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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF: California Physicians' Service, Respondent.	Enforcement Matter No.: 14-212 **ACCUSATION** (Health & Safety Code section 1340 et seq.)

I.

INTRODUCTION

The California Department of Managed Health Care ("the Department") brings the present action to assess administrative penalties against CALIFORNIA PHYSICIANS' SERVICE, DBA BLUE SHIELD OF CALIFORNIA ("Blue Shield") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("the Act") (Health and Safety Code section 1340 et seq.) Blue Shield is a health care service plan licensed under and regulated by the Act.

II.

PARTIES

1. 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.

2. At all times pertinent to the allegations herein, Blue Shield has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is

subject to the regulatory provisions of the Act. Blue Shield is the holder of health care service plan license number 933 0043 which was issued on July 27, 1978, by the Commissioner of the Department of Corporations, predecessor to the Director of the Department. Blue Shield's principal corporate office is located at 50 Beale Street, San Francisco CA, 94105.

III.

JURISDICTION

3. 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.

4. The Department is charged with the task of regulating managed care in the State of California and ensuring that the entities which 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), and 1345, subd. (f).)

5. 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), and 1346, subd. (a)(5).)

6. Health and Safety Code section 1386, subdivision (a),[1] authorizes the Director to take disciplinary action against a health care service plan under the appropriate circumstances. The Director is authorized to assess administrative penalties against a health care service 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 Health and Safety Code section 1386, subdivision (b), which constitute grounds for disciplinary action.

7. Section 1386(b)(6) states the grounds for disciplinary action include instances where a plan has violated or attempted to violate any provision of rule of the Act or any order issued by the Director.

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

8. Section 1386(b)(7) states that any plan which has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition is subject to disciplinary action.

IV.

LEGAL AND FACTUAL BACKGROUND

A. Requirements Applicable to the Grievance System of a Health Plan

9. Section 1368 and the implementing regulations, California Code of Regulations, title 28, section 1300.68 and California Code of Regulations, title 28, section 1300.68.01[2], provide the general statutory and regulatory framework for the grievance system requirements of health care services plans.

10. Section 1368(a)(1), requires health plans to establish and maintain a grievance system under which enrollees may submit their grievances to the plan. The grievance system must ensure adequate consideration of an enrollee's grievance(s), and resolution as appropriate.

11. Rule 1300.68(a) requires that a health plan's grievance system be established in writing and include procedures which will receive, review, and resolve grievances within 30 calendar days of receipt. Pursuant to Rule 1300.68(a)(1), a grievance is defined as a written or oral expression of dissatisfaction regarding the plan or provider, and includes a complaint, dispute, request for reconsideration or appeal. If a plan is unable to distinguish between a grievance and an inquiry, the plan shall consider it a grievance.

12. Section 1368(a)(4)(A) requires a health plan to provide an acknowledgement of an enrollee's grievance within five calendar days of receipt. Rule 1300.68(d)(1), requires the acknowledgement include notice that the grievance has been received and date of receipt, and the name and contact information of the health plan representative who may be contacted about the grievance.

13. Under Section 1368(a)(5), a health plan is 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

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

response shall describe the criteria used and the clinical reasons for its decision.

14. Under Section 1368.01(a), the plan must resolve grievances within 30 calendar days of receipt. Rule 1300.68(d)(3) requires the plan's resolution, containing a written response, be sent within 30 calendar days of receipt, and contain a clear and concise explanation of the plan's reasons for its decision.

15. Section 1368.02(b) requires that the plan include the Department's toll-free 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 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. This section further requires that health plan written notices to enrollees under the grievance process include the following statement:

> The California Department of Manages Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://hmo-help.ca.gov has complaint forms, IMR application forms and instructions on line.

B. *Requirements Applicable to Health Plans Once an Enrollee files a Grievance with the Department of Managed Health Care*

16. Under Rule 1300.68(g)(1)-(5), after an enrollee files a grievance with the Department, the Department will notify the plan. Within 5 calendar days after notification, the

plan must provide documents and information to the Department, including, a written response to the issues raised in the grievance; a copy of the plan's original grievance response to the enrollee; a complete and legible copy of medical records related to the grievance, or a statement that medical records were not used in the grievance resolution; a copy of the cover page and all relevant pages of the enrollee's evidence of coverage with applicable sections underlined; and all other information relied upon by the plan in responding to the enrollee's grievance.

17. Under Rule 1300.68(g)(6), the Department may request additional information from the plan. The plan must respond to the request for additional information within 5 calendar days, or provide the Department with a description of the action being taken to obtain the information, and when the information can be expected.

18. Under Rule 1300.68(h), the Department may designate enrollee complaints for early review. In these cases, the Department may require a shorter time frame for the plan to respond to a request for information.

C. Additional Statutory Requirements at Issue in this Case

19. Section 1367.01(h)(4) requires health plans to provide a written response to a provider's request for treatment. Responses regarding decisions to deny, delay, or modify the services requested must include a clear and concise explanation for the reasons for the decision, a description of the criteria used, and the clinical reasons for decisions regarding medical necessity.

D. Disciplinary Action In This Case

20. As set forth more specifically below, Blue Shield is subject to disciplinary action in this case because Blue Shield violated Health and Safety Code sections 1367.01, subdivision (h)(4); Health and Safety Code sections 1368, subdivisions (a)(1), (a)(4)(A), and (a)(5); Health and Safety Code section 1368.01, subdivision (a); Health and Safety Code section 1368.02, subdivision (b); and California Code of Regulations, title 28, section 1300.68, subdivisions (a), (d)(1), (g) and (h). (See Section 1386(b)(6).)

21. All hearings before the Director are to be held in accordance with the Administrative Procedure Act, and the Director has all of the powers granted under that act. (Health & Saf. Code, § 1397, subd. (a).) The factors for determining an appropriate penalty for

violations of the Knox-Keene Act are set forth in Rule 1300.86.

