Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 238 **VERSION:** AMENDED JUNE 19, 2023

AUTHOR: WIENER **SPONSOR:** CHILDREN NOW

PREVIOUS POSITION: SUPPORT

SUBJECT: HEALTH CARE COVERAGE: INDEPENDENT MEDICAL REVIEW

Summary: Under current law, consumers have a right to request an independent medical review of their health insurance plan's finding that a requested health care service is not medically necessary. The consumer must first file a grievance with their plan and undergo a 30-day review process, at which point the consumer can then decide to request the independent medical review.

This bill seeks to reduce barriers to mental health care for children and young adults, by making the independent medical review process automatic, rather than consumer-initiated, for mental health treatment and substance use disorder treatment denials for children and young adults up to age 26.

Existing Law:

1) Requires every health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage, to also provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. (Health and Safety Code (HSC) §1374.72(a)(1), Insurance Code (IC) §10144.5(a)(1))

2) Defines "mental health and substance use disorders" as a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. (HSC §1374.72(a)(2), IC §10144.5(a)(2))

3) States that "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the patient's specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms - including minimizing its progression – in a manner that is all of the following (HSC §1374.72((a)(3), IC §10144.5(a)(3)):

a) In accordance with generally accepted standards of mental health and substance use disorder care;

b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

c) Not primarily for the economic benefit of the health care service plan or disability insurer and its subscribers/insureds or for the convenience of the patient, treating physician, or other health care provider.

4) Requires the covered benefits to include basic health care services, intermediate services, including residential treatment, partial hospitalization, and intensive outpatient treatment, and prescription drugs (if the plan includes prescription drug coverage). (HSC §1374.72(b), IC §10144.5(b))

5) Establishes within the state an Independent Medical Review System, under which a health plan enrollee can request review of grievances involving a disputed health care service, if specified requirements are met. (HSC §1374.30(a) and (d), IC §10169(a) and (d))

6) Defines a "disputed health care service" as any health care service eligible for coverage and payment under a health care service plan or disability insurance contract that has been denied, modified, or delayed by a decision of the plan or insurer due to a finding that it is not medically necessary. (HSC §1374.30(b), IC §10169(b))

7) Permits an enrolled or insured person to apply for an independent medical review based on medical necessity once they have filed a grievance with their plan or insurer and the disputed decision is upheld or the grievance remains unresolved after 30 days. (HSC §1374.30(j)(3), IC §10169(j)(3))

8) Requires health care service plans and disability insurers to prominently display information on the right of an enrollee or insured to request an independent medical review in every plan or insurance contract, evidence of coverage forms, copies of plan or insurer procedures for resolving grievances, on letters of denials, on grievance forms, and on all written responses to grievances. (HSC §1374.30(i) IC §10169(i))

9) Requires that independent medical review organizations the state contracts with shall be independent of any health care service plan or disability insurer doing business in this state. (HSC §1374.32(a), IC §10169.2(a))

10) Requires the state to adopt the determination of the independent medical review organization, and to promptly issue a written decision to the parties that is binding on the health plan or insurer. (HSC §1374.33(f), IC §10169.3(f))

This Bill:

1) Requires beginning July 1, 2024, a health care service plan or disability insurer that modifies, delays, or denies a health care service based on medical necessity to automatically submit its decision and the information that informed the decision, within 24 hours to the state's Independent Medical Review System without requiring the enrollee to submit a grievance, if the decision is to deny, modify, or delay either of the following for an enrollee up to age 26 (HSC §1374.37(a)(1), IC §10169.6(a)(1)):

   a. A mental health care or substance use disorder service based on consideration of medical necessity; or

   b. The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies if the enrollee has a seriously debilitating or life-threatening mental health or substance use disorder condition.

2) Requires that the health care service plan or disability insurer must notify the enrollee, their representative, the regulating department, and the provider within 24 hours after submitting its decision to the Independent Medical Review System, providing them with copies of specified documents, as well as notice that they may cancel the independent medical review at any time before a determination is made, and that they may provide additional information or documentation. (HSC §1374.37(b), IC §10169.6(b))

3) Provides that this does not apply to Medi-Cal managed care plan contracts. (HSC §1374.37(e))

Comments:

1) **Author's Intent.** The author's office notes that the state's Independent Medical Review (IMR) process is available to consumers whose insurance or health plan has denied a health service because the plan deems it either not medically necessary, or experimental. However, the consumer must initiate this review process after first filing a grievance with their insurance plan and going through a 30 day review process. In the IMR process, an outside provider not affiliated with the insurance plan then reviews the case and makes a determination, which the insurance plan must follow.

   In their fact sheet for the bill, the author's office states the following:

   "While the IMR process allows for greater oversight of health plans, it places the burden on the consumer and delays or prevents children and youth in California from accessing critical, timely mental health treatment. Language barriers, health literacy, and demanding jobs may prevent some parents from filing IMRs, furthering mental health access inequities." "Under SB 238 all children's mental health

treatment denials will be referred to the IMR process. SB 238 will ensure families who do not have the time or ability to file a complaint — or who simply don't know about the process — would have their claims automatically reviewed and young people will receive faster access to treatment."

