

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 617

Introduced by Assembly Member Nazarian

February 20, 2013

An act to amend ~~1341.1 of the Health and Safety Code Section 100501 of, and to add Sections 100506.1, 100506.2, 100506.3, 100506.4, and 100506.5 to, the Government Code~~, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 617, as amended, Nazarian. ~~Health care coverage—California Health Benefit Exchange: appeals.~~

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified. Existing law establishes the California Health Benefit Exchange (Exchange) to implement the federal law. Existing law also requires the Exchange board to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations.

This bill would require the Exchange board to contract with the State Department of Social Services to serve as the Exchange appeals entity designated to hear appeals of eligibility determination or redetermination for persons in the individual market. The bill would establish an appeals process for initial eligibility determinations and

redetermination, including an informal resolution process, as specified, establishing procedures and timelines for hearings with the appeals entity, and notice provisions. The bill would also establish continuing eligibility for individuals during the appeals process.

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the establishment and operation of a principal office and branch offices of the Director of the Department of Managed Health Care.~~

~~This bill would make technical, nonsubstantive changes to that provision.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes. State-mandated local program: no.

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

- 1 SECTION 1. Section 100501 of the Government Code is
- 2 amended to read:
- 3 100501. For purposes of this title, the following definitions
- 4 shall apply:
- 5 (a) “Board” means the board described in subdivision (a) of
- 6 Section 100500.
- 7 (b) “Carrier” means either a private health insurer holding a
- 8 valid outstanding certificate of authority from the Insurance
- 9 Commissioner or a health care service plan, as defined under
- 10 subdivision (f) of Section 1345 of the Health and Safety Code,
- 11 licensed by the Department of Managed Health Care.
- 12 (c) “Exchange” means the California Health Benefit Exchange
- 13 established by Section 100500.
- 14 (d) “Federal act” means the federal Patient Protection and
- 15 Affordable Care Act (Public Law 111-148), as amended by the
- 16 federal Health Care and Education Reconciliation Act of 2010
- 17 (Public Law 111-152), and any amendments to, or regulations or
- 18 guidance issued under, those acts.
- 19 (e) “Fund” means the California Health Trust Fund established
- 20 by Section 100520.
- 21 (f) “Health plan” and “qualified health plan” have the same
- 22 meanings as those terms are defined in Section 1301 of the federal
- 23 act.

1 (g) “SHOP Program” means the Small Business Health Options
2 Program established by subdivision (m) of Section 100502.

3 (h) “State health subsidy program” means a program described
4 in Section 1413(e) of the federal act.

5 ~~(h)~~

6 (i) “Supplemental coverage” means coverage through a
7 specialized health care service plan contract, as defined in
8 subdivision (o) of Section 1345 of the Health and Safety Code, or
9 a specialized health insurance policy, as defined in Section 106 of
10 the Insurance Code.

11 SEC. 2. Section 100506.1 is added to the Government Code,
12 to read:

13 100506.1. An applicant or enrollee has the right to appeal any
14 of the following:

15 (a) An action or inaction related to the individual’s eligibility
16 for a state health subsidy program, or for advance payment of
17 premium tax credits and cost-sharing reductions, the amount of
18 the advance payment of the premium tax credit and level of cost
19 sharing, or eligibility for affordable plan options.

20 (b) An eligibility determination for an exemption from the
21 individual responsibility penalty pursuant to Section 1311(d)(4)(H)
22 of the federal act.

23 (c) A failure to provide timely notice of an eligibility
24 determination or redetermination.

25 SEC. 3. Section 100506.2 is added to the Government Code,
26 to read:

27 100506.2. (a) The entity making a determination of eligibility
28 described in Section 100506.1 shall provide notice of the appeals
29 process at the time of application and determination of eligibility.

30 (b) The entity making a determination of eligibility described
31 in Section 100506.1 shall also issue a combined eligibility notice,
32 as defined by Section 435.4 of Title 42 of the Code of Federal
33 Regulations, that shall contain all of the following:

34 (1) Information about each state health subsidy program for
35 which an individual or multiple family members of a household
36 have been determined to be eligible or ineligible and the effective
37 date of eligibility and enrollment.

38 (2) Information regarding the bases of eligibility for
39 non-Modified Adjusted Gross Income (MAGI) Medi-Cal and the
40 benefits and services afforded to individuals eligible on those

1 bases, sufficient to enable the individual to make an informed
 2 choice as to whether to appeal the determination.

3 (3) An explanation that the applicant or enrollee may appeal
 4 an action or inaction related to an individual's eligibility for a
 5 state health subsidy program with which the applicant or enrollee
 6 is dissatisfied by requesting a hearing consistent with Section
 7 100506.4 and the provisions of Chapter 7 (commencing with
 8 Section 10950) of Part 2 of Division 9 of the Welfare and
 9 Institutions Code.

10 (4) Information on the applicant or enrollee's right to represent
 11 himself or herself or to be represented by legal counsel or an
 12 authorized representative as provided in subdivision (f) of Section
 13 100506.4.

