Assembly Bill No. 617

Passed the Assembly August 27, 2014

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Chief Clerk of the Assembly

Passed the Senate August 26, 2014

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2014, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Sections 100501.1, 100506.1, 100506.2, 100506.3, 100506.4, and 100506.5 to the Government Code, and to amend Sections 10950, 10951, and 10960 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 617, Nazarian. 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 board of the Exchange to establish an appeals process for prospective and current enrollees of the Exchange that complies with all of the 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 board of the Exchange to contract with the State Department of Social Services to serve as the Exchange appeals entity designated to hear appeals of eligibility or enrollment determination or redetermination for persons in the individual market or exemption determinations within the Exchange's jurisdiction. The bill would establish an appeals process for eligibility or enrollment determinations and redeterminations for insurance affordability programs, as defined, or exemption determinations within the Exchange's jurisdiction, 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 a process for continuing eligibility for individuals during the appeals process. The bill would make other related changes, and would specify that certain provisions only be implemented to the extent they do not conflict with federal law.

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

SECTION 1. Section 100501.1 is added to the Government Code, to read:

100501.1. For purposes of this title, the following definitions shall apply:

(a) "Insurance affordability program" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(3) A program that makes available to qualified individuals coverage in a qualified health plan through the Exchange with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under Section 1402 of the federal act.

(b) "Combined eligibility notice" means an eligibility notice that informs an individual, or multiple family members of a household, of eligibility for each of the insurance affordability programs and for enrollment in a qualified health plan through the Exchange, for which a determination of eligibility was made.

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

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

(a) Any action or inaction related to the individual's eligibility for or enrollment in an insurance affordability program, or for advance payment of premium tax credits and cost-sharing reductions, or the amount of the advance payment of the premium tax credit and level of cost sharing, or eligibility for affordable plan options.

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

(c) A failure to provide timely or adequate notice of an eligibility determination or redetermination or an enrollment-related determination.

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

100506.2. (a) The entity making an eligibility or enrollment determination described in Section 100506.1 shall provide notice of the appeals process at the time of application and at the time of eligibility or enrollment determination or redetermination.

(b) The entity making an eligibility or enrollment determination described in Section 100506.1 shall also issue a combined eligibility notice after the Director of Health Care Services determines in writing that the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed for the implementation of this section, but no later than July 1, 2017. The combined eligibility notice shall contain all of the following:

(1) Information about eligibility or ineligibility for Medi-Cal, premium tax credits and cost-sharing reductions, and, if applicable, for the Medi-Cal Access Program, for each individual, or multiple family members of a household, that has applied, including all of the following:

(A) An explanation of the action reflected in the notice, including the effective date of the action.

(B) Any factual bases upon which the decision is made.

(C) Citations to, or identification of, the legal authority supporting the action.

(D) Contact information for available customer service resources, including local legal aid and welfare rights offices.

(E) The effective date of eligibility and enrollment.

(2) Information regarding the bases of eligibility for non-modified adjusted gross income (MAGI) Medi-Cal and the benefits and services afforded to individuals eligible on those bases, sufficient to enable the individual to make an informed choice as to whether to appeal the eligibility determination or the date of enrollment, which may be included with the notice in a separate document.

(3) An explanation that the applicant or enrollee may appeal any action or inaction related to an individual's eligibility for or enrollment in an insurance affordability program with which the

applicant or enrollee is dissatisfied by requesting a state fair hearing consistent with this title and the provisions of Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code.

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

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

(c) This section shall be implemented only to the extent it does not conflict with federal law.

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

100506.3. (a) The board shall enter into a contract with the State Department of Social Services to serve as the Exchange appeals entity designated to hear appeals of eligibility or enrollment determination or redetermination for persons in the individual market, or exemption determinations within the Exchange's jurisdiction. To the extent applicable, the provisions of this title, Subpart F of Part 155 of Title 45 of the Code of Federal Regulations, and Article 7 of Chapter 12 of Title 10 of the California Code of Regulations shall govern the Exchange hearing process. If those provisions are not applicable, the Medi-Cal hearing process established in Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code shall govern the Exchange hearing process.

(b) This section shall be implemented only to the extent it does not conflict with federal law.

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

100506.4. (a) (1) Except as provided in paragraph (2), the State Department of Social Services, acting as the appeals entity, shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of an eligibility or enrollment determination, or exemption determination within the Exchange's jurisdiction, unless there is good cause as provided in Section 10951 of the Welfare and Institutions Code.

