

## **INITIAL STATEMENT OF REASONS**

Proposed Addition to the California Code of Regulations (CCR)

Title 2, § 599.518

Coverage: Member Health Appeals Process

### DESCRIPTION OF THE PUBLIC PROBLEM

The Public Employees' Medical and Hospital Care Act (PEMHCA) allows California Public Employees' Retirement System (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 appeal 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 appeal 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) process for members enrolled in CalPERS Health Maintenance Organization (HMO) health plans, and DMHC's complaint process for members enrolled in CalPERS HMO health plans for matters not eligible for an IMR.

Since CalPERS members are not required to exhaust the aforementioned appeals processes, it is challenging for the CalPERS unit charged with managing appeals. One of the challenges the unit encounters is identifying the various entities that have either reviewed or issued decisions regarding coverage. 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 the ACA requirements regarding internal health claims, appeals, and ER processes. The proposed 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.

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. 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.

## PRE-NOTICE CONSULTATION WITH THE PUBLIC

The proposed regulations contain technical changes needed to clarify the language in PEMHCA regarding the Member Health Appeals Process. Therefore, no pre-notice consultation was done with the public.

## RATIONALE FOR THE DETERMINATION THAT EACH ADOPTION, AMENDMENT, OR REPEAL IS NECESSARY (PURPOSE, BENEFITS, AND GOALS)

### Factual Basis/Rationale

Pursuant to Government Code (GC) § 22794, the Board has the authority to carry out the responsibilities expressly granted or imposed upon it under PEMHCA. Specifically, GC § 22796, subdivision (a), paragraph (2), requires the Board, pursuant to the Administrative Procedure Act, to adopt all necessary rules and regulations to carry out the provisions of PEMHCA. Pursuant to GC § 22848, 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.

### Specific Purpose

CalPERS believes that the adoption to add CCR § 599.518 to PEMHCA will clarify the current CalPERS member appeals process when the member or their family member is dissatisfied with any action or failure to act concerning their health coverage.

### Benefits/Goals

Potential benefits and goals associated with approval of this regulatory package:

- Provides a standardized appeals process for all CalPERS members;
- Eliminates confusion within the appeals process;
- Reduces the risk that the CalPERS Board's decision(s) will be overturned by an independent review organization or another State Agency;
- Reduces the risk of litigation and affirms the CalPERS Board's fiduciary authority in rendering the final decision regarding health coverage.

## MATERIAL RELIED UPON/TECHNICAL, THEORETICAL, AND EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

CalPERS relied upon the 2014 edition of the California Public Employees' Retirement Law (PERL) as a basis for these regulations. There are no other technical, theoretical,

and empirical studies, reports, or documents or other material relied upon for these proposed regulations.

## REASONABLE ALTERNATIVES TO THE REGULATION AND THE AGENCY'S REASON FOR REJECTING THOSE ALTERNATIVES

There are no reasonable alternatives to the regulation and subsequently no reasons for CalPERS rejecting those alternatives.

### Economic Impact Analysis/Assessment

The proposed regulations clarify rules regarding the health coverage appeals process and specifically requires members to exhaust all available appeal processes prior to appealing to the CalPERS Board pursuant to GC § 22848.

Currently, members enrolled in CalPERS EPO and PPO health plans are offered two (2) 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 (6) months from the DMHC, then request a CalPERS AR within 30 days of an adverse determination from the IMR process;
- 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 (6) 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 process, or, depending on the HMO health plan, to binding arbitration or file a civil action in a court of competent jurisdiction. There will not be an economic impact with the addition of these regulations to the CCR.

In accordance with GC § 11346.3 (b), CalPERS has made the following assessments regarding the proposed regulation:

#### Creation or Elimination of Jobs Within the State of California

The proposed regulations clarify rules regarding the health coverage appeals process, specifically requiring members to exhaust all available appeal processes prior to appealing to the CalPERS Board pursuant to GC § 22848.

By adding CCR § 599.518, which only applies to CalPERS members, annuitants, and their family members, CalPERS does not foresee that any jobs in California will be created or eliminated as a result of the proposed regulations.

#### Creation of New or Elimination of Existing Businesses Within the State of California

The proposed regulations clarify rules regarding the health coverage appeals process, specifically requiring members to exhaust all available appeal processes prior to appealing to the CalPERS Board pursuant to GC § 22848.

By adding CCR § 599.518, which only applies to CalPERS members, annuitants, and their family members, CalPERS does not foresee that any new businesses in California will be created or existing businesses eliminated as a result of the proposed regulations.

#### Expansion of Businesses Within the State of California

The proposed regulations clarify rules regarding the health coverage appeals process, specifically requiring members to exhaust all available appeal processes prior to appealing to the CalPERS Board pursuant to GC § 22848.

By adding CCR § 599.518, which applies to CalPERS members, annuitants, and their family members, CalPERS does not foresee that any existing businesses in California will be expanded as a result of the proposed regulations.

#### Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

This regulation does not benefit the health and welfare of California residents, worker safety, or the state's environment.

#### Significant, Statewide Adverse Economic Impact Directly Affecting Business

The proposed regulatory action has no cost impact on either small businesses or on persons in the private sector and no significant, statewide adverse economic impacts that directly affect business.