter attached to her medical records indicates, she must receive this treatment immediately.

Administrator: I have received the paperwork, but it is going to take a little while to process. The medical director has not yet reviewed it. I do not know that he has everything he needs to make a decision. But we will call you as soon as he reviews it.

Patient Advocate: What is the name of the medical director who is making this decision?

Administrator: It will either be Doctor Green or Doctor Yellow.

Patient Advocate: How soon will Doctor Green or Doctor Yellow be reviewing the file?

Administrator: I cannot say. We understand the urgency of the situation and will do this as soon as possible.

Patient Advocate: My sister is in so much pain. I need to give her a timeframe. What is your deadline for making this decision?

Administrator: I am certain they will look at the files this week, but they may need additional information, or to talk to the doctors involved. They will certainly begin the process this week. If they have everything they need, I am sure the decision will be made soon.

Patient Advocate: May I speak to Doctor Yellow or Doctor Green?

Administrator: They are not available. They are in a meeting. They will get to your sister's file as soon as they can, ma'am. Please be patient.

Patient Advocate: I understand you are all very busy. I just would like a timeline for this decision so I can talk with my sister about her options. You understand, don't you?

Administrator: Of course.

Patient Advocate: Can you give me a timeline?

Administrator: I am sorry, ma'am. I can't.

Patient Advocate: I am sorry, your name was Debbie ____.

Administrator: Debbie Red.

Patient Advocate: And who is your Supervisor?

Administrator: Dr. Orange.

Patient Advocate: And who is Doctor Yellow and Doctor Green's Supervisor?

Administrator: Dr. Orange.

Patient Advocate: Is Dr. Orange available?

Administrator: Let me transfer you to his Secretary.

Patient Advocate: Before you do that, will you please leave a message for Doctor Green or Doctor Yellow, whichever will take care of this file, to call me.

Administrator: Yes, ma'am. I have your number. Let me transfer you to Doctor Orange's office.

Pin

"Pinning" is the art of getting a timeframe for a decision and working through the hierarchy in this or any other organization. To pin is to narrow a commitment, a timeframe, a decision. You pin someone down to either get a commitment or more information that will lead to a commitment from a decision-maker. It is especially helpful in this scenario to know what the timelines are that are established by the appropriate state regulations or the applicable accrediting organization. Communicate to the administrator that you know what those timelines are and that you expect them to be complied with.

The commitment is, of course, the goal of what you are pinning for but in some conversations it will be impossible to get a commitment because you are not speaking to a decision-maker.

A P P E N D I X D

Chain of Command

Every hierarchy has a chain of command. HMOs are nothing if not hierarchies. If a customer service representative cannot help you, talk to his or her supervisor immediately. If the supervisor cannot assist in the timeframe necessary, contact his or her boss, the division head, the medical director, the chief executive officer. Go as far up the chain of command as fast as possible. People make decisions most effectively when they feel that making the wrong decision will jeopardize their position.

Finding the chain of command and utilizing it is the modus operandi of pinning down a decision in the corporation. You must remember who you are talking to and the purpose of your conversation. The so-called administrator in the above example was not a decision-maker, but an “informer”—someone who could landscape how the company worked and what the chain of authority was. It would make no sense to argue with this employee about the details of the patient’s condition, coverage or state law’s requirements about covering the patient’s condition. The purpose of this conversation was to find out who to write the letter detailing these facts to and putting the best case forward.

Know who you are talking to at an HMO. It makes no sense to argue your case before a bailiff, you must find the judge.

Sizing up an employee means a persistent but friendly conversation—pushing the limits of the conversation as far as they go, and gathering information. Persistence is the key to effective information gathering and pinning. Most people, however, are uncomfortable pushing the cusp of a conversation beyond what may be considered good manners. These are inhibitions which must be forgotten when an HMO jeopardizes a patient’s health.

The documentation, research and advocacy you contribute to this process can help change things for the better for others. When all else fails, or does not appear to be succeeding in time, enlist others who can help even the balance of power between the patient and the corporation, such as advocacy groups and the media. The level of what is reasonable that you help to establish for yourself or loved one will help clear access to care for those in the future.