14 (5) An explanation of the circumstances under which the
 15 applicant's or enrollee's eligibility may be maintained or reinstated
 16 pending an appeal decision, pursuant to Section 100506.5.

17 SEC. 4. Section 100506.3 is added to the Government Code,
 18 to read:

19 100506.3. The board shall enter into a contract with the State
 20 Department of Social Services to serve as the Exchange appeals
 21 entity designated to hear appeals of eligibility determination or
 22 redetermination for persons in the individual market, pursuant to
 23 Section 100506 and Subpart F of Part 155 of Title 45 of the Code
 24 of Federal Regulations. Except as otherwise provided in this title,
 25 the hearing process shall be governed by the Medi-Cal hearing
 26 process established in Chapter 7 (commencing with Section 10950)
 27 of Part 2 of Division 9 of the Welfare and Institutions Code.

28 SEC. 5. Section 100506.4 is added to the Government Code,
 29 to read:

30 100506.4. (a) (1) Except as provided in paragraph (2), the
 31 State Department of Social Services, acting as the appeals entity,
 32 shall allow an applicant or enrollee to request an appeal within
 33 90 days of the date of the notice of an eligibility determination.

34 (2) The appeals entity shall establish and maintain a process
 35 for an applicant or enrollee to request an expedited appeals
 36 process where there is immediate need for health services because
 37 a standard appeal could seriously jeopardize the appellant's life,
 38 health, or the ability to attain, maintain, or regain maximum
 39 function. If an expedited appeal is granted, the decision shall be
 40 issued within three working days or as soon as is required by the

1 *appellant's condition. If an expedited appeal is denied, the appeals*
2 *entity shall notify the appellant within two days by telephone or*
3 *electronic media, to be followed in writing, of the denial of an*
4 *expedited appeal. If an expedited appeal is denied, the appeal shall*
5 *be handled through the standard appeal process.*

6 *(b) Appeal requests may be submitted to the appeals entity by*
7 *telephone, by mail, in person, through the Internet, or by facsimile.*

8 *(c) The staff of the Exchange may assist the applicant or enrollee*
9 *in making the appeal request.*

10 *(d) (1) Upon receipt of an appeal, the appeals entity shall send*
11 *timely acknowledgment to the appellant that the appeal has been*
12 *received. The acknowledgment shall include information relating*
13 *to the appellant's eligibility for benefits while the appeal is*
14 *pending, an explanation that advance payments of the premium*
15 *tax credit while the appeal is pending are subject to reconciliation,*
16 *an explanation that the appellant may participate in informal*
17 *resolution pursuant to subdivision (g), and information regarding*
18 *how to initiate informal resolution.*

19 *(2) Upon receipt of an appeal, the appeals entity shall send, via*
20 *secure electronic interface, timely acknowledgment of the appeal*
21 *to the entity that made the determination of eligibility being*
22 *appealed.*

23 *(3) Upon receipt of the notice of appeal from the appeals entity,*
24 *the entity that made the determination of eligibility being appealed*
25 *shall transmit, either as a hard copy or electronically, the*
26 *appellant's eligibility record for use in the adjudication of the*
27 *appeal to the appeals entity.*

28 *(4) Upon receipt of an appeal that fails to meet the requirements*
29 *of this section, the appeals entity shall promptly and without undue*
30 *delay send written notice to the appellant that the appeal is not*
31 *accepted and the reason why. The appellant shall be given an*
32 *opportunity to cure, if possible, and the appeals entity shall accept*
33 *amended appeals that fulfill all the requirements for appeal,*
34 *including timeliness.*

35 *(e) A member of the board, employee of the Exchange, a county,*
36 *the Managed Risk Medical Insurance Board (MRMIB), or the*
37 *appeals entity shall not limit or interfere with an applicant or*
38 *enrollee's right to make an appeal or attempt to direct the*
39 *individual's decisions regarding the appeal.*

1 (f) An applicant or enrollee may be represented by counsel or
2 designate an authorized representative to act on his or her behalf,
3 including, but not limited to, when making an appeal request and
4 participating in the informal resolution process provided in
5 subdivision (g).

6 (g) An applicant or enrollee who files an appeal shall have the
7 opportunity for informal resolution, prior to a hearing, that
8 conforms with all of the following:

9 (1) The appellant's right to a hearing shall be preserved if the
10 appellant is dissatisfied with the outcome of the informal resolution
11 process.

12 (2) If the appeal advances to a hearing, the appellant shall not
13 be required to provide duplicative information or documentation
14 that he or she previously provided during the application,
15 redetermination, or informal resolution processes.

16 (3) The informal resolution process shall not delay the timeline
17 for a provision of a hearing.