The author's office also cites the following statistics in their fact sheet:

"Through the IMR process, the diagnosis category of "Mental Disorder" has steadily increased for youth under the age of 21, especially between 2017-2022. In 2021, more than 50% of all youth IMR cases were for a "mental disorder" diagnosis. According to the DMHC Annual Report, approximately 67.5% of enrollees that submitted IMR requests in 2021 received the service(s) or treatment(s) they requested. Of those decisions, 17% were reversed by the health plan before being reviewed, 51% of cases denied by health plans were overturned by IMR providers, and 32% were upheld. In the first quarter of 2022, over 90% of mental health IMRS were overturned or reversed; in the second quarter, it was 82%. Since 2017, the percentage of IMRs overturning health plans' decisions has more than doubled."

2) **Previous Board Position.** At its May 5, 2023 meeting, the Board considered a previous version of this bill and took a "support" position. Substantive amendments to the bill have been made since that time.

3) **Previous Legislation.**

- SB 855 (Chapter 151, Statutes of 2020) required health care service plans or disability insurance policies to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions.

- AB 88 (Chapter 534, Statutes of 1999) required health plans and insurers to provide coverage for the diagnosis and medically necessary treatment of severe mental illness (for persons of any age), and for serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions.

Support and Opposition.

Support

Children Now (sponsor)
Access Reproductive Justice
AFSCME
AIDS Healthcare Foundation
Alliance of Californians for Community Empowerment (ACCE) Action
Autism Speaks
California Alliance of Child and Family Services
California Black Health Network

California Council of Community Behavioral Health Agencies (CBHA)
California Life Sciences
California Medical Association
California Pan - Ethnic Health Network
Center for Autism and Related Disorders (CARD); the
Children's Partnership, the
County Behavioral Health Directors Association of California
Culver City Democratic Club
DBSA California
Didi Hirsch Mental Health Services
Friends Committee on Legislation of California
Health Access California
MCG Health
National Association of Social Workers, California Chapter
National Health Law Program
Steinberg Institute
The Los Angeles Trust for Children's Health
Western Center on Law & Poverty, INC.

Oppose

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

History

06/28/23 From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 3.) (June 27). Re-referred to Com. on APPR.
06/19/23 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
06/01/23 Referred to Com. on HEALTH.
05/25/23 In Assembly. Read first time. Held at Desk.
05/24/23 Read third time. Passed. (Ayes 32. Noes 7. Page 1277.) Ordered to the Assembly.
05/22/23 Read second time. Ordered to third reading.
05/18/23 Read second time and amended. Ordered to second reading.
05/18/23 From committee: Do pass as amended. (Ayes 5. Noes 2. Page 1161.) (May 18).
05/12/23 Set for hearing May 18.
04/24/23 April 24 hearing: Placed on APPR suspense file.
04/18/23 Set for hearing April 24.
04/17/23 Read second time and amended. Re-referred to Com. on APPR.
04/13/23 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (April 12).
04/03/23 Set for hearing April 12.

03/29/23 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
03/27/23 March 29 set for first hearing canceled at the request of author.
03/20/23 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
03/20/23 Set for hearing March 29.
02/01/23 Referred to Com. on HEALTH.
01/25/23 From printer. May be acted upon on or after February 24.
01/24/23 Introduced. Read first time. To Com. on RLS. for assignment. To print.

AMENDED IN ASSEMBLY JUNE 19, 2023

AMENDED IN SENATE MAY 18, 2023

AMENDED IN SENATE APRIL 17, 2023

AMENDED IN SENATE MARCH 29, 2023

AMENDED IN SENATE MARCH 20, 2023

SENATE BILL No. 238

Introduced by Senator Wiener (Coauthors: Senators Gonzalez and Newman) (Coauthor: Assembly Member Garcia)

January 24, 2023

An act to add Section 1374.37 to the Health and Safety Code, and to add Section 10169.6 to the Insurance Code, relating to health care coverage.

legislative counsel's digest

SB 238, as amended, Wiener. Health care coverage: independent medical review.

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 the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.

This ~~bill~~ *bill, commencing July 1, 2024,* would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.

The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the ~~bill.~~ *bill, and to issue interim guidance, as specified.*

Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Disputed health care service decisions under commercial health care coverage are already subject to review like the state's Independent Medical Review System, but appeals must be initiated by enrollees and insureds.

(b) Mental health resources in California are disproportionately hard to access for low-income and minority children, and the online form to file an independent medical review is in English and Spanish only.

(c) The Legislature recently approved Chapter 151 of the Statutes of 2020, a mental health parity law that requires commercial health care service plan contracts and disability insurance policies to provide medically necessary mental health treatment.