(2) The appeals entity shall establish and maintain a process for an applicant or enrollee to request an expedited appeals process where there is immediate need for health services because a standard appeal could seriously jeopardize the appellant's life, health, or the ability to attain, maintain, or regain maximum function. If an expedited appeal is granted, the decision shall be issued as expeditiously as possible, but no later than five working days after the hearing, unless the appellant agrees to a delay to submit additional documents for the appeals record. If an expedited appeal is denied, the appeals entity shall notify the appellant within three days by telephone or through other commonly available secure electronic means, to be followed by a notice in writing, within five working days of the denial of an expedited appeal. If an expedited appeal is denied, the appeal shall be handled through the standard appeal process.

(b) Appeal requests may be submitted to the appeals entity by telephone, by mail, in person, through the Internet, through other commonly available electronic means, or by facsimile.

(c) The staff of the Exchange, the county, or the State Department of Health Care Services or its designee shall assist the applicant or enrollee in making the appeal request.

(d) (1) Upon receipt of an appeal, the appeals entity shall send timely acknowledgment to the appellant that the appeal has been received. The acknowledgment shall include information relating to the appellant's eligibility for benefits while the appeal is pending, an explanation that advance payments of the premium tax credit while the appeal is pending may be subject to reconciliation if the appeal is unsuccessful, an explanation that the appellant may participate in informal resolution pursuant to subdivision (g), information regarding how to initiate informal resolution, and an explanation that the appellant shall have the opportunity to review his or her entire eligibility file, including information on how an income determination was made and all papers, requests, documents, and relevant information in the possession of the entity that made the decision that is the subject of the appeal at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued.

(2) Upon receipt of an appeal request, the appeals entity shall send, via secure electronic means, timely notice of the appeal to

the Exchange and the county, and the State Department of Health Care Services or its designee if applicable.

(3) Upon receipt of the notice of appeal from the appeals entity, the entity that made the determination of eligibility or enrollment being appealed shall transmit, either as a hardcopy or electronically, the appellant's eligibility and enrollment records for use in the adjudication of the appeal to the appeals entity.

(e) A member of the board, employee of the Exchange, a county, the State Department of Health Care Services or its designee, or the appeals entity shall not limit or interfere with an applicant's or enrollee's right to make an appeal or attempt to direct the individual's decisions regarding the appeal.

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

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

(1) A representative of the entity that made the eligibility or enrollment determination shall contact the appellant or the appellant's appropriately authorized representative and offer to discuss the determination with the appellant if he or she agrees.

(2) The appellant's right to a hearing shall be preserved if the appellant is dissatisfied with the outcome of the informal resolution process. The appellant or the authorized representative may withdraw the hearing request voluntarily or may agree to a conditional withdrawal that shall list the agreed-upon conditions that the appellant and the Exchange, county, or the State Department of Health Care Services or its designee shall meet.

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

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

(5) The informal resolution process is voluntary and neither an appellant's participation nor nonparticipation in the informal

resolution process shall affect the right to a hearing under this section.

(6) For eligibility or enrollment determinations for insurance affordability programs based on modified adjusted gross income (MAGI), the appellant or the appellant's appropriately authorized representative may initiate the informal resolution process with the entity that made the determination, except that all of the following shall apply:

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

(B) Counties shall conduct informal resolution involving issues related to non-MAGI Medi-Cal eligibility or enrollment decisions.

(C) The State Department of Health Care Services or its designee shall conduct informal resolution involving issues related to eligibility or enrollment determinations for programs when the State Department of Health Care Services is the entity making the determination.

(7) The staff involved in the informal resolution process shall try to resolve the issue through a review of case documents, in person or through electronic means as desired by the appellant, and shall give the appellant the opportunity to review case documents, verify the accuracy of submitted documents, and submit updated information or provide further explanation of previously submitted documents.

(8) The informal resolution process set forth by the State Department of Social Services for Medi-Cal fair hearings shall be used for the informal resolutions pursuant to this subdivision and shall require the Exchange, county representative, or the State Department of Health Care Services or its designee to do the following:

(A) Review the file to determine the appropriateness of the action and whether a hearing is needed.

(B) Attempt to resolve the matter if the action was incorrect.

