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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF: Blue Cross of California, Respondent.	OAH No.: Enforcement Matter No.: 15-268 **ACCUSATION**

I.

INTRODUCTION

1. The California Department of Managed Health Care (the "Department" or "Complainant") brings the present action to assess administrative penalties against BLUE CROSS OF CALIFORNIA, d/b/a ANTHEM BLUE CROSS ("Respondent" or the "Plan") for violations of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act" or the "Act") (Health & Safety Code, section 1340, *et seq.*), and California Code of Regulations, title 28, promulgated pursuant to the Knox-Keene Act, arising out of its handling of enrollee complaints. [1]

2. Health plans are required to have and maintain a grievance system to ensure that standard enrollee complaints are adequately considered and resolved within 30 days, expedited complaints are adequately considered and resolved within three days, and to ensure the plan timely and thoroughly responds to Department communications and requests for information regarding consumer complaints.

[1] For convenience, a section of the Health and Safety Code is hereinafter referred to as "Section," followed by the section number, and title 28 of the California Code of Regulations is hereinafter referred to as "Rule," followed by the section number.

This is reflected in the Knox-Keene Act's codified legislative intent of "[e]nsuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department." (Health & Saf. Code, §1342, subd. (h).)

3. As set forth below, Respondent's grievance system is defective, and has been for many years. This impacts consumers by causing delays in resolving their health care disputes and consequently creating frustration, stress, and even potentially detrimental effects on their health if appropriate care is delayed. The Department oversees health care service plan grievance systems by reviewing and investigating individual enrollee complaints lodged with the Department's consumer Help Center as well as by conducting routine and non-routine onsite medical surveys of grievance files at the health plan's offices, as authorized under Section 1380, *et seq.* Evidence from both sources supports the conclusions and findings that Respondent's grievance system fails to meet the requirements of the Knox-Keene Act.

4. While this Accusation is based on many consumer complaints that were ultimately referred to the Department, many consumers never had an opportunity to lodge complaints with the Department because the Plan's deficient system resulted in the Plan failing to recognize, identify, and process their complaints as grievances.

5. The Department has found repeated instances of Respondent's failure to recognize an enrollee's complaint as a grievance. In one particularly egregious case, an enrollee was diagnosed with a very serious condition that required extensive surgical intervention and reconstruction. Notwithstanding the Plan's pre-authorization of the procedure, the Plan denied the four-figure claim submitted by the provider (the provider initially submitted an incorrect date of service). In an effort to resolve the issue, the enrollee, the enrollee's provider, the enrollee's broker, and the enrollee's spouse made multiple and increasingly frustrated calls to the Plan. Despite 22 calls, the Plan not only failed to resolve the enrollee's complaint, but – demonstrating troubling consistency – failed to recognize even one of those calls as a grievance under California law. Instead, calls to the Plan's customer service call center resulted in repeated transfers and unfulfilled promises that Plan representatives would call them back. Not until after the enrollee sought assistance from the Department, more than half a year after the treatment, did the Plan finally pay the enrollee's claim.

6. The Department also found repeated instances in which the Plan failed to properly process and resolve enrollee grievances once they were received and identified. This failure creates delay, impacting the resolution of enrollee health care disputes and creates unnecessary frustration and stress. For example, one case involved an enrollee who filed a grievance on March 5, 2015, regarding the Plan's denial of a request for durable medical equipment. The Plan did not resolve his grievance within the required 30-day time frame. Since the enrollee did not hear from the Plan in response to his grievance, he had to make multiple calls to the Plan. Even after three separate calls over the course of one month, the Plan still failed to resolve his grievance. Frustrated, the enrollee finally called the Department for assistance, and the Department contacted the Plan for information. The Plan finally resolved the grievance on May 21, 2015, 47 days past the 30-day grievance-resolution time frame.

7. These are only two of many examples demonstrating how dramatically Respondent's deficient grievance system fails its enrollees. The Legislature expressly mandated that the Department ". . . periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department." (Health & Saf. Code, § 1368.04. subd. (a).) The Director has determined such an enforcement action is warranted, and the Department brings this Accusation against Respondent, seeking administrative penalties for pervasive and ongoing violations of the Knox-Keene Act and accompanying regulations.