Excerpted from Jamie Court and Frank Smith, *Making a Killing: HMOs and the Threat to Your Health* (Common Courage Press) ©1999.

<http://www.makingakilling.org>

Appendix E

USEFUL CODE SECTIONS OF THE CALIFORNIA KNOX-KEENE HEALTH CARE SERVICE PLAN ACT AND REGULATIONS ¹

Doctor-Patient Relationship/Assurance of Quality Care/Continuity of Care/Emergency Care

§ 1342 Intent and Purpose of Legislature — (a) Ensures the continued role of the professional (doctor) as the determiner of your health needs and fosters the traditional relationship of trust and confidence between you and your doctor.

(g) Ensures that you receive available and accessible medical services providing for continuity of care.

§1348.6 Contracts between Health Care Service Plans and Licensed Health Care Practitioners; Prohibition on Certain Incentive Plans

— Prohibits contracts between your health plan and your doctor, or doctor's group, that contain any type of incentive plan which encourages the denial, limitation or delay of specific medically necessary treatments. Does not prohibit capitated payment agreements, wherein doctors are paid a fixed budget for all patients they treat, as long as the payment agreements do not pertain to your doctor making specific medical decisions.

§1367 Requirements for referrals/medical decisions — (d) Your health plan must provide medical services to you providing for continuity of care and ready referral to other providers when good professional practice requires such. (g) Your health plan must assure that medical decisions are made by qualified medical providers, without influence of fiscal or administrative management.

Code of Regulations § 1300.67 Scope of Basic Health Care Services — sets forth the basic health care services required to be provided by a health care service plan to its enrollees, including the availability of emergency services.

Code of Regulations § 1300.67.1 Continuity of Care

— requires that basic health care services shall be provided in a manner which provides continuity of care, including but not limited to:

- (a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;
- (c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee;
- (d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;
- (e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

¹ All code section references are to the California Health & Safety Code. The Knox-Keene Health Care Service Plan Act sets forth the requirements that health care plans must follow. You can access the entire Knox-Keene Act online on the Department of Managed Health Care's Web site at: http://www.dmhc.ca.gov/library/lawregs/knox_keene/knoxkeene.txt

The regulations referenced are standards that further define your rights under the Knox-Keene Act. You can find them at Title 28 of the California Code of Regulations. You can access them online at: <http://www.calregs.com/>

Code of Regulations § 1300.67.2 Accessibility of Services — provides that health services must be readily accessible within each service area of a plan, including that “the location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility” and “that there shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.”

Code of Regulations § 1300.67.3 Standards for Plan Organization — (a)(1) provides that plans must separate medical services from administrative and financial management so that the medical decisions will not be “unduly influenced by fiscal and administrative management.”

Code of Regulations § 1300.67.4 Subscriber and Group Contracts — (a)(3)(A) provides that a benefit cannot be subject to any reduction or limitation that would render the benefit illusory.

Code of Regulations § 1300.70 Quality Assurance Program — sets forth the standards for plans to include in their quality assurance program including that such a program shall be designed to, among other things, ensure that health care providers or institutions are not pressured to render care beyond the scope of their training or experience. Plans that have capitation or risk-sharing contracts must “ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations” and the plan must “have systems in place to monitor QA functions.”

§1363.5 Authorization or Denial of Services; Process; Disclosures; Criteria — Your plan must disclose to the Director of the Department of Managed Health Care and network providers the process under which the company authorizes, modifies or denies health care services. This information also must be made available to you upon request.

§1367.01 Written policies and procedures for review and approval or denial of services

— Your plan must have written policies and procedures establishing the process by which it reviews and approves, modifies, delays, or denies health care services based in whole or in part on medical necessity.