(C) Determine whether a dual agency appeal is required to resolve the matter at hearing and notice the other agency if not already included.

(D) Determine whether interpretation services are necessary and arrange for those services accordingly.

(E) Inform appellants of other agencies that may also be available to resolve the controversy.

(h) (1) A position statement, as required by Section 10952.5 of the Welfare and Institutions Code, shall be made available at least two working days before the hearing on the appeal. The position statement shall be made available electronically by the entity that determined eligibility if the entity has the capacity to send information electronically in a secure manner.

(2) The appeals entity shall send written notice, electronically or in hard copy, to the appellant of the date, time, and location of the hearing no later than 15 days prior to the date of the hearing. If the date, time, and location of the hearing are prohibitive of participation by the appellant, the appeals entity shall make reasonable efforts to set a reasonable, mutually convenient date, time, and location. The notice shall explain what format the hearing shall be held in, via telephone or video conference or in person, and include the right of the appellant to request that the hearing be held via telephone or video conference or in person. The notice shall include instructions for submitting the request on the notice, by telephone or through other commonly available electronic means.

(3) The hearing format may be held via telephone or video conference, unless the appellant requests the hearing be held in person pursuant to paragraph (2).

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

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

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

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

(i) Decisions shall be made within 90 days from the date the appeal is filed and shall be based exclusively on the application of the applicable laws and eligibility and enrollment rules to the information used to make the eligibility or enrollment decision, as well as any other information provided by the appellant during the course of the appeal. The content of the decision of appeal shall include a decision with a plain language description of the effect of the decision on the appellant's eligibility or enrollment, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision, which may be retroactive at the election of the appellant if the appellant is otherwise eligible.

(j) Upon adjudication of the appeal, the appeals entity shall transmit the decision of appeal to the entity that made the eligibility or enrollment determination via a secure electronic means.

(k) If an appellant disagrees with the decision of the appeals entity, he or she may make an appeal request regarding coverage in a qualified health plan through the Exchange to the federal Department of Health and Human Services within 30 days of the notice of decision through any of the methods in subdivision (b).

(*l*) An appellant may also seek judicial review to the extent provided by law. Appeal to the federal Department of Health and Human Services is not a prerequisite for seeking judicial review, nor shall seeking an appeal to the federal Department of Health and Human Services preclude a judicial review.

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

(n) This section shall be implemented only to the extent it does not conflict with federal law.

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

100506.5. For appeals of redetermination of Exchange advance premium tax credits or cost-sharing reductions, upon receipt of notice from the appeals entity that it has received an appeal, the entity that made the redetermination shall continue to consider the applicant or enrollee eligible for the same level of advance

premium tax credits or cost-sharing reductions while the appeal is pending in accordance with the level of eligibility immediately before the redetermination being appealed.

SEC. 7. Section 10950 of the Welfare and Institutions Code is amended to read:

10950. (a) If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services, if his or her application is not acted upon with reasonable promptness, or if any person who desires to apply for public social services is refused the opportunity to submit a signed application therefor, and is dissatisfied with that refusal, he or she shall, in person or through an authorized representative, without the necessity of filing a claim with the board of supervisors, upon filing a request with the State Department of Social Services or the State Department of Health Care Services, whichever department administers the public social service, be accorded an opportunity for a state hearing.

(b) (1) The requirements of Sections 100506.2 and 100506.4 of the Government Code apply to state hearings regarding eligibility for or enrollment in an insurance affordability program administered by the State Department of Health Care Services to the extent that those sections conflict with the state hearing requirements under this chapter.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning July 1, 2015, the department shall provide a semiannual status report to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(3) This subdivision shall be implemented only to the extent it does not conflict with federal law.

(c) Priority in setting and deciding cases shall be given in those cases in which aid is not being provided pending the outcome of the hearing. This priority shall not be construed to permit or excuse the failure to render decisions within the time allowed under federal and state law.

(d) Notwithstanding any other provision of this code, there is no right to a state hearing when either (1) state or federal law requires automatic grant adjustments for classes of recipients unless the reason for an individual request is incorrect grant computation, or (2) the sole issue is a federal or state law requiring an automatic change in services or medical assistance which adversely affects some or all recipients.

(e) For the purposes of administering health care services and medical assistance, the Director of Health Care Services shall have those powers and duties conferred on the Director of Social Services by this chapter to conduct state hearings in order to secure approval of a state plan under applicable federal law.