II.

PARTIES

8. Drew Brereton ("Complainant") is the Deputy Director and Chief Counsel of the Department's Office of Enforcement. Complainant brings this Accusation solely in his official capacity as Deputy Director and Chief Counsel of the Office of Enforcement for the Department.

9. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Section 1345, subdivision (f), and is subject to the statutory and regulatory provisions of the Act. Respondent is the holder of health care service plan license number 933 0303, which was issued on January 7, 1993. Respondent's principal corporate office is located at: 1 WellPoint Way, Thousand Oaks, California. Respondent is a for-profit health care service plan licensed under and regulated by the Knox-Keene Act.

10. According to Respondent's financial statement for the quarter that ended June 30, 2017, Respondent had 3,987,508 total enrollees.

III.

JURISDICTION

11. This Accusation is brought before the Director of the Department ("Director") under the authority conferred in the Act and title 28 of the California Code of Regulations, as specified below.

12. The Department is charged with the task of regulating managed care in the State of California and ensuring that the entities that sell managed care products in California, known as health care service plans, are in compliance with their obligations under the Act. (Health & Saf. Code, §§ 1341, subd. (a), 1345, subd. (f).)

13. The Director is responsible for the performance of all duties and responsibilities vested by law in the Department, including the administration and enforcement of the Act and the rules and regulations adopted thereunder. (Health & Saf. Code, §§ 1341, subd. (c), 1346, subd. (a)(5).)

14. Section 1386, subdivision (a), authorizes the Director to take disciplinary action against a health care service plan under appropriate circumstances. The Director is authorized to assess administrative penalties against a plan if the Director determines, after appropriate notice and opportunity for a hearing, that the plan has committed any of the acts or omissions enumerated in Section 1386, subd. (b), which constitute grounds for disciplinary action.

15. Section 1386, subdivision (b)(6), states that the grounds for disciplinary action against a health care service plan include instances where "[*t*]*he plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.*"

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IV.

RELEVANT STATUTES AND REGULATIONS

16. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, including a complaint, dispute, request for reconsideration, or appeal made by an enrollee or the enrollee's representative. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(1).) Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (*Id.*)

17. Health care service plans, including Respondent, must maintain a system by which enrollees may file grievances. Each system shall provide reasonable procedures in accordance with Department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. (Health & Saf. Code, §1368, subd. (a)(1).)

18. Grievances that are not coverage disputes, or disputes regarding health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and resolution letter. (Health & Saf. Code, § 1368, subd. (a)(4)(B)(i); Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(8).)

19. Health care service plans must provide written acknowledgement within five calendar days of the receipt of a grievance, which shall advise the complainant that the grievance has been received, the date of the receipt, and the name and contact information of the plan representative who may be contacted about the grievance. (Health & Saf. Code, § 1368, subd. (a)(4)(A).)

20. The grievance system shall require the plan to resolve standard grievances within 30 days. (Health & Saf. Code, § 1368.01, subd. (a).) The grievance system shall be established in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a).)

21. The grievance system shall require the plan to provide a written statement on the disposition or pending status of an expedited grievance within three days. (Health & Saf. Code, § 1368.01, subd. (b); Cal. Code Regs., tit. 28, § 1300.68.01, subd. (a)(2).)

22. Health plans are required to provide enrollees with written responses to grievances with a clear and concise explanation of the reasons for the plan's response. (Health & Saf. Code, § 1368, subd. (a)(5).) For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision. (*Id.*) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. (Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(5).) The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applies to the specific health care service or benefit requested by the enrollee. (*Id.*) In addition to the notice set forth at Section 1368.02, subdivision (b), the response shall also include a notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review. (*Id.*)

23. In cases involving an imminent or serious threat to the health of the enrollee, or where the Department determines an earlier review is warranted, the enrollee may seek assistance directly from the Department. In such cases, the Department may require the plan and contracting providers to expedite the delivery of information. The Department may consider the failure of a plan to timely provide the requested information as evidence in favor of the enrollee's position in the Department's review of grievances submitted under Section 1368, subdivision (b) (submitted first to the plan's grievance system). (Cal. Code Regs., tit. 28, § 1300.68, subd. (h).)

