Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 294 **VERSION:** AMENDED JANUARY 11, 2024

AUTHOR: WIENER **SPONSOR:**
- CHILDREN NOW
- COUNTY OF SANTA CLARA

POLICY & ADVOCACY COMMITTEE RECOMMENDATION: NONE

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. It requires the following for mental health treatment and substance use disorder treatment denials based on lack of medical necessity for children and young adults up to age 26:

- Makes the grievance process for non-life threatening conditions automatic, rather than consumer-initiated, and if a grievance is upheld, or is still pending or unresolved after a specified timeframe, it must automatically within 24 hours be submitted to the Independent Medical Review System.

- For life-threatening conditions, the grievance process is not required and the case must automatically and immediately be submitted to the Independent Medical Review System.

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 World Health Organization's International Statistical Classification of Diseases and

Related Health Problems or listed in the most recent version of the American Psychiatric Association's 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 every health care service plan to establish and maintain a grievance system where enrollees may submit their grievances to the plan. The plan must inform its enrollees of the grievance procedures, must provide a written acknowledgement within 5 calendar days of receiving a grievance, and must provide enrollees with written responses to grievances which include a clear and concise explanation of the reasons for the plan's response. (HSC §1368(a)).

5) Provides that after either completing the grievance process or participating in the process for at least 30 days, an enrollee may submit the grievance to the Department of Managed Health Care for review. If the Department determines that a case involves an imminent and serious threat to the health of the patient, then they are not required to complete the grievance process or participate in the grievance process for 30 day before submitting to the Department for review. (HSC §1368(b))

6) Requires the grievance system to resolve grievances within 30 days, and must include a requirement for expedited review for cases that involve an imminent and serious threat to the health of the patient. (HSC §1368.01(a) and (b))

7) 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, IC §10169)

8) 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))

9) 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))

10) 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))

11) 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))

12) 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) Beginning July 1, 2025, requires a health care service plan or disability insurer that provides coverage for mental health or substance use disorders must treat a modification, delay, or denial of an authorization for coverage of treatment request for a mental health or substance used disorder for an enrollee up to age 26 as if it is also a grievance submitted by an enrollee under the grievance process prescribed by law. (HSC §1368.012(a), IC §10169.4(a))

2) Requires this automatic grievance to be treated by the plan or insurer in the same manner as a grievance seeking to appeal a decision. It must be considered to have been submitted by the enrollee or insured on the same date as the decision to modify, delay or deny the requested treatment is issued, and the enrollee or insured is not required to take any additional action to initiate or continue the grievance process. (HSC §1368.012(b), IC §10169.4(b))

3) Requires the plan or insurer to provide a written acknowledgement of the grievance to the enrollee or insured along with the notification of the decision to modify, delay, or deny the requested treatment. The acknowledgement must contain specified information, including an explanation of the grievance process, timelines for completion, criteria to expedite, and plan or insurer contact information. It must also include a statement that the enrollee or insured may choose to withdraw the grievance. A withdrawal does not disqualify the enrollee or

insured from submitting a grievance on the same issue later. (HSC §1368.012(b) and (c), IC §10169.4(b) and (c))

4) Provides that these automatically generated grievances are subject to automatic submission to Independent Medical Review if they are pending or unresolved within prescribed timeframes or if the health care service plan or disability insurer upholds its decision to modify, delay, or deny requested treatment. (HSC §1368.012(d), IC §10169.4(d))

5) Requires beginning July 1, 2025, a health care service plan or disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance, or has a grievance that is pending or unresolved upon expiration of the prescribed timeframe, to automatically submit its decision and the information that informed the decision, within 24 hours to the state's Independent Medical Review System if the decision is to deny, modify, or delay either of the following for an enrollee or insured 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 lack 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.

6) Specifies that requiring the grievance process to be completed before automatic submission to the Independent Medical Review System does not apply in cases involving an imminent and serious threat to the enrollee or insured's health. In these cases, the health care service plan or disability insurer must immediately submit the case to the Independent Medical Review System and coordinate with the enrollee or insured on submission of all required information and documentation. (HSC §1374.37(a)(3), IC §10169.6(a)(3))

7) Requires that the health care service plan or disability insurer must notify the enrollee or insured, 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))

8) Requires the health care service plan or disability insurer to coordinate with the enrollee or insured and the provider for completion of a signed Independent Medical Review application that includes consent to release medical records. (HSC §1374.37(b)(2), IC §10169.6(b)(2))

9) Provides that the regulating department may close an Independent Medical Review case submitted automatically if the enrollee or insured fails to complete an Independent Medical Review application within 30 days of being notified that the application is incomplete. (HSC §1374.37(b)(3), IC §10169.6(b)(3))

10) Provides that the above does not apply to Medi-Cal managed care plan contracts. (HSC §§1368.012(e), 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. If the issue is not resolved, the consumer may then file an IMR request, and 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."