22. This Accusation is not intended to, nor does it limit the Department's authority to take any and all additional appropriate action as provided under the authority of the Knox-Keene Action and title 28 of the California Code of Regulations with regard to same or similar violations which occurred during the same time period.

E. Enrollee Grievances At Issue In This Case[3]

23. The Department has identified thirty-three enrollee grievances in which Blue Shield has violated one or more Knox-Keene Act statutes or regulations. The facts of these grievance files are summarized below.

Matter 14-212[4]

24. In December 2012, the enrollee went to a non-preferred provider facility for urgent treatment for kidney stones. Blue Shield processed the resulting claims under the enrollee's non-urgent/non-emergent, non-preferred provider benefits.

25. The enrollee filed a grievance with Blue Shield on February 19, 2013, and requested Blue Shield reprocess the claims as urgent/emergent services. Blue Shield denied the grievance on March 11, 2013, on the basis that the services were provided by an out-of-network ("OON") provider and were processed as a non-preferred provider level of benefit. Blue Shield did not respond to the enrollee's complaint that the services were urgent or emergent, thereby requiring reimbursement at the higher rate.

26. The enrollee appealed the grievance denial to the Department. On April 25, 2013, the Department requested that Blue Shield obtain medical records and perform a clinical review by no later than noon on April 30, 2013. On May 1, 2013, Blue Shield responded to the Department that it was awaiting medical records and requested additional time.

27. During the Department's investigation, the enrollee provided medical records from the OON provider. The Department requested that Blue Shield perform a clinical review of the enrollee's treatment records to determine if the services were covered under the urgent or emergent

[3] In the interest of judicial efficiency, these matters are being prosecuted as a group. This group prosecution is not intended to represent the universe of violations during the relevant time period.

[4] Matters referred to throughout are internal Department references, and are used only for case identification.

benefits. After its review, Blue Shield reversed its denial and reprocessed the enrollee's claim as urgent or emergent services.

Matter 14-214

28. The Enrollee filed a complaint with the Department and requested that Blue Shield authorize and cover breast reconstruction surgery by a female provider. The enrollee stated that due to traumatic events in her past she required treatment by female health providers and Blue Shield did not have any in-network female providers that could perform the surgery. On May 2, 2013, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on May 7, 2013. Blue Shield's response was received on May 7, 2013, however it failed to address the enrollee's grievance regarding her request for a female surgeon. On May 17, 2013, the Department sent a second request for additional information to Blue Shield, requesting Blue Shield to address the enrollee's request for a female provider and produce the names of three in-network female providers. Blue Shield did not respond to the Department until May 28, 2013.

Matter 14-221

29. On March 4, 2014, the enrollee emailed Blue Shield and complained that his providers had encountered difficulties submitting claims for covered services. On March 13, 2014, the enrollee emailed Blue Shield and complained he had not received a response regarding his daughter's occupational therapy claims. On March 20, 2014, the enrollee emailed Blue Shield and complained about the lack of communication from Blue Shield to both himself and his providers. Blue Shield did not open grievance files regarding the March 4, March 13, or March 20 emails.

30. The enrollee filed a complaint with the Department on March 27, 2014, regarding the online Explanation of Benefits ("EOB") for his daughter's occupational therapy treatment and the reduced reimbursement rates for OON providers. On March 27, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on April 1, 2014. Blue Shield requested the matter be returned to Blue Shield because the enrollee had not filed a grievance before contacting the Department. The Department approved Blue Shield's request, and Blue Shield initiated the grievance on March 27, 2014. Blue

Shield responded to the enrollee's grievance on April 24, 2014; however, it failed to address the subject of the enrollee's grievance. The enrollee contacted the Department on May 8, 2014, and the Department re-opened the file.

31. On May 16, 2014, The Department sent Blue Shield a request for additional information in the form of a Request for Health Plan Information ("RHPI"), which was due on May 21, 2014. On May 20, 2014, Blue Shield provided an incomplete response to the Department's RHPI. Specifically, the response did not include the cover page of the Evidence of Coverage ("EOC"), the relevant EOC pages, and records of calls or correspondence. On June 2, 2014, the Department sent Blue Shield a request for the missing information, which was due June 9, 2014. Blue Shield's response to this request was received on June 9, 2014.

Matter 14-231

32. The enrollee contacted the Department requesting coverage for OON services, including prescriptions, and complained about the quality of service she had received from Blue Shield. On May 20, 2013, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on May 28, 2013. Blue Shield timely responded on May 28, 2013; however, the response failed to address all of the issues contained in the enrollee's complaint and failed to provide the information requested by the Department. The majority of Blue Shield's response pertained to a different provider than the provider identified in the enrollee's complaint. On May 31, 2013, the Department sent Blue Shield a request for additional information, requesting the missing information by June 7, 2013. Blue Shield's response, while timely, again failed to address all of the issues raised in the enrollee's complaint. Blue Shield did not provide all of the requested information and address all issues contained in the enrollee's complaint until June 10, 2013.

Matter 14-451

33. The enrollee requested orthotics to treat her foot pain. The enrollee requested that her provider make customary castings and moldings and requested authorization for an OON lab to fill the prescription. Blue Shield denied this request and the enrollee filed a grievance with Blue Shield on July 29, 2013. Blue Shield denied the grievance on August 26, 2013, explaining that

custom foot orthotics were not a covered benefit, that the enrollee had not tried over the counter orthotics and relied, in part, on the Orthotic Benefits section of the enrollee's EOC to support its decision.

34. The enrollee filed a complaint with the Department on September 24, 2013. On October 1, 2013, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on October 7, 2013. Blue Shield's response failed to address the enrollee's request to authorize OON lab services. The Department made a second request for the information on October 28, 2013, Blue Shield then completed its response.

Matter 14-452

35. On March 10, 2013, the enrollee's authorized representative filed a grievance with the Department regarding a denial of coverage for a specific treatment for the enrollee's cerebral palsy. On March 21, 2013, Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on March 26, 2013. Blue Shield's response failed to contain a copy of the grievance acknowledgment letter sent to the enrollee.