§1371.4 Emergency Services and Care; Authorization; Payments Providers; Treatment Following Stabilization; Payments to Providers; Assumption and Delegation of Responsibilities

— Your health plan must pay for you to receive emergency services until which time you are stabilized. Your health plan must pay for 24 hour access when your emergency condition has been stabilized but your treating provider deems you too unsafe to discharge. Even if you are not at an HMO-contracted hospital you may receive treatment until the treating provider stabilizes your condition. Once you have been stabilized, your plan may require pre-authorization for medical care after you have been stabilized. If your plan disagrees with your treating provider’s recommendation for medical care once you have been stabilized, the plan must have their own medical personnel take over your care or transfer you to one of their facilities.

Code of Regulations § 1300.71.4 Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services — In addition to the requirement that your plan pay for all services until you are stabilized, your plan must approve or disapprove your health care provider’s request for authorization to provide necessary post-stabilization medical care within 30 minutes of the request.

§1380 Onsite Medical Survey of Health Delivery System of Plan — The DMHC shall conduct periodic medical surveys of your plan to determine the overall performance of your plan in the delivery of health care. These surveys must be made open to public inspection within 180 days of completion of the survey unless the director of the DMHC requires more time for a full and fair report. You may receive a single copy of a summary of the final report’s findings free of charge upon request to the DMHC.

Second Opinion / Grievance Procedures / Independent Review

§1383.1 Second Medical Opinions; Policy Statement of Plan; Notice to Enrollees

— Your plan must provide you with information regarding how and under what circumstances you may receive a second medical opinion.

§1383.15 Second opinion — Your health plan must provide or authorize a second opinion by an appropriately qualified health care professional who has the training and expertise relating to your particular condition for which you are requesting a second opinion.

§1368 Grievance System — Your health plan must have a grievance system in place that you may submit your grievance to. The plan must adequately consider and rectify grievances. Your plan must notify you upon enrollment and annually thereafter where and how to file a grievance, including the appropriate location and phone number to contact. After participating in your plan's grievance system for 30 days, you may submit your grievance to the Department of Managed Health Care for review. In cases where there is a serious threat to your health, however, you may submit your grievance to the Department without having to participate in your plan's process for thirty days.

§1368.01 Resolution Period; Grievance Status and Disposition Statement; Expedited Review

— (a) Your plan's grievance system must resolve your grievance within 30 days.

(b) Your plan must provide for expedited reviews in cases where there is an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Your plan must inform you and the Department of Managed Health Care (DMHC) in writing of their expedited review decision, or its pending status, no later than 72 hours after receiving the grievance.

§1368.02 Complaints About Health Care Service Plans, Toll-Free Number; Notice of Number; Ombudsperson

— You may call the DMHC for assistance when you have a grievance involving an emergency, your plan has not satisfactorily resolved your grievance, or your grievance has remained unresolved for more than 30 days. Your plan must provide you with the DMHC's toll-free complaint hotline number in your plan contract, "Evidence of Coverage" document and any grievance process documents you receive.

§1370.4 Independent Review Process; Experimental and Investigational Therapies for Individual Enrollees; Requirements; Definitions; Accreditation; Record

— Your plan must have an external, independent review process to review the

plan's decisions regarding experimental or investigational therapies when you meet specific requirements including, but not limited to, having a life-threatening condition and standard therapies have not helped to improve your condition.

§ 1374.30 Independent Review System

— Commencing January 1, 2001, all enrollees in health care service plans have the right to an "independent review" of any disputed health care service, including any denial, delay or modification by the plan of a covered health care service due to a finding that the service is not medically necessary. This review is conducted by an independent medical review organization approved by the Department of Managed Health Care. Your health care plan must inform you of this right in your member handbook, plan contract or other evidence of coverage forms.

§ 1374.31 Imminent threat to health;

Expedited review — When your health is seriously threatened, all necessary documents must be transferred from your plan to the independent review organization within 24 hours after your request for independent review is approved. In "extraordinary and compelling cases" the Department may grant your request for review without your having participated in your plan's grievance process.