(d) In California, 13 percent of children 3 to 17 years of age, inclusive, reported having at least one mental, emotional, developmental, or behavioral health problem, and 8 percent of children have a serious emotional disturbance that limits participation in daily activity.

(e) In 2021, mental health disorder diagnosis cases made up 48 percent of all total youth independent medical reviews, up from 36 percent in 2017.

(f) Since 2017, the percentage of health care service plan and disability insurer decisions about youth mental health disorders that were overturned by the Independent Medical Review System has more than doubled to 79 percent.

(g) Like older adults, children and youth represent a vulnerable population. However, children and youth covered by commercial health care coverage do not have the protections afforded by Medicare procedures. If a Medicare Advantage (Part C) health plan upholds its initial adverse organization determination to deny a drug or service, the plan must automatically submit the case file and its decision for review by the Part C Independent Review Entity.

SEC. 2. Section 1374.37 is added to the Health and Safety Code, to read:

1374.37. (a) (1) ~~A~~ *Commencing July 1, 2024, a* health care service plan that modifies, delays, or denies a health care ~~service,~~ *service* based in whole or in part on medical necessity consistent with this chapter, including, but not limited to, Sections 1363.5, 1367.01, 1374.72, and 1374.721, shall automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System and all information that informed the health care service plan's conclusion, without requiring an enrollee to submit a grievance, if the decision is to deny, modify, or delay either of the following with respect to an enrollee up to 26 years of age:

(A) A mental health care or substance use disorder service based on consideration of medical necessity.

(B) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the enrollee has a seriously debilitating or life-threatening mental health or substance use disorder condition, as defined in Section 1370.4. The independent medical review for experimental or investigational therapies, drugs, devices, procedures, or other therapies shall be consistent with Section 1370.4.

(2) An independent medical review required under this subdivision is subject to any relevant provisions of this article that do not otherwise conflict with the express requirements of this section.

(b) (1) Within 24 hours after submitting its decision to the Independent Medical Review System pursuant to subdivision (a), the health care service plan shall provide notice to the department, the enrollee, the enrollee's representative, if any, and the enrollee's provider. The notice shall include both of the following:

(A) Notification to the enrollee that the enrollee or their representative may cancel the independent medical review at any time before the rendering of a determination and may provide additional information or documentation as described in paragraph (3) of subdivision (m) of Section 1374.30.

(B) Instructions for canceling the independent medical review and submitting additional information or documentation.

(2) Concurrent with the notice specified in paragraph (1), the health care service shall provide the enrollee and the enrollee's provider with copies of all documents described in subdivision (n) of Section 1374.30.

(c) Sections 1374.72, 1374.721, 1374.724, and 1374.73 apply for purposes of this section.

(d) If an enrollee or their representative cancels the independent medical review consistent with this section, they may seek an independent medical review consistent with Section 1370.4 or this article.

(e) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 10169.6 is added to the Insurance Code, to read:

10169.6. (a) (1) ~~A~~ *Commencing July 1, 2024, a* disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity consistent with this chapter, including, but not limited to, Sections 10123.135, 10144.5, and 10144.52, shall automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System and all information that informed the disability insurer's conclusion, without requiring an insured to submit a grievance, if the decision is to deny, modify, or delay either of the following with respect to an insured up to 26 years of age:

(A) A mental health care or substance use disorder service based on consideration of medical necessity.

(B) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the insured has a seriously debilitating or life-threatening mental health or substance use disorder condition, as defined in Section 10145.3. The independent medical review for experimental or investigational therapies, drugs, devices, procedures, or other therapies shall be consistent with Section 10145.3.

(2) An independent medical review required under this subdivision is subject to any relevant provisions of this article that do not otherwise conflict with the express requirements of this section.

(b) (1) Within 24 hours after submitting its decision to the Independent Medical Review System pursuant to subdivision (a), the disability insurer shall provide notice to the department, the

insured, the insured's representative, if any, and the insured's provider. The notice shall include both of the following:

(A) Notification to the insured that the insured or their representative may cancel the independent medical review at any time before the rendering of a determination and may provide additional information or documentation as described in paragraph (3) of subdivision (m) of Section 10169.

(B) Instructions for canceling the independent medical review and submitting additional information or documentation.

(2) Concurrent with the notice specified in paragraph (1), the disability insurer shall provide the insured and the insured's provider with copies of all documents described in subdivision (n) of Section 10169.

(c) Sections 10144.5, 10144.51, 10144.52, and 10144.57 apply for purposes of this section.

(d) If an insured or their representative cancels the independent medical review consistent with this section, they may seek an independent medical review consistent with Section 10145.3 or this article.

(e) *(1)* The commissioner may *issue guidance regarding compliance with this section, no later than January 1, 2027. The guidance not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this paragraph shall remain in effect until the commissioner promulgates regulations pursuant to paragraph (2).*

(2) The commissioner may promulgate regulations subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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