Matter 14-519

36. On June 2, 2014, the enrollee contacted Blue Shield to complain that Blue Shield was not paying her oncology providers. The enrollee requested that Blue Shield perform a review to allow her continuity of care with her current OON providers. Blue Shield did not initiate a grievance at that time.

37. The enrollee filed a complaint with the Department on June 24, 2014. In response to the Department's inquiries, Blue Shield requested the matter be returned to Blue Shield, since the enrollee had not filed a grievance. The Department denied Blue Shield's request, as Blue Shield failed to initiate a grievance on June 2, 2014, in response to the enrollee's initial complaint.

Matter 14-536

38. The enrollee contacted the Department on August 21, 2014, because her coverage had been canceled without notice, and the enrollee needed to refill essential prescriptions.

Although the enrollee had been paying her premiums, she was informed that Blue Shield had been applying her payments to an old policy. The Department determined that an earlier review of the enrollee's case was warranted. On August 22, 2013, the Department requested a detailed explanation from Blue Shield as to why it misapplied payments, and requested a response by noon on August 26, 2014. Blue Shield responded at 4:28 p.m. on August 26, 2013, but the response did not include a detailed explanation, as requested by the Department. The Department made a second request for the information on August 27, 2014. Blue Shield provided the requested information on August 28, 2013.

Matter 14-543

39. On July 24, 2014, the enrollee complained to the Department about Blue Shield's failure to properly record payments made on his account, cancellation of his account, and raised quality of service concerns regarding the payment of his premiums. On July 24, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on July 29, 2014. On August 4, 2014, the Department sent Blue Shield a request for additional information which specifically included a request for an explanation of the circumstances for the cancellation, and the difficulties encountered in accepting the enrollee's payments. The response was due on August 11, 2014. On August 19, 2014, Blue Shield requested an extension to respond to August 20, 2014. Blue Shield provided a copy of the EOC on August 20, 2014, but requested an extension to August 21, 2014, to provide additional information. Despite the additional time, Blue Shield provided an incomplete response on August 21, 2014. The Department made a second request for a complete response on August 27, 2014. Blue Shield finally provided the information on August 29, 2014.

Matter 14-544

40. On August 6, 2014, the enrollee complained to the Department that Blue Shield continued to bill her for cancelled coverage. The enrollee also complained about Blue Shield's excessive hold times. On August 11, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on August 18, 2014. On August 16, 2014, Blue Shield responded, requesting the matter be

returned to Blue Shield for processing as a grievance. On August 24, 2014, the Department advised Blue Shield that its request to return the matter to the Plan was denied, and the Department requested additional information, under Rule 1300.68(g)(6), with a response due August 29, 2014. Blue Shield responded on August 29, 2014, and stated that the documents would follow by fax. However, Blue Shield did not provide the documents until September 9, 2014.

Matter 14-565

41. On September 25, 2014, the enrollee contacted the Department and requested reimbursement for services received in February 2014. On September 25, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on September 30, 2014. The Department requested that Blue Shield address the enrollee's request for reimbursement. On September 30, 2014, Blue Shield timely responded, but failed to provide the information requested, including a response to the enrollee's reimbursement request. On October 22, 2014, the Department sent Blue Shield a second request for the information, under Rule 1300.68(g)(6). Blue Shield did not provide a response until October 27, 2014.

Matter 15-016

42. On August 4, 2014, the enrollee contacted Blue Shield and complained about her infant daughter's loss of health plan coverage. On September 16, 2014, the enrollee called again and asked why the coverage was still not active. Blue Shield did not initiate grievances for the enrollee's expressions of dissatisfaction.

43. On October 9, 2014, the enrollee contacted the Department. On October 14, 2014, Blue Shield requested the matter be returned to Blue Shield for consideration under its grievance process, because the enrollee had failed to complete Blue Shield's thirty-day grievance process. The Department denied Blue Shield's request, because the Department determined that it warranted early review as the complaint concerned coverage cancellation. On October 27, 2014, Blue Shield provided a vague and incomplete response which also failed to address the issues raised in the enrollee's complaint. On October 27, 2014, the Department requested Blue Shield provide a complete response. Blue Shield provided the required information on October 30, 2014.

Matter 15-024

44. On June 3, 2014, the enrollee filed a grievance regarding Blue Shield's failure to deduct her May premium from her bank account. Blue Shield never responded to this grievance.

45. On October 1, 2014, the enrollee contacted the Department and raised several issues, including Blue Shield's failure to respond to her June 3, 2014, grievance. On October 10, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on October 15, 2014. Blue Shield's response did not include any information regarding the June 3, 2014 grievance. On November 6, 2014, the Department sent Blue Shield a request for additional information, under Rule 1300.68(g)(6), again asking Blue Shield for any records or documents regarding the grievance. Blue Shield responded on November 7, 2014, acknowledging that the grievance was received but it failed to respond because it was returned to customer service in error.

Matter 15-032

46. On November 3, 2014, the enrollee contacted the Department regarding her urgent request for a spinal injection due to severe pain from scoliosis. The Department determined that the enrollee's complaint qualified for an expedited review. On November 4, 2014, the Department notified Blue Shield, under Rule 1300.68(h), of the receipt of the enrollee's complaint, and a response was due from Blue Shield on November 7, 2014. Blue Shield failed to provide any response to the expedited request until November 11, 2014, when it advised the Department that the request had been misplaced. Blue Shield requested an extension until November 14, 2014, to respond.

Matter 15-037

47. On October 2, 2014, the enrollee contacted the Department requesting Blue Shield reprocess claims for services as in-network. On October 7, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on October 13, 2014. On October 10, 2014, Blue Shield responded to some of the enrollee's complaints, but failed to provide a written response addressing the enrollee's request that her claims be reprocessed as in-network. On October 17, 2014, the

Department requested Blue Shield respond by October 20, 2014. Blue Shield did not provide the written response until October 21, 2014.