The author's office notes that SB 294 will improve the process for families facing barriers. It will subject denials for life threatening conditions to the Independent Medical Review process automatically. It will also automatically place non-life-threatening denials in the grievance process.

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

"The number of IMRs for the diagnosis category of "Mental Disorder" has steadily increased for youth under the age of 21, especially from 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 2022 received the service(s) or treatment(s) they requested. Of those decisions, 19% were reversed by the health plan before being reviewed, 49% 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) **Policy and Advocacy Committee Recommendation.** The Board's Policy and Advocacy Committee did not get a chance to consider this bill at its April 2024 meeting.

3) **Staff Recommendation.** Staff recommends that the Board consider supporting this bill.

4) **Related Legislation - Previous Board Position.** The Board analyzed a very similar bill to this bill last year; SB 238 (Wiener). At its August 2023 meeting, the Board took a "support" position on that bill.

   The provisions of SB 238 have now been moved into this bill. However, it should be noted that the bill has been substantively changed since when moving into the new version, with the most notable change being an automatic grievance submittal for denials for non-life-threatening conditions before the automatic Independent Medical Review process is begun.

5) **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.

6) **Support and Opposition**

   Support

   Children Now (sponsor)
   County of Santa Clara (sponsor)
   American Academy of Pediatrics, California
   California Alliance of Child and Family Services
   California Association of Social Rehabilitation Agencies
   California Children's Hospital Association
   California Pan-Ethnic Health Network
   Courage California
   Foster Care Counts
   Friends Committee on Legislation of California
   Health Access California
   Jewish Family and Children's Services of San Francisco Bay Area
   National Health Law Program

Steinberg Institute
The Kennedy Forum
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

7) History

01/29/24 In Assembly. Read first time. Held at Desk.
01/29/24 Read third time. Passed. (Ayes 31. Noes 7. Page 3049.) Ordered to the Assembly.
01/22/24 Read second time. Ordered to third reading.
01/18/24 From committee: Do pass. (Ayes 4. Noes 2. Page 3011.) (January 18).
01/17/24 Set for hearing January 18.
01/16/24 January 16 hearing: Placed on APPR suspense file.
01/12/24 Set for hearing January 16.
01/11/24 Read second time and amended. Re-referred to Com. on APPR.
01/10/24 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 2. Page 2970.) (January 10).
01/04/24 Set for hearing January 10.
01/03/24 Re-referred to Com. on HEALTH.
01/03/24 From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
09/14/23 Re-referred to Com. on RLS.
09/14/23 Withdrawn from committee.
09/13/23 From committee with author's amendments. Read second time and amended. Re-referred to Com. on GOV. & F.
09/13/23 Senate rules suspended.
02/15/23 Referred to Coms. on GOV. & F. and HOUSING.
02/03/23 From printer. May be acted upon on or after March 5.
02/02/23 Introduced. Read first time. To Com. on RLS. for assignment. To print.

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AMENDED IN SENATE JANUARY 11, 2024

AMENDED IN SENATE JANUARY 3, 2024

AMENDED IN SENATE SEPTEMBER 13, 2023

SENATE BILL No. 294

Introduced by Senator Wiener

February 2, 2023

An act to add Sections 1368.012 and 1374.37 to the Health and Safety Code, and to add Sections 10169.4 and 10169.6 to the Insurance Code, relating to health care coverage.

legislative counsel's digest

SB 294, 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, commencing July 1, 2025, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe 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, 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.

This bill, commencing July 1, 2025, would require a health care service plan or disability insurer that provides ~~treatment~~ *coverage* for mental health or substance use disorders to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured. The bill would require a plan or insurer to provide a written acknowledgment of a grievance that is automatically generated and would specify the circumstances under which that grievance is required to be submitted automatically to independent medical review.

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.

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 1368.012 is added to the Health and Safety Code, to read:

1368.012. (a) Commencing July 1, 2025, a health care service plan that provides ~~treatment~~ *coverage* for mental health or substance use disorders pursuant to Section 1374.72 shall treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an enrollee up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee in accordance with Sections 1368, 1368.01, and 1368.015.