24. Every health care service plan shall publish the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the plan's telephone number, and the Department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan, and on all written responses to grievances. (Health & Saf. Code, § 1368.02, subd. (b).)

25. An enrollee may submit a grievance to the Department. The Department shall notify the plan and, within five calendar days after notification, the plan shall provide information to the Department, including a written response to the issues raised by the grievance, a copy of the plan's original response sent to the enrollee regarding the grievance, a copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage ("EOC"), with the specific applicable sections underlined, and all information used by the plan or relevant to the resolution of the grievance. (Cal. Code Regs., tit. 28, § 1300.68, subds. (g), (g)(1)–(2), (g)(4)–(5).)

26. The Department may request additional information or medical records from the plan. Within five calendar days of receipt of the Department's request, the plan shall forward information and records that are maintained by the plan or any contracting provider. If requested information cannot be timely forwarded to the Department, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected. (Cal. Code Regs., tit. 28, § 1300.68, subd. (g)(6).)

27. The Department shall periodically conduct an onsite medical survey, similar to an audit or inspection, of the health care delivery system of each plan. The survey shall include, among other things, a review of the procedures for obtaining health services and internal procedures for assuring quality of care and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees. (Health & Saf. Code, § 1380, subd. (a).)

28. Through these surveys under Section 1380, the Department shall periodically review the plan's grievance system, including the records of grievances received by the plan, and assess the effectiveness of the plan policies and actions taken in response to grievances. (Cal. Code Regs., tit. 28, § 1300.68, subd. (c).)

29. The onsite medical survey of a plan shall include, but not be limited to, the grievance procedure required by Section 1368, including the availability to enrollees and subscribers of grievance procedure information, the time required for and the adequacy of the response to grievances and the utilization of grievance information by plan management. (Cal. Code Regs., tit. 28, § 1300.80, subd. (b)(6)(C).)

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30. The Director may, after appropriate notice and an opportunity for a hearing, assess administrative penalties if the Director determines that a health plan has knowingly committed or has performed with a frequency that indicates a general business practice, either: (1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01; or (2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear. (Health & Saf. Code, § 1368.04, subds. (b)(1), (2).)

31. The Department's licensees are subject to discipline for "any conduct that constitutes fraud or dishonest dealing or unfair competition as defined by Section 17200 of the Business and Professions Code." (Health & Saf. Code, § 1386, subd. (b)(7).) Unfair competition "shall mean any unlawful, unfair or fraudulent business act or practice." (Emphasis added.) (Bus. & Prof. Code, § 17200.)

V.

FACTUAL ALLEGATIONS

32. Enrollees in health care service plans communicate with their health plans for a variety of reasons, including billing questions, coverage disputes, or complaints about the care they received from a provider. Regardless of the reason for the communication, enrollees have the right to submit a complaint, called a grievance, with the plan. The Knox-Keene Act includes a number of consumer protections, one of which requires that health care service plans must have and maintain effective administrative capacity to process and resolve enrollee grievances. (Health & Saf. Code, §§ 1367, subd. (h), 1368.) A "grievance" is broadly defined in Rule 1300.68.01(a) as ". . . a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative . . .."

33. The Knox-Keene Act prescribes the protections required to be in every plan's grievance system including, for example, the requirement that grievances must be acknowledged by the plan in writing within five days (Health & Saf. Code, § 1368, subd. (a)(4)(A)); must be resolved within 30 days (Health & Saf. Code, § 1368.01, subd. (a)); and, the resolution letter must include a clear and concise

explanation of the reason for the plan's response. (Health & Saf. Code, § 1368, subd. (a)(5).) Further, plans are required to maintain a written record of every grievance received. (Cal. Code Regs, tit. 28, § 1300.68, subd. (b)(5).) An enrollee dissatisfied with the plan's response to the grievance may file a complaint with the Department. (Health & Saf. Code, § 1368, subd. (b)(1)(A).)