Matter 15-154

48. On October 6, 2014, the enrollee contacted the Department regarding a dispute over Blue Shield's calculation of allowable amounts for OON services. On January 9, 2015, the Department made a request for additional information, with a response due by January 14, 2015. On January 15, 2015, the Department sent a follow-up request. Blue Shield did not provide the requested information until January 16, 2015.

Matter 15-310

49. On November 12, 2014, the enrollee contacted the Department regarding reimbursement for past services and quality of service. On November 20, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on November 25, 2014. Blue Shield's response, while timely, was incomplete as it failed to address the enrollee's quality of service concerns. The Department made a second request for the information on December 11, 2014. Blue Shield provided an amended response on December 12, 2014.

Matter 15-432

50. On July 1, 2014, the enrollee contacted the Department regarding a request for reimbursement for emergency services. On July 10, 2014, the Department sent Blue Shield notice, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on July 15, 2014. On July 30, 2014, the Department sent Blue Shield a request for additional information with a response due by August 6, 2014. Blue Shield failed to respond to the request, and on December 9, 2014, the Department sent a follow-up email. Blue Shield did not provide the information until December 22, 2014.

Matter 15-433

51. The enrollee was covered under three different Blue Shield plans at various times for the 2012 calendar year, each with different deductible requirements. On March 14, 2013, the enrollee filed a grievance regarding her deductible and maximum copayment/co-insurance

responsibility for 2012. Blue Shield did not respond to the grievance until May 17, 2013. The grievance resolution letter contained accumulation totals for the deductible and copayment/co-insurance amounts applied to the enrollee's individual family plan for the 2012 calendar year.

52. On June 27, 2013, the enrollee filed a second grievance regarding errors in her 2012 accumulation total. Blue Shield partially denied the grievance on July 24, 2013. Blue Shield stated that it had provided incorrect accumulation totals in the May 17, 2013, grievance resolution letter, and changed its prior resolution of the enrollee's grievance.

53. On or about July 10, 2013, the enrollee contacted the Department. On July 19, 2013, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on July 24, 2013. On July 24, 2013, Blue Shield provided an incomplete response; specifically, Blue Shield failed to include a copy of the March 14, 2013, grievance acknowledgment letter.

Matters 15-434 and 15-435

54. The enrollee and her spouse enrolled in a PPO plan effective July 1, 2014. In or about September 2014, the spouse was unable to schedule provider appointments or obtain medications because Blue Shield's database listed him as inactive. Customer service logs reflect the spouse contacted Blue Shield on September 3, 2014, and asked why he was not showing on the database as covered. Blue Shield advised that the incident was reported and the system would be updated in 24 - 48 hours.

55. On September 6, 2014, the enrollee sent Blue Shield an email and complained that Spouse could not use his benefits without paying for the entire service. Blue Shield did not initiate a grievance based on the enrollee's email. Sixteen days later, on September 22, 2014, Blue Shield responded to the email and thanked the enrollee for her inquiry. On September 9, 12, 23, and 25, 2014, the enrollee sent Blue Shield emails that complained about her spouse's lack of coverage and raised several quality of service issues. The enrollee made several requests for partial reimbursement of the premiums. On September 23, 24, and 29, 2014, Blue Shield responded to the emails and thanked the enrollee each time for her inquiries. At no time did Blue Shield initiate a grievance for any of the enrollee's written complaints. Because Blue Shield mis-classified these

calls as inquiries rather than grievances, the enrollee did not receive the required information about the Department.

56. On September 25, 2014, the spouse contacted the Department. On September 26, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on October 1, 2014. On October 1, 2014, Blue Shield provided an incomplete response; specifically, Blue Shield failed to provide a copy of the enrollee's EOC cover page.

Matter 15-437

57. On July 23, 2014, the enrollee filed a written complaint with Blue Shield regarding multiple billing errors. Blue Shield mischaracterized the enrollee's grievance as an inquiry, but acknowledged receipt on August 7, 2014. However, Blue Shield's letter did not include required language about contacting the Department.

58. On July 26, 2014, the enrollee sent another written complaint to Blue Shield, and again it failed to classify the written complaint as a grievance. On August 21, 2014, Blue Shield sent a letter acknowledging the enrollee's "inquiry." On September 5, 2014, Blue Shield sent a letter to the enrollee, stating that Blue Shield had resolved the enrollee's billing complaints, and her bills should be corrected going forward. Blue Shield failed to include in the letter the required language about contacting the Department.

59. The enrollee's billing complaints were not corrected and the enrollee sent Blue Shield written complaints dated October 6 and 14, 2014. The October 6 complaint advised Blue Shield that the enrollee intended to file a complaint with the Department if the matter was not resolved in ten days. The October 14 complaint complained of an additional billing error. In both instances Blue Shield again failed to consider the enrollee's expression of dissatisfaction as a grievance.

60. The enrollee filed a complaint with the Department on November 1, 2014. The enrollee complained about billing concerns and about concerns she had received notification that her coverage had been canceled effective October 31, 2014. On November 24, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the

enrollee's complaint, and a response was due from Blue Shield on December 1, 2014. Blue Shield responded on December 2, 2014, and the response did not include information relevant to the resolution of the enrollee's grievance.

Matter 15-438

61. The enrollee's provider requested post service authorization for occipital nerve block injections for treatment of the enrollee's Temporomandibular Joint ("TMJ") pain and migraine headaches. Blue Shield's delegated medical group denied the request on March 27, 2014, based on a lack of medical necessity. The denial stated the steroid injection was non-emergent and could be rendered safely by a pain management specialist. The denial letter did not provide a clear and concise explanation for the denial, or include clinical criteria for the denial.