(b) *(1)* A grievance automatically generated pursuant to subdivision (a) shall be treated by the plan and the department in the same manner as a grievance seeking to appeal the decision of the health care service plan to modify, delay, or deny the requested treatment for the enrollee, and shall be considered to have been submitted by the enrollee or the enrollee's representative to the plan on the same date as the decision to modify, delay, or deny the requested treatment is issued by the plan. The plan shall not require the enrollee or the enrollee's representative to take any additional action to initiate or continue the grievance processing procedure. ~~The~~

(2) The plan shall provide ~~the~~ *a* written acknowledgment of the grievance generated pursuant to subdivision (a) as required pursuant to paragraph (4) of subdivision (a) of Section 1368 concurrent with the notification to the enrollee of the decision to modify, delay, or deny the requested treatment. The acknowledgment shall include an explanation of the grievance process and relevant timeframes for completion, criteria *under subdivision (c) of Section 1374.33* for treatment of a grievance as an expedited case, including whether the present grievance is to be processed on an expedited ~~basis,~~ *basis and automatically submitted to the independent medical review system under Section 1374.37,* contact information for the plan, including a telephone number through which the enrollee may receive a status update on the grievance or withdraw the automatically generated grievance, and contact information for the department.

(c) The acknowledgment described in subdivision (b) shall include a statement that the enrollee may choose to withdraw the automatically generated grievance. A withdrawal by the enrollee or their representative of a grievance automatically generated pursuant to this section before the health care service plan's determination on the grievance shall not, by itself, disqualify the

enrollee or their representative from later submitting a grievance related to the same underlying modification, delay, or denial of the requested mental health or substance use disorder treatment.

(d) Grievances automatically generated pursuant to subdivision (a) that are pending or unresolved upon expiration of the relevant timeframe specified in Sections 1368.01 and 1374.30 or for which the health care service plan upholds its decision to modify, delay, or deny the requested treatment are subject to automatic submission to independent medical review pursuant to Section 1374.37.

(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 1374.37 is added to the Health and Safety Code, to read:

1374.37. (a) (1) Commencing July 1, 2025, a health care service plan that, itself or through its delegates, upholds its decision, in whole or in part, to modify, delay, or deny a health care service in response to a grievance submitted by an enrollee or processed pursuant to Section 1368.012, or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe specified in Sections 1368.01 and 1374.30, 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 if the health care service plan's 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 the lack of medical necessity of the requested covered health care service, in whole or in part.

(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, including notice ~~requirements~~ *requirements, the assessment fee system under Section 1374.35,* and provisions regarding the department's authority to determine the nature of a grievance as a matter of coverage or medical necessity, in whole or in part.

(3) The requirement that an enrollee complete the health care service plan grievance process before automatic submission of a decision to the Independent Medical Review System pursuant to paragraph (1) shall not apply to cases involving an imminent and serious threat to the health of the ~~patient,~~ *enrollee,* as described in subparagraph (A) of paragraph (1) of subdivision (b) of Section 1368. In those circumstances, the health care service plan shall immediately submit the case to the Independent Medical Review System and coordinate with the enrollee or the enrollee's representative on the submission of all information and documentation required by the department to process the expedited independent medical review.

(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.

(C) The department's application for independent medical review.

(D) Any other content that is required by the department.

(2) Concurrent with the notice specified in paragraph (1), the health care service plan shall provide the enrollee and the enrollee's provider with copies of all documents described in subdivision (n) of Section 1374.30. The health care service plan shall coordinate with the enrollee and provider for the completion of a signed independent medical review application *that includes consent to*

release medical records and, if necessary, an authorized ~~assistant~~ *representative* form.

(3) The department may close independent medical review cases submitted automatically pursuant to this section if the enrollee or authorized ~~assistant~~ *representative* fails to complete an independent medical review application within 30 days of the department notifying the enrollee or authorized ~~assistant~~ *representative* and provider of the incomplete application.

(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.

(f) The department shall provide a quarterly public report on the number of automatic ~~grievance cases,~~ *independent medical review cases that are received,* the number of automatic ~~grievance cases resolved and closed, and the number of Independent Medical Review applications sent from the Department of Managed Health Care and returned to the Department of Managed Health Care.~~ *independent medical review cases that are resolved, the outcome of resolved cases, and the number of automatic independent medical review cases that are canceled and closed.*

SEC. 4. Section 10169.4 is added to the Insurance Code, to read:

10169.4. (a) Commencing July 1, 2025, a disability insurer that provides ~~treatment~~ *coverage* for mental health or substance use disorders pursuant to Section ~~1374.72~~ *10144.5* shall treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the insured in accordance with this article.

