PROPOSED REGULATORY ACTION BY CALPERS

Addition of § 599.518
Title 2 of the California Code of Regulations (CCR)

§599.518 Coverage: Member Health Appeals Process

Prior to appealing to the board and accorded an opportunity for a fair hearing pursuant to Government Code section 22848, an employee or annuitant must complete the requirements in subsections (b) and (c), if applicable.

(a) As used in this section and Government Code section 22848:
- (1) "Administrative hearing" means the fair hearing described in Government Code section 22848.
- (2) "Administrative review" means the process by which an employee or annuitant appeals to the board as permitted under Government Code section 22848.
- (3) "Complaint" means the same as "grievance."
- (4) "Coverage" means a health benefit provided by a plan to employees and annuitants and their family members and described in the plan's evidence of coverage.
- (5) "Dissatisfied with any action or failure to act" means a complaint or grievance an employee or annuitant may have regarding his or her coverage or the coverage of his or her family members.
- (6) "Evidence of coverage" means a booklet provided by a plan to employees and annuitants and their family members describing their coverage and in effect for the period when an employee or annuitant has a complaint or grievance.
- (7) "Grievance" means a written or oral expression of dissatisfaction regarding coverage and shall include a complaint, dispute, request for reconsideration or appeal made by an employee or annuitant. Where it is not possible to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(b) Exhaustion of complaint or grievance process.

An employee or annuitant who is dissatisfied with any action or failure to act in connection with his or her coverage or the coverage of his or her family members must file a complaint or grievance and participate in and exhaust the complaint or grievance process, including all levels of appeal, provided by the plan in which he, she or any family member is enrolled.

(c) Exhaustion of other appeals processes.

If the employee or annuitant is dissatisfied with the decision from the plan's complaint or grievance process as described in subsection (b), the

DRAFT

employee or annuitant may request an administrative review as described in subsection (d) unless the employee or annuitant's complaint or grievance is eligible for one of the appeals processes listed in paragraphs (1) through (3) of this subsection. The plan's evidence of coverage will provide information about eligibility for the appeals processes listed in paragraphs (1) through (3) of this subsection. If the employee or annuitant's complaint or grievance is eligible for one of the appeals processes listed in paragraphs (1) through (3) of this subsection, the employee or annuitant must participate in and exhaust that appeals process before requesting an administrative review.

(1) The Department of Managed Health Care's complaint system.

(2) The Department of Managed Health Care's independent medical review system.

(3) The external review process administered by a plan in accordance with the Patient Protection and Affordable Care Act (Pub. L. No. 111 -148).

(d) Request for administrative review.

If an employee or annuitant is dissatisfied with the decision from the appeals processes outlined in subsection (b) or subsection (c), he or she may request an administrative review of the decision. Only requests that involve an issue regarding coverage are eligible for an administrative review. The employee or annuitant must request an administrative review and receive a decision from the unit charged with the processing and oversight of health appeals before the employee or annuitant may request an administrative hearing. An employee or annuitant may not request an administrative review if he or she decides to resolve a complaint or grievance through arbitration or by filing a civil action in a court of competent jurisdiction as may be provided for in the plan's evidence of coverage. Complaints or grievances alleging medical malpractice, quality of care or quality of services provided by a plan are not eligible for administrative review.

(1) A request for administrative review must be filed with the unit charged with the processing and oversight of health appeals within thirty (30) days of the date the employee or annuitant receives a decision from an appeals process described in subsection (b) or (c). The request for administrative review shall be in writing, state the grounds on which it is requested, the relief that is sought and include all supporting evidence. Supporting evidence includes, but is not limited to, copies of medical records, statements of health

DRAFT

care providers, and copies of medical bills submitted or paid by the employee or annuitant.

(2) The unit charged with the processing and oversight of health appeals shall acknowledge the request for administrative review in writing within 15 days of receipt of the request. The unit charged with the processing and oversight of health appeals shall review the request and may request additional documentation. If the employee or annuitant does not provide the requested additional documentation within the timeframe specified by the unit charged with the processing and oversight of health appeals, CalPERS may terminate the administrative review. Written notification of the administrative review decision shall be mailed to the employee or annuitant within 60 days of receipt of all pertinent information.

(e) Request for administrative hearing.

If an employee or annuitant is dissatisfied with the administrative review decision, he or she may request an administrative hearing.

(1) An employee or annuitant must request an administrative hearing in writing within 30 days of the date of the administrative review decision. The date of the administrative review decision will be indicated on the written notification the unit charged with the processing and oversight of health appeals is required to send to the employee or annuitant pursuant to subsection(d)(2). Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an administrative hearing, not to exceed thirty (30) days. Good cause includes, but is not limited to, delays in receiving additional documents supporting the employee or annuitant’s case, inability to file timely for causes beyond the employee or annuitant’s control, and acts of nature.

(2) The request for an administrative hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to an employee or annuitant's case not previously submitted for administrative review. An employee or annuitant may, but is not required to, be represented by an attorney.

(3) If the request for an administrative hearing is granted, it will be conducted in accordance with the Administrative Procedure Act (Title 2, Division 3, Part 1 (commencing with Section 11500) of the Government Code). After taking testimony and receiving evidence, an administrative law judge will issue a proposed decision and this decision will be presented to the board. If the board adopts the

DRAFT

proposed decision as its own decision at an open meeting, this decision will be provided in writing to the employee or annuitant within two weeks of the board's open meeting where the decision was adopted.

(4) An employee or annuitant who is dissatisfied with the board's decision as described in paragraph (3) of this subsection may petition the board for reconsideration or may appeal to the Superior Court. An employee or annuitant may not pursue civil legal remedies until after exhausting administrative review and an administrative hearing.

(f) This section shall apply to employees and annuitants enrolled in a supplemental plan if their dissatisfaction with any action or failure to act in connection with their coverage or the coverage of their family members involves a health benefit provided by the plan that is not a health benefit covered by Medicare.

(g) The requirements specified in subsections (b) and (c) shall not apply to an employee or annuitant who is dissatisfied with any action or failure to act in connection with his or her eligibility for coverage or the eligibility for coverage of his or her family members.

Note: Authority cited: Sections 22794 and 22796, Government Code.
Reference: Section 22848, Government Code

DRAFT