62. On September 29, 2014, the enrollee filed a grievance with Blue Shield. On October 21, 2014, Blue Shield denied the enrollee's grievance on the basis the service requested was not a covered benefit, as the provider was only contracted for neurology services. Blue Shield further stated that the enrollee's medical group had an in-network neurosurgeon available to administer the epidural steroid injection. However, the enrollee was requesting occipital nerve block injection, not epidural steroid injection.

63. On November 13, 2014, the enrollee contacted the Department. On November 26, 2014, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on December 1, 2014. Blue Shield responded on December 1, 2014, however it failed to include documents relied upon in making the determination.

Matter 16-099

64. On December 22, 2014, the enrollee called Blue Shield to complain that he was unable to pay his premium with his credit card, and had been unable to do so since November. Blue Shield failed to consider the enrollee's expression of dissatisfaction as a grievance.

65. On January 22, 2015, the enrollee complained to Blue Shield regarding its denial of a previously authorized procedure after cancellation of his policy. Again, Blue Shield failed to initiate its grievance process upon receipt of the enrollee's expression of dissatisfaction. It was not

until February 5, 2015, when the enrollee filed a written complaint, that Blue Shield initiated the grievance process.

Matter 16-100

66. On March 4, 2015, the enrollee filed a complaint with the Department. On March 6, 2015, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on March 11, 2015. On March 11, 2015, Blue Shield advised the Department it had received the enrollee's grievance on March 6, from the Department, and requested the matter be returned to Blue Shield to complete the grievance process. Blue Shield stated the grievance review process would be completed by April 5, 2015. Blue Shield did not send the enrollee a written acknowledgment of receipt of the grievance.

67. On April 16, 2015, the Department requested a completed RHPI response. Blue Shield provided, among other documents, the written grievance resolution letter dated April 21, 2015. Blue Shield admitted that although it had requested the Department return the complaint to Blue Shield for grievance processing, Blue Shield had not initiated the grievance.

Matter 16-101

68. On February 4, 2015, the enrollee's medical group denied the enrollee's request for chemotherapy and cancer treatment with an Out of Network ("OON") oncologist. However, on February 9, 2015, the medical group authorized one office visit with the OON oncologist.

69. On February 10, 2015, the enrollee filed a grievance with Blue Shield. On February 13, 2015, Blue Shield responded to the grievance by providing the authorization from the medical group for one office visit with the OON provider. However, the enrollee's grievance requested ongoing chemotherapy and cancer treatment with the OON oncologist. Blue Shield's grievance resolution letter failed to address this issue. The enrollee appealed Blue Shield's decision on February 17, 2015. Blue Shield denied the enrollee's appeal on February 20, 2015, stating that the treatment requested was not a covered benefit, and the medical group had an available in-network provider.

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Matter 16-243

70. On February 12, 2015, the enrollee filed a grievance with Blue Shield, and requested coverage for treatment of a molar fracture caused by an accidental injury. Blue Shield denied coverage on February 27, 2015, on the basis that under the enrollee's EOC, benefits were provided for treatment of damage to natural teeth caused solely by an accidental injury.

71. On May 17, 2015, the enrollee filed an appeal of Blue Shield's denial with the Department. On June 3, 2015, Blue Shield advised the Department the enrollee's benefits covered treatment of damage to natural teeth caused solely by an accidental injury but were limited to palliative services necessary for the enrollee's initial medical stabilization. Blue Shield's February 27, 2015, grievance resolution letter failed to contain this clear explanation of its decision.

Matter 16-250

72. On August 17, 2015, the enrollee, through her representative, contacted the Department and requested assistance in getting her health plan coverage retroactively canceled. On August 25, 2015, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on August 31, 2015. On August 25, 2015, the Department also sent Blue Shield a request for additional information in the form of an RHPI form, which was due August 31, 2015. Blue Shield's August 31, 2015, response was incomplete and did not include a completed RHPI form. The Department made a second request on September 2, 2015. Blue Shield provided the RHPI form on September 3, 2015.

Matter 16-252

73. On October 30, 2014, Blue Shield received two emails from the enrollee. The enrollee complained that Blue Shield's provider list was "pitifully outdated," accused Blue Shield of false advertising, and advised that she was ready to file a complaint. Blue Shield responded to the enrollee's e-mails five days later by return e-mail, and thanked the enrollee for her inquiry. Blue Shield's e-mail did not include the mandatory information about complaining to the Department. Blue Shield attached a list of providers within a five mile radius of the enrollee's

address. Blue Shield failed to initiate its grievance process upon receipt of the enrollee's expression of dissatisfaction.

Matter 16-253

74. On March 23, 2015, the enrollee contacted the Department and requested assistance with an authorization for Stage 4 cancer treatment at a specific treatment facility. The Department determined that the case qualified for an expedited review. On April 3, 2015, the Department sent a request for additional information to Blue Shield. The Department requested a response by April 6, 2015. Blue Shield provided a partial response on April 6, 2015, and advised the Department a supplemental response would be provided no later than April 8, 2015. Blue Shield failed to provide the supplemental information until April 14, 2015.

Matter 16-254

75. On February 26, 2015, the enrollee called Blue Shield and asked if he could be covered by benefits while overseas for several months. Blue Shield referred the enrollee to its website to file an appeal. On February 26, 2015, the enrollee wrote a letter to Blue Shield, which Blue Shield received on March 3, 2015. The letter was addressed to the attention of Member Services Grievances. The enrollee explained that he required infusion treatment every seven weeks, the cost of which was a covered benefit but was approximately $30,000 for each infusion. He requested information on how he could obtain the infusions and how an overseas provider could submit a claim directly to Blue Shield. Although the enrollee stated his request was "not a grievance per se," he stressed it was an important matter for which he needed help. Blue Shield did not classify the February 26 phone call or letter as a grievance.