34. Respondent has established as one of its business practices a grievance resolution process for its enrollees to submit complaints to the Plan. (Health & Saf. Code, § 1368, subd. (a)(1).)

35. Respondent has been disciplined by the Department for 2,102 violations referred from the Help Center between January 1, 2002, and August 1, 2016, in cases solely involving grievance system violations, for which Respondent has paid the Department $5,956,500 in administrative penalties.

36. In addition to the grievance system violations referred to above (which have already been prosecuted and resolved through settlement), this Accusation alleges Respondent violated the grievance laws an additional 246 times in 175 cases referred from the Department's Help Center, covering the period of December 13, 2013, through August 1, 2016.[2] As set forth below, these are evidence of not only individual violations, but also support the finding of systemic violations discussed herein as well.

37. In addition to the prosecution of Respondent's grievance violations related to Help Center case files, between January 1, 2002, and July 31, 2016, the Department also conducted a systemic review through six medical surveys of Respondent's operations – including its grievance system – in which the Department found significant numbers of grievance system violations. After each survey, Respondent proposed specific corrective action to address the violations. While Respondent allegedly implemented the proposed corrective action, significant problems remain, as described below.

38. The Department conducted a Routine Survey of the Respondent between November 4, 2013, and February 11, 2014 ("Routine Survey"). During this survey, and during the Follow-Up Survey of the Respondent, which was conducted between July 12, 2016, and September 21, 2016 ("Follow-Up Survey"), the Department reviewed grievance files from the period September 1, 2011, through August 31, 2013, and found a statistically significant number of instances in which Respondent failed to

[2] The Department's Help Center referred 175 files for prosecution of grievance system violations alone (i.e., excluding cases with violations in addition to grievance system violations). While the Department is not specifically identifying the files in this public Accusation, it has, concurrently with the service of this Accusation, provided Respondent with a complete list of each grievance system violation file to enable Respondent to review the matters.

adequately consider enrollee grievances, representing a systemic problem. In addition, of the 246 violations referred by the Help Center, there are at least 29 cases regarding enrollee grievances that were submitted to the Plan between 2013 through 2016, in which the Department found Respondent failed to adequately consider the enrollee's grievance, including, among other things, failing to resolve each of the enrollee's complaints in cases where the enrollee submitted multiple complaints, failing to consider all information material to resolution of the complaint, and failing to identify the enrollees' clear expressions of dissatisfaction as grievances.

39. During the Routine and Follow-Up Surveys, the Department found, in its review of grievance files, a statistically significant number of instances in which Respondent misclassified standard grievances as exempt grievances, representing a systemic problem.

40. During the Routine and Follow-Up Surveys, the Department found, in its review of grievance files, a statistically significant number of instances in which Respondent failed to provide the enrollee with a written acknowledgement of its receipt of the grievance within five calendar days of receipt, representing a systemic problem. Further, in at least 53 cases regarding enrollee grievances that were submitted to the Plan between 2013 through 2016, the Department found Respondent had committed this same violation.

41. In at least 94 cases regarding enrollee grievances that were submitted to the Plan between 2013 through 2016, Respondent failed to resolve enrollee grievances within 30 calendar days of receipt.

42. During the Routine and Follow-Up Surveys, the Department found, in its review of grievance files, a statistically significant number of instances in which Respondent failed to provide the enrollee with a clear and concise explanation of the reasons for the Plans' response, and/or failed to describe the criteria used or the clinical reasons for a medical decision, and/or failed to specify the provision in the contract, evidence of coverage, or member handbook that excluded the disputed service, and/or failed to include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the enrollee may contact the Department to determine eligibility for independent medical review. This statistically significant number of violations represents a systemic problem. Further, in at least three cases regarding enrollee grievances that were submitted to the Plan from 2013 through 2016, the Department found Respondent committed the same violations.