§ 1374.34 Disputed health care service; Review; Reimbursement for urgent care; Audit of cases

— Your plan must act promptly to provide you with services that are determined through the independent review process to be medically necessary and may not do anything to prolong the independent review process. If you had to secure urgent care outside of your plan's network for services that were later found to be medically necessary, your plan must reimburse you for the cost of those services.

**Plan Contracts/Documents/
Advertising**

§ 1352.1 New or Modified Plan Contract; Publication or Distribution of Disclosure Form or Evidence of Coverage

— All "Evidence of Coverage" documents written by your plan must not be deceptive, untrue or misleading.

Code of Regulations § 1300.52.1 Material Modification to Plan Contract

— Any material modification to a plan contract must be preapproved by the Department of Managed Health Care.

§1360 (b)(3) Advertising or Solicitation; Written or Printed Statement or Item; Verbal Statement

— All coverage statements and promises made verbally by your HMO must be held to the same standards as those for printed matter.

§1361 Advertising; Requirements; Correction or Retraction — All advertisements by your plan must meet the same level of scrutiny as any other plan document, such as your health care contract. Advertisements cannot be false or misleading. All advertising documents must be sent to the DMHC by your plan.

§1363 Disclosure Forms; Contents; Uniform Health Plan Benefits and Coverage Matrix

— Your health plan must use disclosure forms that indicate all benefits, services and terms of your contract with the company. The disclosure forms must be in clearly organized and readily understandable, and include any limitations of coverage, full cost of premiums, co-payment requirements, renewal terms, and the like.

Code of Regulations §1300.63 Disclosure Forms — sets forth the specific requirements to which a plan's disclosure forms must conform.

§1395 Soliciting and Advertising; Nature of Plan; Operation; Ownership by a Professional; Construction — Your plan's advertisements may not refer to services or costs, or use "words of comparison" (e.g. "lowest prices") unless the plan has verifiable data to substantiate the claims. Your plan cannot advertise prices that are fraudulent, misleading or deceitful.

Prescription Drugs

§1367.20 Prescription Drug Benefits; Formulary List

— Every health care plan that provides prescription drug benefits and maintains one or more lists of drugs covered by the plan (known as a "drug formulary") must provide a copy of the list to members of the public upon request. The list must be broken down by health categories and indicate whether any drugs on the list are preferred over other drugs.

§1367.21 Prescription Drugs Under Health Care Service Plans; Nonapproved Uses

— Health plans that provide prescription drug benefits are prohibited from excluding coverage for drugs that your doctor prescribes for a use other than the use that has been approved for marketing

by the federal Food and Drug Administration (FDA)(known as an "off-label use"), when the drug is 1) approved by the FDA; 2) prescribed by a licensed health care professional that contracts with the plan for a life-threatening or chronic and seriously debilitating conditions; and 3) the drug has been recognized for treatment of that condition by one of the medical sources specified in the statute. If you are denied coverage for an off-label use of a drug pursuant to this section on the basis that its use is experimental or investigational, that decision is subject to the independent review process under section 1370.4. (Medi-Cal plans are exempt from the requirements of this code section)

§1367.215 Requests for pain management medications for terminally ill patients; time in which authorized or denied — Every health plan that provides prescription drug benefits must provide coverage for appropriately prescribed pain management medications for terminally ill patients when medically necessary. The plan must approve requests for authorization of coverage for a terminally ill patient within 72 hours.

§1367.22 Prescription drug benefits; coverage for drugs approved before July 1, 1999

— Any health plan contract that is issued, amended, or renewed on or after July 1, 1999 that covers prescription drug benefits may not limit or exclude coverage for a drug that had been previously prescribed to you when a plan doctor continues to prescribe the drug, provided that the drug is appropriately prescribed and is considered safe and effective. The doctor is not prohibited from prescribing another drug covered by the plan that is medically appropriate for the patient, nor are generic drug substitutions prohibited.

§1367.24 Authorization for nonformulary prescription drugs — Every plan that provides prescription drug benefits must maintain an expeditious process through which doctors can obtain authorization for drugs which are not on the list of drugs specifically covered by the plan (nonformulary prescription drugs). A description of the process must be on file with the Department of Managed Health Care, including timelines. If your plan denies a request for authorization for a nonformulary drug, it must provide the reasons for the denial in a notice to you and notify you that you have a right to file a grievance with the plan if you object to the denial.