76. On March 17, 2015, the enrollee called Blue Shield and asked about the status of his request. The enrollee asked for a response in writing regarding his concerns. Call log transcripts reflect the enrollee stated he was originally instructed to write a letter to Member Services Grievances, he needed to make sure the infusion medication was covered, explained he could not afford to pay for the medication on his own and he didn't know if he could take the trip without the information. The enrollee was advised he would receive a letter within the month; however, Blue Shield did not classify the phone call as a grievance.

77. On March 18, 2015, Blue Shield responded to the enrollee by e-mail, thanked him for his inquiry regarding continuity of care while traveling outside the United States and encouraged him to contact a customer service representative to better respond to his inquiry.

78. Blue Shield provided the enrollee a Request for Continuity of Care Services form which the enrollee completed and faxed to Blue Shield on March 19, 2015, along with another copy of the February 26, 2015, letter. The enrollee complained he did not have the provider information asked for earlier and referred Blue Shield to its previous letter. Blue Shield denied his continuity of care request on April 3, 2015, stating that the care requested was not available from out of country providers.

79. On April 20, 2015, the enrollee filed a complaint with the Department. Blue Shield subsequently advised the Department that it had misclassified the enrollee's request as a request for continuity of care while overseas rather than an inquiry about covered benefits while overseas for an extended period, and therefore had not initiated a grievance on behalf of the enrollee.

Matter 16-255

80. On March 23, 2015, Blue Shield denied the enrollee's provider's request for authorization for services as not a covered benefit. On April 1, 2015, the enrollee telephoned Blue Shield and was advised the provider was OON. The enrollee complained she was not aware the provider was OON and asked to speak with a supervisor. Blue Shield did not classify the enrollee's complaint as a grievance. Blue Shield did not initiate the grievance review process until a second call from the enrollee on April 8, 2015.

Matter 16-256

81. On June 24, 2015, the enrollee filed a grievance with Blue Shield regarding a request for vocal cord surgery with an OON provider. Blue Shield acknowledged receipt of the grievance by letter dated June 25, 2015. Blue Shield did not respond to the enrollee's request, and as a result, the enrollee had to cancel a surgery scheduled for July 15, 2015. On July 31, 2015, the enrollee filed a complaint with the Department of Insurance. The complaint was redirected to the Department on August 7, 2015. Blue Shield did not respond to the enrollee's grievance until August 13, 2015, after the Department become involved.

Matter No. 16-257

82. In August 2014, the enrollee required orthodontic treatment due to an injury sustained in December 2013. On August 11, 2014, the enrollee telephoned Blue Shield and inquired about his medical coverage for dental issues. The call log entry states the enrollee was informed this could be covered if the procedure was for medical reasons. The orthodontic services were performed on August 12, 2014, and billed for a total of $3,300.

83. On September 12, 2014, the enrollee called Blue Shield regarding the coverage for the claim, complained his call was transferred multiple times, and was concerned he was told to obtain a note from his physician that stated the orthodontic treatment was medically necessary. Blue Shield did not initiate a grievance. The enrollee called October 1 and 17, regarding the status of the claim. On October 17, 2014, Blue Shield confirmed receipt of the claim but advised it had been forwarded to dental claims. Blue Shield advised the enrollee to submit a claim with an itemized bill.

84. On November 6, 2014, the enrollee contacted Blue Shield and requested specific information regarding submitting his claim. During the call he stated that he had been going back and forth with Blue Shield and was always transferred to dental although the claim was for medical. Blue Shield did not initiate a grievance. On November 7, 2014, the enrollee faxed Blue Shield a Statement of Claim, a medical necessity letter from his primary care physician, and an itemized billing statement from the orthodontic provider. The enrollee's fax detailed the claim was intended for the medical claims department, not dental claims and that there was a great deal of confusion about his issue. On November 20, 2014, the enrollee called Blue Shield to check on the status of the claim. He was advised Blue Shield had received the fax but the claim should be mailed. The enrollee complained he was previously told to fax the claim. Blue Shield advised the enrollee the claim contained dental codes, not medical codes. The enrollee complained he understood the issues with the medical vs. dental codes but submitted the information based upon what he had previously been advised to do. Again, Blue Shield did not initiate a grievance. On November 24, 2014, Blue Shield again acknowledged receipt of the claim.

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85. On January 7, 2015, the enrollee was advised the claim was pending. On January 29, 2015, call transcripts reflect several times the enrollee expressed frustration and dissatisfaction. The call was escalated to a supervisor. The supervisor advised the enrollee his claim would be processed within 30 – 45 days from January 7, 2015; however, Blue Shield did not initiate a grievance. The enrollee called Blue Shield on February 19, 2015. Blue Shield advised the enrollee the claim was probably not being processed because it contained dental codes rather than medical codes. The enrollee expressed frustration and complained he had dealt with Blue Shield about the issue repeatedly since September and he did everything he was told to do. Blue Shield advised the enrollee the claim would in all likelihood be denied because the medical plan only covered dental services performed in a hospital and submitted with medical coding. Blue Shield stated it would send the claim for processing once again and if still not processed, the enrollee could file a grievance.

86. On March 15, 2015, the enrollee contacted the Department of Insurance ("DOI"). On March 24, 2015, DOI contacted Blue Shield to determine proper jurisdiction for the enrollee's complaint. DOI determined that the Department was the proper jurisdictional agency, and DOI forwarded the enrollee's complaint to the Department. On March 24, 2015, six months after the enrollee began contacting Blue Shield; the Plan initiated its grievance system review. The grievance was initiated only upon receipt of the jurisdictional inquiry by DOI.

87. On April 6, 2015, the Department notified Blue Shield, under Rule 1300.68(g), of the Department's receipt of the enrollee's complaint, and a response was due from Blue Shield on April 13, 2015. On April 13, 2015, Blue Shield requested that the enrollee's grievance be returned to Blue Shield for resolution claiming that the enrollee had failed to complete Blue Shield's grievance process. Blue Shield's response also stated that the grievance was received on March 24, 2015. Blue Shield requested until April 23, 2015, to respond to the enrollee. On April 20, 2015, Blue Shield responded to the grievance with a denial stating, in part, that the itemized bill faxed on November 7, 2014, was for dental services not medical services.