43. In at least three cases regarding enrollee grievances that were submitted to the Plan from 2013 through 2016, and that contained information that the enrollee was experiencing an imminent threat to his or her health (including, but not limited to severe pain or the potential loss of life, limb, or major bodily function), Respondent failed to expedite processing of the grievance and/or failed to immediately inform the enrollee or subscriber in writing of their right to notify the Department, or both.

44. During the Routine and Follow-Up Surveys, the Department found, in its review of grievance files, a statistically significant number of instances in which Respondent failed to include some or all of the following information in its written response to enrollee grievances: 1) the Department's toll-free telephone number; 2) the Department's TDD phone number for the hearing and speech impaired; 3) the Department's website address; and 4) the Plan's telephone number, representing a systemic problem. Additionally, in at least three cases regarding enrollee grievances that were submitted to the Plan from 2013 through 2016, the Department found the Respondent committed the same violations.

45. During the Routine and Follow-Up Surveys, the Department found, in its review of grievance files, a statistically significant number of instances in which Respondent failed to send some or all of the following information to the Department within five days of receipt of an enrollee grievance from the Department: 1) a written response to the issues raised in the enrollee's grievance; 2) a copy of the Plan's original response sent to the enrollee regarding the grievance; 3) a copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage ("EOC") with the specific applicable sections underlined; and 4) all other information used by the Plan or relevant to the resolution of the grievance, representing a systemic problem. Further, in at least 57 cases regarding enrollee grievances that were submitted to the Plan from 2013 through 2016, the Department found Respondent committed the same violations.

46. In at least four cases regarding enrollee grievances that were submitted to the Plan from 2013 through 2016 and that contained information that the enrollee was experiencing an imminent threat to his or her health (including, but not limited to severe pain or the potential loss of life, limb, or major bodily function), Respondent failed to expedite delivery of information requested by the Department.

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VI.

CAUSES FOR DISCIPLINE

I. FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain a Grievance System to Ensure Adequate Consideration of a Grievance)

[Health & Saf. Code, § 1368, subd. (a)(1) / Cal. Code Regs., tit. 28, §1300.68, subd. (a)(1)]

47. Complainant hereby incorporates by reference paragraphs 1-46.

48. Health care service plans that violate any portion of the Act or the Department's regulations are subject to discipline by the Department. (Health & Saf. Code, § 1386, subd. (b)(6)).

49. Every health plan must establish and maintain a grievance system that shall provide reasonable procedures in accordance with Department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. (Health & Saf. Code, § 1368, subd. (a)(1); Rule 1300.68, subd. (a)(1).)

50. During the Routine and Follow-Up Surveys, the Department reviewed grievance files and found a statistically significant number of instances in which Respondent failed to consider expressions of dissatisfaction as grievances, and failed to maintain a grievance system providing reasonable procedures to ensure adequate consideration of a grievance, in violation of Section 1368, subdivision (a)(1) and Rule 1300.68, subdivision (a)(1).

51. Further, the Department found Respondent committed that same violation in 29 matters that occurred between 2013 and 2016 and that have not yet been prosecuted. Together with the survey findings, this represents a systemic problem. Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

II. SECOND CAUSE FOR DISCIPLINE

(Misclassification of Standard Grievances as Exempt Grievances)

[Health & Saf. Code, § 1368, subd. (a)(4)(B)(i) / Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(8)]

52. Complainant hereby incorporates by reference paragraphs 1-51.

53. Grievances that are not coverage disputes, disputed heath care services involving medical necessity or experimental or investigational treatment, and that are resolved by the next business day following receipt, are exempt from the requirements of Section 1368, subdivisions (a)(4)(A) and (a)(5).

The plan must, however, maintain a log of all these exempt grievances, and the log must be periodically reviewed by the plan. The log must also include, for each complaint, the date of the call, the name of the complainant, the complainant's member identification number, the nature of the grievance, the nature of the resolution, as well as the name of the plan representative who took the call and resolved the grievance. (Health & Saf. Code, § 1368, subd. (a)(4)(B)(i).)