Glossary

acute condition or illness – a condition or illness that only lasts for a short period of time and usually is stopped with the appropriate care without requiring ongoing treatment. A common cold is an acute illness, as is a heart attack, because these conditions are short-lived and do not necessarily require continued care.

administrative record – all the papers, documents and recorded testimony in a proceeding before a health plan’s administrative body.

appeal – review of a health plan decision regarding a patient’s health care with which the patient and/or his or her doctor disagrees. An “appeal” can refer to both review through the plan’s own grievance process and a review by other outside decision-makers, such as the Department of Managed Health Care and independent medical review organizations.

arbitrary or capricious – depending on individual discretion and not fixed by standards or rules; lacking a rational basis.

arbitration – a process of resolving disputes out of court through the use of a neutral decision-maker that is usually agreed to by contract.

authorization – approval by a health care plan required in order for a patient to receive health care, including specific treatments, procedures or tests.

bad faith – willful failure to carry out legal obligations.

battery – an unlawful act of applying force to the person of another without consent.

capitation payment – a fixed, lump-sum paid to doctors by health care plans, typically on a monthly basis, to care for patients regardless of condition.

chronic condition or illness – a condition or illness that requires ongoing treatment for a long period of time that may extend over a person’s entire lifetime.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA is a law that gives certain employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. COBRA applies to group health plans with 20 or more employees in the private sector and those sponsored by state and local governments.

copayment – a fixed sum of money paid by a patient each time he or she receives certain health care services. For example, plans may charge a copayment of \$10 for a visit to a doctor’s office, above and beyond what the health plan pays the doctor.

conservatorship – a legal relationship created when a person, official, or institution is designated to take over and protect the interests of someone who is incompetent.

continuity of care – medical treatment received without interruption.

contract – an agreement between a health plan and a patient or his or her employer that describes what health care services are covered by the plan, how much the plan will pay for those services, and what premiums must be paid by the patient or his or her employer. A plan usually also has a contract with certain doctors who will provide health care services to members of the plan.

contracted provider – a hospital, doctor, or other health care provider who has an agreement with a health care plan to provide health care services to members of the plan.

coverage – a process by which a health plan determines what health care services or products will be paid for by the plan.

damages – monetary compensation in a legal action awarded to someone who has been injured by another.

Declaration Under The Natural Death Act

– a legal document that any person of sound mind over the age of 18 can execute that will govern the withholding or withdrawal of life-sustaining treatment. (California Health & Safety Code section 7186.5)

denial of care – a decision made by a health care plan not to pay for (or provide coverage for) a particular health care service or product.

Department of Managed Health Care (DMHC) – the state agency in California with the authority to regulate health care plans.

<http://www.dmhc.ca.gov>

Phone: (888) HMO-2219 or (800) 400-0815

Durable Power of Attorney For Health Care

– a legal document that designates a person to make certain health care decisions, as directed in the document, on a person’s behalf when that person is unconscious or otherwise unable to

communicate with a treating doctor. (see California Probate Code section 4606, et. seq.)

duty of ordinary care – an obligation owed by one person to another to avoid injury to him or her.

emergency care – medical care provided to patients with severe, life-threatening conditions that require urgent attention.

emergency medical condition – a medical condition that in the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

emotional distress – a highly unpleasant emotional reaction (as anguish, humiliation, or fury) that results from another’s conduct and for which damages may be sought.

employer group health plan – a package of medical benefits provided to all employees by their employer, usually through an HMO or network of approved doctors.

ERISA, “Employee Retirement Income Security Act of 1974” – a federal law that regulated pension, health and welfare benefits offered by employers to their employees. Under ERISA, some employer group health plans are exempt from state laws and regulations that govern insurance.