88. On May 8, 2015, the Department sent a request for additional information, which was due May 13, 2015. On May 13, 2015, the Department agreed to give Blue Shield until

May 26, 2015, to provide the requested items. On May 27, 2015, Blue Shield advised it required additional time and the information would be provided by June 2, 2015. Blue Shield did not provide the requested information until June 5, 2015. On June 11, 2015, the Department requested additional information from Blue Shield and, under Rule 1300.68(g)(6), these were due June 16, 2015. Blue Shield did not provide a response to the Department's request until June 18, 2015.

V.

FIRST CAUSE FOR DISCIPLINE

(Failure to Provide a Clear and Concise Explanation in Response to a Treatment Request)

[Health & Saf. Code, § 1367.01, subd. (h)(4)]

89. Complainant re-alleges all matters set forth in paragraphs 1-88 and incorporates them herein.

90. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

91. Health plans are required to provide a written response to a provider's request for treatment. Where the plan's decision is to deny, delay, or modify the services requested, the response shall include a clear and concise explanation of the reasons for the decision, a description of the criteria used, and the clinical reasons for decisions regarding medical necessity. (Health & Saf. Code, § 1367.01, subd. (h)(4).)

92. In Matter 15-438, discussed above, Blue Shield failed to provide a clear and concise explanation for the denial of coverage, and failed to provide any clinical reasons for the denial of medical necessity. Blue Shield is therefore subject to discipline for a violation of Health and Safety Code section 1367.01, subdivision (h)(4).

SECOND CAUSE FOR DISCIPLINE

(Failure to Adequately Consider and Rectify the Enrollee's Grievance.)

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

93. Complainant re-alleges all matters set forth in paragraphs 1-92 and incorporates them herein.

94. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

95. Health plans are required to establish and maintain a grievance system for enrollees to submit their grievances to the plan. The grievance system must include reasonable procedures according to the Department's regulations. The grievance system must be such that is ensures adequate consideration of an enrollee's grievances, and resolution as appropriate. (Health & Saf. Code, § 1368, subd. (a)(1).)

96. The grievance system must be established in writing and include procedures which will receive, review and resolve grievances within 30 calendar days of receipt. (Cal. Code Regs., tit 28, § 1300.68, subd. (a).)

97. A grievance is defined as "a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. The Department considers a complaint to be the same as a grievance. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(1)-(2).)

98. In Matters 14-212, 15-024, 15-433, 15-438, 16-100, and 16-101, discussed above, Blue Shield failed to give adequate consideration to the enrollees' grievances, including but not limited to, failing to evaluate the enrollee's stated complaints, failing to review relevant documentation, and failing to provide a resolution within Blue Shield's grievance system. Blue Shield is therefore subject to discipline for violations of Health and Safety Code section 1368, subdivision (a)(1).

99. In Matters 14-221, 14-519, 15-016, 15-435, 15-437, 16-099, 16-252, 16-254, 16-255 and 16-257, discussed above, Blue Shield failed to classify the enrollees' written or oral expressions of dissatisfaction, or complaints as grievances, therefore failed to initiate the grievance system, and thereby adequately consider the enrollees' grievances. In so doing, Blue Shield deprived the enrollees of their consumer protections under the Knox-Keene Act and title 28 of the California Code of Regulations. Blue Shield is therefore subject to discipline for violations of

California Code of Regulations, title 28, section 1300.68, subdivision (a).

THIRD CAUSE FOR DISCIPLINE

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

[Health & Saf. Code, § 1368, subd. (a)(5)]

100. Complainant re-alleges all matters set forth in paragraphs 1-99 and incorporates them herein.

101. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

101. 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).)

102. In Matters 14-451 and 16-243, discussed above, Blue Shield failed to provide to enrollees written responses with a clear and concise explanation of the reasons for Blue Shield's response. Specifically in Matter 14-451, Blue Shield improperly relied on specific provisions in the evidence of coverage, providing incongruous reasoning to the enrollee and the Department. In Matter 16-243, Blue Shield failed to provide full and complete reason for the denial of services, by mis-citing the terms and conditions of the Evidence of Coverage in response to the enrollee's initial grievance, in violation of Section 1368(a)(5). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

FOURTH CAUSE FOR DISCIPLINE

(Failure to Timely Provide Written Acknowledgement of a Grievance)

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

103. Complainant re-alleges all matters set forth in paragraphs 1-102 and incorporates them herein.

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104. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

105. 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. (Health & Saf. Code, § 1368, subd. (a)(4)(A).) This acknowledgement must advise the complainant that the grievance has been received and the date of receipt, and it must identify and provide the name and contact information of the health plan representative who may be contacted about the grievance. (Cal. Code Regs, tit. 28, § 1300.68, subd. (d)(1).)

106. In Matters 15-435, 15-437, 16-100, and 16-254, discussed above, Blue Shield received the enrollees' expressions of dissatisfaction which constituted grievances for the purpose of Rule 1300.68(a)(1). Blue Shield thereafter failed to timely provide written acknowledgement of enrollees' grievances within five calendar days, or at all. Blue Shield's failures to provide acknowledgement of receipt of the grievances are violations of Section 1368(a)(4)(A) and Rule 1300.68(d)(1). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

FIFTH 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, subd. (d)(3)]

107. Complainant re-alleges all matters set forth in paragraphs 1-106 and incorporates them herein.

108. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

109. The grievance system shall require the plan to resolve non-expedited grievances within 30 days. (Health & Saf. Code, § 1368.01, subd. (a).)

110. 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

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provider or entity with delegated authority to administer and resolve the plan's grievance system. (Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(3).)

