



## Agenda Item 7

April 15, 2014

**ITEM NAME:** Proposed Regulations - Coverage: Member Health Appeals Process

**PROGRAM:** Health Benefits

**ITEM TYPE:** Action

### **RECOMMENDATION**

Approve staff's recommendation to pursue proposed regulations to clarify the current California Public Employees' Retirement System (CalPERS) member appeals process when they are dissatisfied with any action or failure to act in connection with their or a family member's health coverage.

### **EXECUTIVE SUMMARY**

Staff is recommending approval to pursue proposed regulations that clarify the current CalPERS member appeals process for health coverage. The Public Employees' Medical and Hospital Care Act (PEMHCA) allows CalPERS members, who are dissatisfied with any action or failure to act in connection with their health benefits coverage or that of a family member, the right to appeal to the CalPERS Board of Administration (Board) and an opportunity for a fair hearing. PEMHCA, however, does not require CalPERS members to exhaust any appeals processes provided by the health plans or any state agency that may regulate the health plan in which members and their dependents are enrolled. These appeals processes include the Patient Protection Affordable Care Act's (ACA) External Review (ER) process for members enrolled in CalPERS Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) health plans, the Department of Managed Health Care's (DMHC) independent medical review (IMR) system for members enrolled in CalPERS Health Maintenance Organization (HMO) health plans, and DMHC's complaint system for members enrolled in CalPERS HMO health plans for matters not eligible for IMR.

Since CalPERS members are not required to exhaust the aforementioned appeals processes, it has become very challenging for the CalPERS unit charged with managing appeals that go to the Board. If members were required to exhaust these processes before appealing to the Board, it would greatly improve the management of these appeals. Moreover, by availing themselves of these appeals processes, members may receive the outcome they are seeking thus obviating the need to appeal to the Board.

## **STRATEGIC PLAN**

The agenda item supports Goal C, Engage in State and national policy development to enhance the long-term sustainability and effectiveness of our programs.

## **BACKGROUND**

As indicated above, prior to appealing to the Board, PEMHCA does not require CalPERS members to exhaust any appeals processes provided by their health plans or a state agency that may regulate the plan in which they are enrolled. The health plans' evidences of coverage (EOCs), however, do require members to participate and exhaust the plans' internal appeals process before appealing to the Board. The EOCs further apprise members of their appeal rights, including the right to appeal to the Board, but there is no requirement for CalPERS members to exhaust any other available appeals processes before appealing to the Board. Depending on the plan, the EOCs may inform members that they also have the right to submit the dispute to binding arbitration or file a civil action in a court of competent jurisdiction. If members select binding arbitration or file a civil action in a court of competent jurisdiction, the EOCs inform members that they are precluded from appealing to the Board.

Many of the disputes that members have with their coverage revolve around questions of medical necessity. In July 2010, the federal government proposed interim final regulations that implemented ACA requirements regarding internal health claims, appeals, and external review processes. These regulations require group health plans and health insurance issuers to provide an independent ER process for adverse benefit determinations based on medical necessity. Health plans or insurance issuers can require that internal appeals be exhausted prior to the ER. The health plan or insurance issuer must provide individuals enrolled in the plan at least four (4) months to request a review, assign reviews on a random basis to ensure independence, and complete a standard review within a 45 day time frame.

The federal Center for Consumer Information and Oversight (CCIIO) has determined that the IMR process administered by the DMHC meets the requirements of these regulations. And, CalPERS has contracted with Anthem Blue Cross, the third party administrator for the EPO and PPO health plans, to comply with these requirements. In addition, existing law allows individuals enrolled in an HMO to appeal to the DMHC's complaint system for adverse determinations that do not involve questions of medical necessity.

CalPERS employs an administrative review (AR) process to facilitate appeals to the Board as permitted under PEMHCA. After completing the plan's internal review process, CalPERS members can request an AR, the ER process, if eligible, DMHC's IMR system, if eligible, or review by DMHC's compliant system for non-medical necessity questions.

## **ANALYSIS**

Currently, members enrolled in CalPERS EPO and PPO health plans are offered two options upon receiving the health plan's final adverse benefit determination based on medical necessity. The member can:

- Request an ER within four (4) months, then request a CalPERS AR within 30 days of an adverse determination from the ER process; or
- Request a CalPERS AR within 30 days, then request an ER within four (4) months of the CalPERS AR determination.

If a final adverse benefit determination does not involve a question of medical necessity, the member can request a CalPERS AR within 30 days of the determination.