(f) The Director of Health Care Services may contract with the State Department of Social Services for the provisions of state hearings in accordance with this chapter.

(g) As used in this chapter, "recipient" means an applicant for or recipient of public social services except aid exclusively financed by county funds or aid under Article 1 (commencing with Section 12000) to Article 6 (commencing with Section 12250), inclusive, of Chapter 3 of Part 3, and under Article 8 (commencing with Section 12350) of Chapter 3 of Part 3, or those activities conducted under Chapter 6 (commencing with Section 18350) of Part 6, and shall include any individual who is an approved adoptive parent, as described in subdivision (C) of Section 8708 of the Family Code, and who alleges that he or she has been denied or has experienced delay in the placement of a child for adoption solely because he or she lives outside the jurisdiction of the department.

SEC. 8. Section 10951 of the Welfare and Institutions Code is amended to read:

10951. (a) A person is not entitled to a hearing pursuant to this chapter unless he or she files his or her request for the same within 90 days after the order or action complained of.

(b) (1) Notwithstanding subdivision (a), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 90 days after the order or action complained of

and there is good cause for filing the request beyond the 90-day period. The director may determine whether good cause exists.

(2) For purposes of this subdivision "good cause" means a substantial and compelling reason beyond the party's control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause. The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after the order or action complained of.

(3) This section shall not preclude the application of the principles of equity jurisdiction as otherwise provided by law.

(c) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department shall implement this section through an all-county information notice no later than January 1, 2008. The department may also provide further instructions through training notes.

SEC. 9. Section 10960 of the Welfare and Institutions Code is amended to read:

10960. (a) Within 30 days after receiving the decision of the director, which is the proposed decision of an administrative law judge adopted by the director as final, a final decision rendered by an administrative law judge, or a decision issued by the director himself or herself, the affected county or applicant or recipient may file a request with the director for a rehearing. The director shall immediately serve a copy of the request on the other party to the hearing and that other party may within five days of the service file with the director a written statement supporting or objecting to the request. The director shall grant or deny the request no later than the 35th working day after the request is made to ensure the prompt and efficient administration of the hearing process. If the director grants the request, the rehearing shall be conducted in the same manner and subject to the same time limits as the original hearing.

(b) The grounds for requesting a rehearing are as follows:

(1) The adopted decision is inconsistent with the law.

(2) The adopted decision is not supported by the evidence in the record.

(3) The adopted decision is not supported by the findings.

(4) The adopted decision does not address all of the claims or issues raised by the parties.

(5) The adopted decision does not address all of the claims or issues supported by the record or evidence.

(6) The adopted decision does not set forth sufficient information to determine the basis for its legal conclusion.

(7) Newly discovered evidence, that was not in custody or available to the party requesting rehearing at the time of the hearing, is now available and the new evidence, had it been introduced, could have changed the hearing decision.

(8) For any other reason necessary to prevent the abuse of discretion or an error of law, or for any other reason consistent with Section 1094.5 of the Code of Civil Procedure.

(c) The notice granting or denying the rehearing request shall explain the reasons and legal basis for granting or denying the request for rehearing.

(d) The decision of the director, which is the proposed decision of an administrative law judge adopted by the director as final, a final decision rendered by an administrative law judge, or a decision issued by the director himself or herself, remains final pending a request for a rehearing. Only after a rehearing is granted is the decision no longer the final decision in the case.

(e) Notwithstanding any other provision of law, a rehearing request or decision shall not be a prerequisite to filing an action under Section 10962.

(f) (1) Notwithstanding subdivision (a), an applicant or recipient otherwise may be entitled to a rehearing pursuant to this chapter if he or she files a request more than 30 days after the decision of the director is issued, or if he or she did not receive a copy of the decision of the director, or if there is good cause for filing beyond the 30-day period. The director may determine whether good cause exists.

(2) For purposes of this subdivision, “good cause” means a substantial and compelling reason beyond the party’s control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause. The department shall not grant a request for a rehearing

for good cause if the request is filed more than 180 days after the order or action complained of.

(3) This section shall not preclude the application of the principles of equity jurisdiction as otherwise provided by law.

(g) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department shall implement this section through an all-county information notice no later than January 1, 2008. The department may also provide further instructions through training notes.

Approved _____, 2014

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Governor