(b) *(1)* A grievance automatically generated pursuant to subdivision (a) shall be treated by the insurer and the department

in the same manner as a grievance seeking to appeal the decision of the disability insurer to modify, delay, or deny the requested treatment for the insured, and shall be considered to have been submitted by the insured or the insured's representative to the insurer on the same date as the decision to modify, delay, or deny the requested treatment is issued by the insurer. The insurer shall not require the insured or the insured's representative to take any additional action to initiate or continue the grievance processing procedure. ~~The~~

(2) The insurer shall provide ~~the~~ *a* written acknowledgment of the grievance generated pursuant to subdivision (a) concurrent with the notification to the insured *under subdivision (h) of Section 10123.135* of the decision to modify, delay, or deny the requested treatment. The acknowledgment shall include an explanation of the grievance process and relevant timeframes for completion, criteria *under subdivision (c) of Section 10169.3* for treatment of a grievance as an expedited case, including whether the present grievance is to be processed on an expedited ~~basis,~~ *basis and automatically submitted to the Independent Medical Review System under Section 10169.6,* contact information for the insurer, including a telephone number through which the insured may receive a status update on the grievance or withdraw the automatically generated grievance, and contact information for the department.

(c) The acknowledgment described in subdivision (b) shall include a statement that the insured may choose to withdraw the automatically generated grievance. A withdrawal by the insured or their representative of a grievance automatically generated pursuant to this section before the disability insurer's determination on the grievance shall not, by itself, disqualify the insured or their representative from later submitting a grievance related to the same underlying modification, delay, or denial of the requested mental health or substance use disorder treatment.

(d) Grievances automatically generated pursuant to subdivision (a) that are pending or unresolved upon expiration of the relevant timeframe specified in Section 10169 or for which the disability insurer upholds its decision to modify, delay, or deny the requested treatment are subject to automatic submission to independent medical review pursuant to Section 10169.6.

SEC. 5. Section 10169.6 is added to the Insurance Code, immediately following Section 10169.5, to read:

10169.6. (a) (1) Commencing July 1, 2025, a disability insurer that, itself or through its delegates, upholds its decision, in whole or in part, to modify, delay, or deny a health care service in response to a grievance submitted by an insured or processed pursuant to Section 10169.4, or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe specified in Section 10169, 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 if the disability insurer's 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 the lack of medical necessity of the requested covered health care service, in whole or in part.

(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, including notice ~~requirements~~ *requirements, the assessment fee system under Section 10169.5,* and provisions regarding the department's authority to determine the nature of a grievance as a matter of coverage or medical necessity, in whole or in part.

(3) The requirement that an insured complete the disability insurer grievance process before automatic submission of a decision to the Independent Medical Review System pursuant to paragraph (1) shall not apply to cases involving an imminent and serious threat to the health of the ~~patient,~~ *insured,* as described in subdivision (c) of Section 10169.3. In those circumstances, the disability insurer shall immediately submit the case to the Independent Medical Review System and coordinate with the insured or the insured's representative on the submission of all

information and documentation required by the department to process the expedited independent medical review.

(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.

(C) The department's application for independent medical review.

(D) Any other content that is required by the department.

(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. The ~~disability~~ insurer shall coordinate with the insured and provider for the completion of a signed independent medical review application *that includes consent to release medical records* and, if necessary, an authorized ~~assistant~~ *representative* form.

(3) The department may close independent medical review cases submitted automatically pursuant to this section if the insured or authorized ~~assistant~~ *representative* fails to complete an independent medical review application within 30 days of the department notifying the insured or authorized ~~assistant~~ *representative* and provider of the incomplete application.

(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) 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.~~ *section and Section 10169.4.*

(f) The department shall provide a quarterly public report on the number of automatic ~~grievance cases,~~ *independent medical review cases that are received,* the number of automatic ~~grievance cases resolved and closed, and the number of Independent Medical Review applications sent from the Department of Managed Health Care and returned to the Department of Managed Health Care.~~ *independent medical review cases that are resolved, the outcome of resolved cases, and the number of automatic independent medical review cases that are canceled and closed.*

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B 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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