

**ATTACHMENT B**  
**STAFF'S ARGUMENT**

## **STAFF'S ARGUMENT TO ADOPT THE PROPOSED DECISION**

Robin G. Leiter-Cohen (Respondent) was employed by the City of Brisbane, which contracts with CalPERS to provide health care coverage to its employees. By virtue of her employment, Respondent was eligible to participate in the PERS Choice health care plan offered through the provisions of the Public Employees' Medical and Hospital Care Act (PEMHCA). CalPERS contracted with Anthem Blue Cross (Anthem) to administer the medical claims of PERS Choice. As part of her health care coverage, PERS Choice provided Respondent with an Evidence of Coverage (EOC) booklet each year. The EOC contains the terms and conditions of the plan, including provisions concerning covered benefits and payment of claims.

On three separate occasions, Respondent received services rendered by three Non-Preferred Providers of PERS Choice. Respondent submitted claims for reimbursement for the services provided by the Non-Preferred Providers to Anthem. Anthem processed payment of Respondent's claims in accordance with the allowable amount for reimbursement to Non-Preferred Providers. In response, Respondent filed an appeal with Anthem requesting that it review the claims for additional reimbursement. Upon further review, Anthem determined it had reimbursed Respondent in accordance with the provisions of the PERS Choice plan for reimbursement of Non-Preferred Providers, as outlined in the EOC booklets. Anthem informed Respondent that her claims were not eligible for additional reimbursement, and any further reconsideration regarding the amount of reimbursement should be sent to CalPERS.

Respondent appealed Anthem's determination to CalPERS. After thorough review of the information provided by Respondent and Anthem, CalPERS staff determined that the PERS Choice plan did not provide for a higher allowable amount than the amount established in the EOC booklet for services rendered by Non-Preferred Providers. In response, Respondent submitted a timely appeal of staff's determination and a hearing was held to determine whether Respondent was entitled to an increase in the allowable amount for services provided by Non-Preferred Providers.

Prior to hearing, CalPERS explained the hearing process to Respondent and the need to support her case with witnesses and documents. CalPERS provided Respondent with a copy of the administrative hearing process handbook. CalPERS answered Respondent's questions and clarified how to obtain further information on the process.

At the hearing, Respondent was not present, despite being sent notice of the date, time and location of the hearing. The Administrative Law Judge (ALJ) found that CalPERS complied with the notice requirements, pursuant to Government Code sections 11505 and 11509. Therefore, the matter proceeded as a default pursuant to Government Code section 11520.

Present at the hearing was Anthem's Account Consultant, Cheryl Rushing. Ms. Rushing testified about the difference between Preferred Providers (providers who have agreed to accept the PERS Choice plan's payment as payment in full for covered

services) and Non-Preferred Providers (providers who have not agreed to accept the plan's payment as payment in full for covered services). Ms. Rushing explained that the allowable amounts paid to Preferred and Non-Preferred Providers were based on factors such as the providers' geographic area, market considerations, and providers' charge patterns. Ms. Rushing's testimony also established that the PERS Choice EOC did not include additional reimbursement for the services Respondent received from Non-Preferred Providers.

According to the terms of the PERS Choice EOC, "[t]he allowable amount for covered services provided by Non-Preferred Providers is usually lower than what they customarily charge." Moreover, the EOC explains that "Non-Preferred Providers may bill the Member for the difference between the Allowable Amount and the Non-Preferred Provider's billed charges . . ." The term allowable amount, as defined in the EOC, indicates it is:

the allowance or negotiated amount . . . for the service(s) rendered, or the provider's Billed Charge, whichever is less. The Allowance is . . . such other amount as the Preferred Provider and Blue Cross of California or the local Blue Cross and/or Blue Shield Plan have agreed will be accepted as payment for the service(s) rendered;

Based on the EOC, combined with Ms. Rushing's testimony, the ALJ found that there was not adequate evidence in Respondent's appeal to support her request to receive more than the allowable amount for services provided by Non-Preferred Providers. For that reason, the ALJ concluded that Respondent is not entitled to additional reimbursement. Accordingly, the ALJ denied Respondent's appeal.

The Proposed Decision is consistent with the law and the facts. For the reasons stated above, staff argues that the Board should adopt the Proposed Decision.

Because the Proposed Decision applies the law to the salient facts of this case, the risks of adopting the Proposed Decision are minimal. The member may file a motion with the Board under Government Code section 11520(c), requesting that, for good cause shown, the Decision be vacated and a new hearing be granted.

September 17, 2014

  
\_\_\_\_\_  
RENEE SALAZAR  
Senior Staff Attorney