Evidence of Coverage – a detailed summary of health care services that is available to patients under a certain health care plan, usually provided upon enrollment in the plan.

exhaustion - using all available means of review before proceeding to the next level of review.

experimental or investigational treatments – a treatment that a doctor recommends for a particular illness that may not be the standard method of treatment; health care plans may often refuse to cover costs for treatments that they consider experimental or investigational.

fiduciary relationship – a relationship created when one person owes a legal duty to act for the benefit of another; the physician/patient relationship is considered a “fiduciary relationship.”

fraud – intentional deception or concealing of facts that results in an injury to another.

gag rules – any provision in a health care plan contract that may limit a doctor’s ability to communicate freely with his or her patients regarding patients’ health care options. California law prohibits health plans from putting gag rules in their contracts.

grievance – a complaint by a patient to the administration of a health care plan; such complaints may relate to quality of care, a denial or delay of coverage for a treatment or product, or disputes over the amount that a plan has paid towards health services received.

grievance review process – process that all health plans are required to establish internally in order to review complaints by patients about any decisions by the plan that negatively impact a patient’s ability to receive quality health care. The Department of Managed Care also has a grievance review process in place that will review patients’ grievances if they receive no satisfactory resolution through their health plan.

group health plan or group coverage – a health plan which is offered through a specified group of people, such as employees of a particular employer or members of an association.

guardianship – a relationship created for one to take over the care of the person or property of another, often a minor.

health care “contractors” – various entities under contract with your health care plan that may include medical groups, independent practice associations, pharmaceutical benefits managers, and medical service organizations that are not themselves a health care service plan or health care provider.

Health Care Financing Administration (HCFA) – federal agency that runs the Medicare and Medicaid programs.

health care provider – a qualified licensed professional such as a doctor, dentist, optometrist, etc. or an institution such as a hospital, clinic, nursing facility, etc., that provides health care services to patients under a contract with a health care plan.

health care service plan – used in California law to refer to any person or entity that arranges for health care services to be provided to subscribers or enrollees, or to pay for or reimburse any part of the cost for those services, in exchange for a

Glossary *continued*

prepaid or periodic charge paid by or on behalf of the subscribers or enrollees. HMOs are examples of health care service plans. All health care service plans are subject to regulation by the Department of Managed Health Care.

Health Insurance Portability And Accountability Act or HIPAA (also known as the Kassebaum-Kennedy Act) – the federal law designed to allow employees to move freely from one job to another without the risk of becoming uninsured for their most serious health problems. This law sets limits on the ability of health care plans to exclude coverage for “preexisting conditions.”

health maintenance organization (HMO) – an HMO is the most common form of a managed health care plan under which health services are delivered and paid for through one organization. An HMO requires its participants to use only certain health providers and hospitals, usually those within its own network.

independent medical review organizations – organizations that will contract with the Department of Managed Health Care to conduct reviews of certain denials of treatment by health care plans. These organizations are subject to qualifications set by the Department of Managed Health Care and must be entirely independent of any health plan.

independent practice associations (IPA) – an association of physicians and other health care providers, who contract with an HMO to provide services to enrollees, but usually still see non-HMO patients and patients from other HMOs.

independent review process – a process administered by the Department of Managed Health Care to review health plans’ denials of care decisions based on medical necessity. The process is “independent” of your health care plan.

individual health plan – health care insurance that you purchase in the private market that is not a part of any “group health plan” provided through an employer or other organization.

informed consent – consent to medical treatment by a patient, or to participation in a medical experiment by a subject, after achieving an understanding of the risks and benefits.

injunction – a legal remedy to stop a party from continuing to perform a particular action.

judgment – a final decision by a court as to the rights of parties to a lawsuit.

liable – to be responsible for; to be obligated by law.

liaison – person that establishes and maintains communication between two parties in order to achieve mutual understanding and cooperation.