111. In Matters 15-433, 16-100, and 16-256, discussed above, Blue Shield received grievances from the enrollees, and initiated the grievance process. However, Blue Shield failed to resolve the enrollees' grievances within the statutory timeline. In Matters 16-254, 16-255 and 16-257, Blue Shield received the enrollees' expressions of dissatisfaction, but failed to initiate the grievance process for the enrollees, and thereby failed to resolve the enrollees' grievances within 30 calendar days. Blue Shield's failures to resolve the enrollees' grievances within 30 days are violations of Section 1368.01(a), and Rule 1300.68(d)(3). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

SIXTH CAUSE FOR DISCIPLINE

(Failure to set forth Required Language in Appropriate Format)

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

112. Complainant re-alleges all matters set forth in paragraphs 1-111 and incorporates them herein.

113. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

114. Every health care 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).)

115. In Matters 15-435, 15-437, and 16-252 discussed above, Blue Shield failed to provide to the enrollees the required information about complaining to the Department, in violation of Section 1368.02(b). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Timely Provide Initial Information to the Department)

[Cal. Code Regs., tit. 28, § 1300.68, subd. (g)(1)-(5)]

116. Complainant re-alleges all matters set forth in paragraphs 1-115 and incorporates them herein.

117. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

118. After an enrollee files a grievance with the Department, the Department shall notify the plan. Within 5 calendar days after notification, the plan shall provide documents and information to the Department. This information includes, a written response to the issues raised in the grievance; a copy of the plan's original grievance response to the enrollee; a complete and legible copy of medical records related to the grievance, or a statement that medical records were not used in the grievance resolution; a copy of the cover page and all relevant pages of the enrollee's evidence of coverage with applicable sections underlined; and all other information relied upon by the plan in responding to the enrollee's grievance. (Cal. Code Regs., tit. 28, § 1300.68, subd. (g)(1)-(5).)

119. In Matters 14-214, 14-221, 14-231, 14-544, 14-452, 15-016, 15-024, 15-037, 15-310, 15-433, 15-434, and 15-437, discussed above, the Department notified Blue Shield that the Department had received a complaint from an enrollee. Upon notification by the Department, Blue Shield was obligated to provide certain documents to the Department within five calendar days. In each of these matters, Blue Shield failed to provide some, or all of the required documents within 5 calendar days of receipt of notice from the Department in violation of Rule 1300.68(g)(1)-(5). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Timely Provide Additional Information to the Department)

[Cal. Code Regs., tit. 28, § 1300.68, subd. (g)(6)]

120. Complainant re-alleges all matters set forth in paragraphs 1-119 and incorporates

them herein.

121. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

122. The Department may request additional information from the plan. (Health & Saf. Code, § 1368, subd. (b)(3).) Within 5 calendar days of receipt of the request for additional information, the plan must forward the requested information to the Department. If the information cannot be timely forwarded to the Department, the plan response must provide a description of the actions being taken to obtain the information, and when the information is expected to be received. (Cal. Code Regs., tit. 28, § 1300.68, subd. (g)(6).) A request for additional time to respond is not sufficient without a description of actions being taken to obtain the information.

123. In Matters 14-212, 14-214, 14-543, 15-154, 15-432, 16-250, 16-253, and 16-257, discussed above, the Department sent requests for additional documents or information to Blue Shield. Blue Shield failed to provide responsive documents and information in response to the Department's request for additional information within 5 calendar days, or to provide a response to the Department describing the actions being taken to obtain the information and when the information was expected, in violation of Rule 1300.68(g)(6). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

NINTH CAUSE FOR DISCIPLINE

(Failure to Expedite a Response Pursuant to the Department's Determination)

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

124. Complainant re-alleges all matters set forth in paragraphs 1-123 and incorporates them herein.

125. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

126. Where an enrollee's grievance involves an imminent or serious threat to the health

of the enrollee, including but not limited to severe pain, potential loss of life, limb or major bodily function, or where the Department determines an earlier review is warranted, the Department may require the plan to expedite the delivery of information. (Cal. Code Regs., tit. 28, §§ 1300.68, subd. (h) and 1300.68.01, subd (a).)

127. In Matters 14-536, 14-565, and 15-032, discussed above, the Department determined that the case qualified for earlier review; however, Blue Shield failed to expedite its response and did not provide the requested information to the Department by the requested response date. Blue Shield's failures to timely respond to the Department's expedited requests are violations of Rule 1300.68(h). Blue Shield is therefore subject to discipline pursuant to Section 1386(b)(6).

TENTH CAUSE FOR DISCIPLINE

(Unfair Competition)

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

128. Complainant re-alleges all matters set forth in paragraphs 1-127 and incorporates them herein.

129. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

130. The Department may discipline its licensees 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).)

131. "[U]nfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice…" (Bus. & Prof. Code, § 17200.) (Unfair Competition Law or UCL.)

132. An unlawful business practice or act under the UCL means an act or practice, committed pursuant to business activity, which is at the same time forbidden by law. Conduct by a health care service plan in violation of the Knox-Keene Act is therefore considered unfair competition under the UCL.

133. As a health care service plan, Blue Shield's business activities include establishing and maintaining a grievance system which shall ensure adequate consideration of enrollee

grievances and rectification where appropriate. (Health & Saf. Code, § 1368, subd. (a)(1).) Establishing and maintaining a grievance system provides an essential consumer protection for a plan's enrollees. Any failure of the grievance system deprives consumers of these protections.

134. In each of the 34 cases brought forth here, Blue Shield failed to act in a manner consistent with maintaining a grievance system to ensure adequate consideration of its enrollees' grievances. As such, Blue Shield has engaged in conduct that meets the definition of an unlawful business practice within the meaning of the UCL. Because the actions of Blue Shield and/or its delegates constitute unfair competition, as defined in the UCL, Blue Shield is subject to disciplinary action by the Department. (Health & Saf. Code, § 1386, subd. (b)(7).)

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 Blue Shield, in the amount of $322,500 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: December 8, 2017

DREW BRERETON
Deputy Director | Chief Counsel
Office of Enforcement