54. If a grievance does not fall within the limited definition of an exempt grievance, it is referred to as a standard grievance. During the Routine and Follow-Up Surveys, the Department found a statistically significant number of instances in which Respondent failed to correctly identify standard grievances, in violation of Section 1368, subdivision (a)(4)(B)(i) and Rule 1300.68, subdivision (d)(8). For each complaint Respondent failed to classify as a grievance, Respondent failed to resolve that enrollee's grievance within the timeframes established in Section 1368.01. Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

III. THIRD CAUSE FOR DISCIPLINE

(Failure to Timely Provide Written Acknowledgement of a Grievance with all Required Information)

[Health & Saf. Code, § 1368, subd. (a)(4)(A) / Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(1)]

55. Complainant hereby incorporates by reference paragraphs 1-54.

56. Health plans are required to provide written acknowledgement of each grievance received from an enrollee within five calendar days of the receipt of the grievance, and the acknowledgement must advise the complainant that the grievance has been received, and include the date of receipt, as well as the name and contact information of the health plan representative who may be contacted about the grievance. (Health & Saf. Code, § 1368, subd. (a)(4)(A)(i)–(iii).)

57. During the Routine and Follow-Up Surveys, the Department reviewed grievance files and found a statistically significant number of instances in which Respondent failed to timely provide written acknowledgement of enrollee grievances with all required information, in violation of Section 1368, subdivision (a)(4)(A) and Rule 1300.68, subdivision (d)(1).

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58. In addition, the Department found that Respondent committed this same violation in each of approximately 53 cases that occurred between 2013 and 2016 and that have not yet been prosecuted. Together with the survey findings, this represents a systemic problem. Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

IV. FOURTH CAUSE FOR DISCIPLINE

(Failure to Resolve a Grievance within 30 Days of Receipt)

[Health & Saf. Code, § 1368.01, subd. (a) / Cal. Code Regs., tit. 28, § 1300.68, subds. (a), (d)(3)]

59. Complainant hereby incorporates by reference paragraphs 1-58.

60. The plan's grievance system shall require the plan to resolve grievances within 30 days. (Health & Saf. Code, § 1368.01, subd. (a).)

61. The grievance system shall be established in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. (Cal. Code Regs., tit. 28, § 1300.68, subds. (a), d(3).)

62. In each of approximately 94 cases that occurred between 2013 and 2016 and that have not yet been prosecuted, Respondent failed to resolve the grievance within 30 days, thereby violating Section 1368.01, subdivision (a), and Rule 1300.68, subdivisions (a) and (d)(3). Respondent is therefore subject to disciplinary action under Section 1386, subdivision (b)(6).

V. FIFTH CAUSE FOR DISCIPLINE

(Failure to Describe the Clinical Reasons for the Plan's Medical Necessity Determination)

[Health & Saf. Code § 1368, subd. (a)(5) / Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(5)]

63. Complainant hereby incorporates by reference paragraphs 1-62.

64. Health plans are required to provide enrollees with written responses to grievances with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision. (Health & Saf. Code §1368, subd. (a)(5).)

65. Plan responses to grievances involving a determination that the requested service is not a covered benefit must specify the provision in the contract, evidence of coverage, or member handbook

that excludes the service. The plan's written response must either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition, the response must also include a notice that, if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review. (Cal. Code Regs., tit. 28, §1300.68, subd. (d)(5).)

66. During the Routine and Follow-Up Surveys, the Department reviewed grievance files and found statistically significant instances in which Respondent failed to provide to enrollees written responses with a clear and concise explanation of the reasons for the Plan's response, failed to describe the criteria used or the clinical reasons for the decision, failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service, and/or failed to include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary that the enrollee may contact the Department to determine eligibility for independent medical review, in violation of Section 1368, subdivision (a)(5) and Rule 1300.68, subdivision (d)(5). Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

67. In approximately three cases that occurred between 2013 and 2016 and that have not yet been prosecuted, the Department found that Respondent committed this same violation. Together with the survey findings, this represents a systemic problem. Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

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VI. SIXTH CAUSE FOR DISCIPLINE

(Failure to Provide Written Statement to Enrollee and Department on Disposition or Pending Status of an Urgent Matter within Three Days of Receipt of the Grievance)
[Health & Saf. Code, § 1368.01, subd. (b) / Cal. Code Regs., tit. 28, § 1300.68.01, subds. (a)(1), (2)]

68. Complainant hereby incorporates by reference paragraphs 1-67.

69. The health plan grievance system must include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the Department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

70. Respondent failed to expedite grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, or failed to immediately inform enrollees and subscriber in writing of their right to notify the Department of the grievance, in each of approximately three cases that occurred between 2013 and 2016 and that have not yet been prosecuted, thereby violating Section 1368.01, subdivision (b) and Rule 1300.68.01, subdivisions (a)(1) and (2). Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b).