Members enrolled in CalPERS HMO plans are offered the following options upon receiving the health plan's final adverse benefit determination based on medical necessity. The member can:

- Request an IMR within six months from the DMHC, then request a CalPERS AR within 30 days of an adverse determination from the IMR system;
- Request the CalPERS AR within 30 days, and if the AR determination is adverse to the member, request an IMR from the DMHC so long as the request for IMR is within six months of the health plan's final adverse benefit determination;
- Depending on the HMO health plan, submit the matter to binding arbitration or file a civil action in a court of competent jurisdiction.

If a final adverse benefit determination does not involve a question of medical necessity, the member can submit the dispute to CalPERS AR within 30 days of the determination, DMHC's complaint system, or, depending on the HMO health plan, to binding arbitration or file a civil action in a court of competent jurisdiction.

As this description illustrates, members have many options for appeal. The current process is challenging for the unit charged with processing and oversight of health appeals, and places the Board's fiduciary decision at risk of being overturned by an independent review organization or State agency. Additionally, in the current situation, members in almost identical situations are likely being treated differently. The proposed changes standardize member appeal processes.

### Current State Statutes

Government Code (GC) § 22794 states the Board shall have all powers reasonably necessary to carry out the authority and responsibilities expressly granted or imposed upon it under PEMHCA

GC § 22848 states that “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 under this part shall have the right of appeal to the board and shall be accorded an opportunity for a fair hearing. The hearings shall be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3.”

#### Proposed Regulations

##### Addition of Proposed Title 2, CCR § 599.518

The proposed regulation would add § 599.518, comprised of a general statement and several subsections, to the California Code of Regulations (CCR), Title 2. The following is a summary of the proposed regulation:

##### Addition of Proposed Title 2, CCR § 599.518, General Statement

The proposed regulation would add § 599.518, general statement, to the CCR to require members to complete the requirements of subsections (b) and (c), if applicable, before appealing to the Board pursuant to GC§ 22848.

##### Addition of Proposed Title 2, CCR § 599.518, Subsection (a)

The proposed regulation would add § 599.518, subsection (a), to the CCR to provide specific definitions for terms used in the proposed regulation.

##### Addition of Proposed Title 2, CCR § 599.518, Subsection (b)

The proposed regulation would add § 599.518, subsection (b), to the CCR to require members that are dissatisfied with any action or failure to act in connection with their coverage or the coverage of their family members to 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 they or any of their family members are enrolled.

##### Addition of Proposed Title 2, CCR § 599.518, Subsection (c)

The proposed regulation would add § 599.518, subsection (c), to the CCR to permit members to request an AR if they are dissatisfied with the decision from the plan's complaint or grievance process as described in subsection (b) unless the complaint or grievance is eligible for one of the appeals processes listed in paragraphs (1) through (3) of this subsection. If the complaint or grievance is eligible for one of these appeals processes, members must participate in and exhaust these appeals processes before requesting an AR.

##### Addition of Proposed Title 2, CCR § 599.518, Subsection (d)

The proposed regulation would add § 599.518, subsection (d), to the CCR to specify the requirements for requesting an AR and to describe the AR process.

Addition of Proposed Title 2, CCR § 599.518, Subsection (e)

The proposed regulation would add § 599.518, subsection (e), to the CCR to specify the requirements for requesting an administrative hearing and to describe the administrative hearing process.

Addition of Proposed Title 2, CCR § 599.518, Subsection (f)

The proposed regulation would add § 599.518, subsection (f), to the CCR to state that § 599.518 applies to members enrolled in a supplemental plan if their dissatisfaction with any action or failure to act in connection with their coverage involves a health benefit provided by the plan but not covered by Medicare.

Addition of Proposed Title 2, CCR § 599.518, Subsection (g)

The proposed regulation would add § 599.518, subsection (g), to the CCR to exempt disputes regarding eligibility for coverage from the requirements of subsections (b) and (c) of § 599.518.

**BUDGET AND FISCAL IMPACTS**

The Member Health Appeals Process regulations will standardize staff procedures across plans and reduce administrative complexity. We do not forecast a reduction of staffing as a result of this simplification.

**BENEFITS/RISKS**

Potential benefits of this proposed regulation are:

- A standardized appeals process for all CalPERS members.
- The elimination of possible confusion regarding steps to follow within the existing process.
- Affirmation of the CalPERS Board's fiduciary authority to render the final decision regarding health coverage.

**ATTACHMENT**

Proposed Regulatory Action - Coverage: Member Health Appeals Process Regulations

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KATHY DONNISON, Chief  
Health Plan Administration Division  
Benefit Programs Policy and Planning

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ANN BOYNTON  
Deputy Executive Officer  
Benefit Programs Policy and Planning