18 (4) For eligibility determinations for state health subsidy
19 programs based on modified adjusted gross income (MAGI), the
20 appellant may initiate the informal resolution process with the
21 entity that made the eligibility determination, except that all of the
22 following shall apply:

23 (A) The Exchange shall conduct informal resolution involving
24 issues related only to the Exchange, including, but not limited to,
25 exemption from the individual responsibility penalty pursuant to
26 Section 1311(d)(4)(H) of the federal act, offers of affordable
27 employer coverage, special enrollment periods, and eligibility for
28 affordable plan options.

29 (B) Counties shall conduct informal resolution involving issues
30 related to non-MAGI Medi-Cal.

31 (C) MRMIB shall conduct informal resolution involving issues
32 related only to the Access for Infants and Mothers Program or the
33 Healthy Families Program.

34 (5) The staff involved in the informal resolution process shall
35 try to resolve the issue through a review of case documents, and
36 shall give the appellant the opportunity to review case documents,
37 verify the accuracy of submitted documents, and submit updated
38 information or provide further explanation of previously submitted
39 documents.

1 (6) *The informal resolution process set forth by the State*
2 *Department of Health Care Service’s Manual of Policies and*
3 *Procedures Section 22-073 shall be used for the informal*
4 *resolutions pursuant to this subdivision.*

5 (h) (1) *A position statement, as required by Section 10952.5 of*
6 *the Welfare and Institutions Code, shall be electronically available*
7 *at least two working days before the hearing on the appeal.*

8 (2) *The appeals entity shall send written notice, electronically*
9 *or in hard copy, to the appellant of the date, time, and location of*
10 *the hearing no later than 15 days prior to the date of the hearing.*
11 *If the date, time, and location of the hearing are prohibitive of*
12 *participation by the appellant, the appeals entity shall make*
13 *reasonable efforts to set a reasonable, mutually convenient date,*
14 *time, and location.*

15 (3) *The format of the hearing may be telephonic, video*
16 *teleconference, or in person.*

17 (4) *The hearing shall be an evidentiary hearing where the*
18 *appellant may present evidence, bring witnesses, establish all*
19 *relevant facts and circumstances, and question or refute any*
20 *testimony or evidence, including, but not limited to, the opportunity*
21 *to confront and cross-examine adverse witnesses, if any.*

22 (5) *The hearing shall be conducted by one or more impartial*
23 *officials who have not been directly involved in the eligibility*
24 *determination or any prior appeal decision in the same matter.*

25 (6) *The appellant shall have the opportunity to review his or*
26 *her appeal record and all documents to be used by the appeals*
27 *entity at the hearing, at a reasonable time before the date of the*
28 *hearing as well as during the hearing.*

29 (7) *Cases and evidence shall be reviewed de novo by the appeals*
30 *entity.*

31 (i) *Decisions shall be made within 90 days from the date the*
32 *appeal is filed, or as soon as administratively feasible, and shall*
33 *be based exclusively on the application of the eligibility rules to*
34 *the information used to make the eligibility decision, as well as*
35 *any other information provided by the appellant during the course*
36 *of the appeal. The content of the decision of appeal shall include*
37 *a decision with a plain language description of the effect of the*
38 *decision on the appellant’s eligibility, a summary of the facts*
39 *relevant to the appeal, an identification of the legal basis for the*

1 decision, and the effective date of the decision, which may be
 2 retroactive.

3 (j) Upon adjudication of the appeal, the appeals entity shall
 4 transmit the decision of appeal to the entity that made the
 5 determination of eligibility via a secure electronic interface.

6 (k) If an appellant disagrees with the decision of the appeals
 7 entity, he or she may make an appeal request regarding issues
 8 relating to the Exchange to the federal Health and Human Services
 9 Agency within 30 days of the notice of decision through any of the
 10 methods in subdivision (b).

11 (l) An appellant may also seek judicial review to the extent
 12 provided by law.

13 (m) Nothing in this section, or in Sections 100506.1 and
 14 100506.2, shall limit or reduce an appellant's rights to notice,
 15 hearing, and appeal under Medi-Cal, county indigent programs,
 16 or any other public programs.

17 SEC. 6. Section 100506.5 is added to the Government Code,
 18 to read:

19 100506.5. For appeals of redeterminations, upon receipt of
 20 notice from the appeals entity that it has received an appeal, the
 21 entity that made the redetermination shall continue to consider
 22 the applicant or enrollee eligible while the appeal is pending in
 23 accordance with the level of eligibility immediately before the
 24 redetermination being appealed.

25 SECTION 1. ~~Section 1341.1 of the Health and Safety Code is~~
 26 ~~amended to read:~~

27 ~~1341.1. The director shall have his or her principal office in~~
 28 ~~the City of Sacramento, and may establish branch offices in the~~
 29 ~~City and County of San Francisco, in the City of Los Angeles, and~~
 30 ~~in the City of San Diego. The director shall from time to time~~
 31 ~~obtain the necessary furniture, stationery, fuel, light, and any other~~
 32 ~~proper convenience for the transaction of the business of the~~
 33 ~~Department of Managed Health Care.~~