VII. SEVENTH CAUSE FOR DISCIPLINE

(Failure to Include Required Language in Appropriate Format on Grievance-Related Communications and Notices)

[Health & Saf. Code, § 1368.02, subd. (b)]

71. Complainant hereby incorporates by reference paragraphs 1-70.

72. Every health care plan must publish the Department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on

copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances.

73. During the Routine and Follow-Up Surveys, the Department reviewed grievance files and found a statistically significant number of instances in which Respondent failed to publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances, in violation of Section 1368.02, subdivision (b).

74. In addition, in three cases that occurred between 2013 and 2016 and that have not yet been prosecuted, the Department found that Respondent committed that same violation. Together with the survey findings, this represents a systemic problem. Respondent is therefore subject to discipline pursuant to Section 1386, subdivision (b).

VIII. EIGHTH CAUSE FOR DISCIPLINE

(Failure to Timely Provide Information to the Department Regarding the Enrollee's Grievance)

[Cal. Code Regs., tit. 28, § 1300.68, subds. (g), (g)(1)–(2), (g)(4)–(g)(6)]

75. Complainant hereby incorporates by reference paragraphs 1-74.

76. An enrollee may submit a grievance to the Department. The Department then notifies the plan, and within five calendar days after notification, the plan must provide information to the Department, including a written response to the issues raised by the grievance, a copy of the plan's original response sent to the enrollee regarding the grievance, a copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage ("EOC"), with the specific applicable sections underlined, and all information used by the plan or relevant to the resolution of the grievance.

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77. In each of 57 separate cases that occurred between 2013 and 2016 and that have not yet been prosecuted, the Department found that Respondent failed to timely and thoroughly provide information to the Department regarding the issues raised in the enrollee's grievance as required under Rule 1300.68, subdivision (g), thereby violating Rule 1300.68, subdivisions (g), (g)(1), (g)(2), (g)(4), (g)(5) and (g)(6). Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

IX. NINTH CAUSE FOR DISCIPLINE

(Failure to Expedite Plan Response Pursuant to the Department's Instructions in an Early Review Case)

[Cal. Code Regs., tit. 28, § 1300.68, subd. (h)]

78. Complainant hereby incorporates by reference paragraphs 1-77.

79. In cases involving an imminent or serious threat to the health of the enrollee, or where the Department determines an earlier review is warranted, the enrollee may seek assistance directly from the Department. In such cases, the Department may require the plan and contracting providers to expedite the delivery of information. The Department may consider the failure of a plan to timely provide the requested information as evidence in favor of the enrollee's position in the Department's review of grievances submitted under subdivision (b) of Section 1368 of the Act (submitted first to the plan's grievance system).

80. In each of four separate cases that occurred between 2013 and 2016 and that have not yet been prosecuted, the Department found that Respondent failed to expedite the delivery of requested information, thereby violating Rule 1300.68, subdivision (h). Accordingly, Respondent is subject to disciplinary action under Section 1386, subdivision (b)(6).