Major Risk Medical Insurance Program (MRMIP) – a state-operated program that provides health care to qualifying Californians unable to obtain health insurance in the private market due to serious health conditions. The program is provided through contracts with various health plans. Participants in the program are responsible for the cost of program premiums, and the program supplements those premiums to cover the cost of care from the state’s tobacco tax funds.

managed care – a method of financing and delivering health care for a set fee using a network of physicians and other health care providers. The network coordinates and refers patients to its health providers and hospitals, and monitors the amount and patterns of care delivered. Managed care plans usually limit what services patients may receive by using “gatekeepers” to make sure services considered unnecessary or referrals outside the network are kept to a minimum.

Medicaid/Medi-Cal – a joint federal and state program that provides health insurance to low income people who meet specific eligibility requirements.

Medical Information Bureau (MIB) – MIB is a company that keeps a database of medical record information on individuals as provided to them by insurance companies who subscribe to their services. Insurance companies use information obtained from MIB to make decisions regarding your eligibility for coverage at the time of application for insurance benefits.

medical malpractice – negligent care provided to a patient by a doctor or managed care plan that results in harm to the patient.

medical records – any information about you, in electronic or physical form, regarding your medical history, mental or physical condition, or treatment in the possession of or derived from an HMO, health insurer, or any health care provider

are subject to California laws protecting your medical record confidentiality.

medically necessary – health care products and services that are considered to be appropriate and would assist in the diagnosis or treatment of a disease.

Medicare – a federal health insurance program that provides medical benefits to all persons over age 65 who receive Social Security benefits or are disabled and meet specific eligibility requirements.

morbidity – a diseased state.

negligence – failure to exercise the degree of care that a reasonable person would exercise in the same circumstances.

networks of health care providers – groups of hospitals, physicians, and other providers that offer health care plans and patients an organized, comprehensive system of care.

ombudsman – a problem solver who assists patients with complaints, either working directly for a health care plan or an outside agency.

pain and suffering – a type of damages awarded in a lawsuit for physical and mental injury that result from a wrong done or suffered.

participating provider – a hospital or doctor who has a contract with a health care plan to provide health care services to the patients of that plan for a specified rate. Patients will usually be charged lower or no out-of-pocket fees when they use participating providers.

patient/physician relationship – the relationship established between you and your doctor when he or she begins treating you that gives rise to a number of legal obligations on the part of your doctor to ensure that you receive continued health care.

plan contract – an agreement between a health care plan and its subscribers or enrollees pursuant to what health care services are provided.

plan medical director or administrator – an employee of a managed health care plan that has the authority to approve or deny coverage for patients in accordance with the terms of the plan.

preexisting condition – a condition that was diagnosed or treated within a certain period (six months under CA and federal law) prior to the

patient's joining a particular health care plan. Plans may only limit coverage for preexisting conditions for up to six months, in most cases.

Preferred Provider Organization (PPO) – a large group of hospitals and doctors under contract to a managed care plan who deliver services for set fees. In a PPO, patients must choose their health provider from an approved list and must pay extra for specialty services received outside the PPO group.

punitive damages – a monetary award for the injured party who prevails in a lawsuit that serves to punish the wrongdoer, usually where there has been malicious or willful misconduct.

referral – authorization by a doctor or health care plan to receive other health care services under the plan such as diagnostic tests or care from a specialist.

specialist – a doctor who has received extensive training in a specific area of medicine.

specialty care center – a center that is accredited or designated by an agency of the state or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening, or degenerative and disabling, disease or condition for which it is accredited or designated.

stabilized – state reached when one's physical condition is considered within normal ranges of function.

standard of review – the term used to describe on what basis a court will review a lower court's decision.

status-based discrimination – being treated differently on the basis of one's sex, race, class, medical condition or other distinguishing characteristic.

statute of limitations – the time within which a person may file a particular type of lawsuit, after which such actions will not be allowed.

substance abuse – using drugs or medications in manner that is harmful to one's health.

transfer – to move or transport to another facility.

utilization review – process in a health care plan to determine whether a particular health care treatment is medically necessary and appropriate for a patient's needs.



THE FOUNDATION FOR TAXPAYERS AND CONSUMER RIGHTS
1750 Ocean Park Blvd., Suite 200 • Santa Monica CA 90405-4938