X. TENTH CAUSE FOR DISCIPLINE

(Repeated Failure to Act Promptly and Reasonably to Investigate and Resolve Grievances with Such Frequency That Indicates a General Business Practice)

[Health & Saf. Code § 1368.04, subds. (b)(1), (2)]

81. Complainant hereby incorporates by reference paragraphs 1-80.

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82. The Director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following: (1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01; and (2) Repeated failure to act promptly and reasonably to investigate and resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

83. As described in paragraphs 35 through 37 above, the Plan's history of deficiencies demonstrates its consistent and ongoing failure to act promptly and reasonably to investigate and resolve grievances. Respondent has a long history of compliance issues, documented in survey reports since 2002, including the reports of the surveys in issue in this case. For the 2013 Routine Survey, the Department conducted an in-depth review of a random sample of 94 standard grievance files to evaluate Respondent's grievance system for processing enrollee complaints. The Department found Respondent did not timely and adequately consider, investigate, and rectify enrollee grievances. Numerous files reviewed in the Routine Survey and Follow-Up Survey reflected a combination of problematic issues, demonstrating noncompliance with various requirements set forth under Section 1368, subdivision (a) and Rule 1300.68, subdivisions (a) and (d). Due to the multitude and complexity of issues discovered within individual grievances, the Department identified several patterns of non-compliance that were particularly striking and demonstrate Respondent's inability to fulfill its overall obligation to maintain a grievance system that consistently ensures adequate consideration and rectification of enrollee grievances. The areas of concern included:

a) The Plan does not adequately consider clear, sometimes repeated, expressions of dissatisfaction as grievances, and therefore fails to promptly process them in a timely manner;

b) The Plan does not adequately consider and resolve all enrollee grievances, whether a single issue or multiple issues are raised;

c) The Plan does not perform a thorough investigation of enrollee grievances to ensure appropriate resolution; and

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d) The Plan's written responses to enrollees do not contain clear and concise explanations of the resolution, indicating inadequate consideration of the grievances.

84. Based on this evidence, Respondent's grievance violations demonstrate that Respondent continues to repeatedly fail to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01 and repeatedly fail to act promptly and reasonably to investigate and resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear, thereby violating Section 1368.04, subdivisions (b)(1) and (2). Respondent is therefore subject to disciplinary action under Section 1386, subdivision (b)(6).

XI. ELEVENTH CAUSE FOR DISCIPLINE

(Engaging in Any Conduct that Constitutes Fraud or Dishonest Dealing or Unfair Competition, as Defined by Section 17200 of the Business and Professions Code)

[Health & Saf. Code § 1386, subd. (b)(7)]

85. Complainant hereby incorporates by reference paragraphs 1-84.

86. The Department may, after appropriate notice and opportunity for a hearing, by order assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action. (Health & Saf. Code, § 1386, subd. (a).) Among the grounds for disciplinary action are: "any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code." (Health & Saf. Code, § 1386, subd. (b)(7).) Conduct by a health care service plan in violation of the Knox-Keene Act is sufficient to assert a cause of action for violation of [Section 17200]. (*Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 706; *California Medical Assn. v. Aetna US Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 169.)

87. Unfair competition means and includes any unlawful, unfair, or fraudulent business act or practice. (Bus. & Prof. Code, § 17200, also referred to as the Unfair Competition Law, or "UCL".)

88. Among its many business practices, Respondent operates a grievance system for its enrollees pursuant to Health and Safety Code section 1368, subd. (a). As detailed above, Respondent's conduct of this business practice results in numerous violations of the Knox-Keene Act statutes and regulations governing health plan grievance systems. (Health & Saf. Code, § 1368.04, subds. (b)(1),

(2).) Since violations of the Knox-Keene Act or the Department's regulations constitutes unfair competition as defined by Section 17200 of the Business and Professions Code, Respondent's conduct in operating its grievance system constitutes unfair competition. Respondent is subject to disciplinary action for engaging in conduct meeting the definition of unfair competition under Business and Professions Code, section 17200. (Health & Saf. Code, § 1386, subd. (b)(7)).

VII.

PRAYER

WHEREFORE, Complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty against the Respondent pursuant to Rule 1300.86, in the amount of $5,000,000 for the violations of the Knox-Keene Act and the accompanying rules and regulations it has committed as alleged in this Accusation.

WHEREFORE, Complainant also prays for such other and further relief as the Director deems proper.

Dated: Nov 15, 2017

By: _____
DREW BRERETON
Deputy Director | Chief Counsel
Office of Enforcement
Department of Managed Health Care