# 2010th Anniversary

## CELEBRATING

***A Decade of Promoting Healthier Californians***

Advocacy Regulations Protection

Timely Access Dedication

Consumer Rights Prevention

Leadership Patient Advocacy

Consumer Awareness

High Quality Health Care

DEPARTMENT OF

# Managed Health Care

# Message from Director Cindy Ehnes

California is a state of "firsts" in consumer health care rights.

The Department of Managed Health Care (DMHC) is the only agency in the country dedicated solely to regulating health plans and assisting consumers. California was the first to establish an Independent Medical Review program to evaluate treatment decisions, the first to change rescission practices, the first to establish uniform waiting times for appointments with physicians, the first to require that health plans provide language interpreters and translated consumer materials at all points-of-service, and will soon be among the first to have regulations enacted establishing a licensure process for discount health card companies.

But it was not always this way. A decade ago, the managed care model was under siege. Consumers feared that some industry practices created incentives to delay or deny them care. Provider groups and some health plans were teetering on the brink of insolvency, and others had closed their doors, stranding patients. A number of important consumer and industry stakeholders saw the need for a brand new agency focused solely on the oversight of Health Maintenance Organizations (HMOs).

In 1999, under the leadership of Assemblyman Martin Gallegos and Senator Jackie Speier, a series of legislative bills was enacted to address Californian's concerns. As a result, for the first time in the nation's history, an organization was established dedicated to aiding HMO members and enforcing their rights. That entity, the DMHC, opened its doors in July of 2000, led by its first Director, Daniel Zingale, a dedicated advocate for the consumer.

The year 2010 marks a major milestone for consumers and the managed care industry in California -- the ten-year anniversary of the establishment of the DMHC. Today, the HMO model of comprehensive coverage, coordinated through a network of physician groups, remains the dominant type of coverage in the California marketplace. Moreover, this model is demonstrating increased value as California premiums for HMO coverage are 12 percent lower than the national average.

With the advent of health care reform, California has again emerged as a model for the nation, as the concepts of Accountable Care Organizations and patient-centered medical homes are touted as necessary building blocks for a transformed health care industry. The long list of achievements -- large and small -- is due to the dedication and diligence of the current and former employees of the DMHC. Because of their efforts, the DMHC was cited in 2009 by the Centers for American Progress as one of the nation's two most effective health regulators.

I am proud to have had the privilege for the past 6 ½ years of leading this talented staff, who are devoted every day to ensuring that all health plan members get the right care at the right time. This report is dedicated to their achievements and accomplishments during this decade, protecting California consumers and assuring access to quality health care services while ensuring the sustainability of this unique California health care delivery system.

Cindy

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# Ten Years by the Numbers

- More than 1 million consumers have been assisted by the Help Center.
- The DMHC has recovered more than $14 million for consumers through its Help Center and Enforcement Offices.
- The Help Center has administered nearly 12,000 Independent Medical Reviews, and slightly more than half were decided in favor of consumers, allowing them to receive care that was previously denied.
- As the result of the DMHC's actions to end rescissions, the number of consumers who had coverage improperly rescinded or cancelled was reduced from a high of 1,552 in 2005 to only four in 2009.
- Nearly $35 million in fines and penalties have been assessed to health plans that were in violation of the law.
- The Provider Complaint Unit has received more than 29,500 provider complaints and has recovered more than $22 million in payments owed to physicians and hospitals.
- The Licensing Division has approved more than 85 new plans and products now available to the public.
- A total of 18 unlicensed discount health card companies have been ordered to cease operations or become licensed.
- The DMHC oversaw the transition of 2,313 kidney patients to transplant lists at other hospitals after the closure of a Northern California kidney transplant center in 2006. A subsequent enforcement action resulted in a $3 million contribution to Donate Life California, for outreach efforts which resulted in increased organ donations.
- The DMHC secured more than $450 million in community benefits for California consumers through the establishment of community investment programs.

# Protecting Consumer Rights

## Establishment of the Help Center

The Department of Managed Health Care and its Help Center opened on July 1, 2000. The Help Center is dedicated to ensuring that consumers understand their rights and receive prompt and effective responses to their health care concerns. Patient rights advocates, health care professionals, and consumer service representatives are available to help consumers resolve something as simple as a paperwork mix-up or as complicated as a life-saving medical issue. In addition, Help Center staff routinely monitor health plans to ensure that they comply with the law and fulfill their obligations to enrollees, and when they don't, seek appropriate corrective action. Complaint data is collected and used to identify systemic issues and to improve the managed health care delivery system. This dedicated group of professionals are the heart of the DMHC.

## The Right to Independent Medical Review

On January 1, 2001, California became the first state in the nation to institute Independent Medical Reviews (IMR), a legally binding system for reviewing health plan denials of care.

The IMR program is pivotal to the Help Center's focus on resolving patient complaints with health plans as expeditiously as possible through its clinical, legal and consumer assistance staff. While every health plan must have its own system for handling enrollee complaints, its reviews are usually conducted by its own medical staff or network providers. The DMHC contracts with an independent review organization to review the cases. An IMR allows consumers who have been denied treatment or medical care to have those decisions reviewed by physicians or other appropriate medical professionals who are not affiliated with their health plans, giving every California health plan member a right to a free second opinion.

## Curbing Balance Billing

In 2008, the DMHC passed regulations, among the strongest in the nation, to fully protect consumers from balance billing for emergency services. Balance billing occurs when the emergency services physician is not paid his/her full charged fee by the health plan, and so bills the patient for the balance. The DMHC's regulation takes the patient out of the middle of such billing disputes between providers and health plans. The California Supreme Court, in Prospect Medical Group v. Northridge Emergency Physicians, affirmed in 2009 that balance billing is unlawful under the Knox-Keene Act.

In 2010, the DMHC settled People vs. Prime Healthcare Services, the case it brought against a California hospital system that was accused of balance billing HMO patients for emergency services received at its hospitals. In the settlement, Prime agreed not to balance bill any health plan enrollee, not to assign any current unpaid balance bills to collection, to audit its records for the prior six years to determine whether any enrollees paid balance bills, and to provide refunds with interest. In addition, the settlement requires Prime to donate $1.2 million to California community clinics to provide health care services in the state's neediest areas.

## Regulating Discount Plans

Later this year, the DMHC will become one of the first states in the nation to enact regulations to license discount health card entities. The regulations will include full consumer protections, such as strict advertising restrictions, measurable discounts, verifiable provider contracts, and uniform cancellation policies.

Beginning in 2004, the DMHC began to crack down on fraudulent discount health card companies, which promise deep discounts from doctors, hospitals and pharmacies, and risk-free cancellation policies with full refunds. However, DMHC

# Protecting Consumer Rights

investigators discovered that when members tried to use the discount cards, they learned that the physicians on the plan's list of providers had never heard of the discount plan, had no agreements with it to offer discount prices, or already offered the same or better discounts to any cash-paying patient.

To date, the DMHC has ordered 18 fraudulent discount health card companies to cease operations or become licensed. Five discount health plans or products are currently licensed. Since 2003, the Help Center has assisted more than 1,000 consumers with questions or problems with unlicensed discount health entities. A Consumer Alert in both English and Spanish has been issued and posted on the DMHC website, and the issue has been further publicized through media events. In early August, the Federal Trade Commission announced its own crackdown on fraudulent discount health plans, and commended the DMHC for its national groundbreaking work in protecting consumers.

## Ending Rescission

Actions by the DMHC in 2008 and 2009 established California as the first state in the nation to halt the harsh health plan practice known as improper rescission of coverage, giving consumers a ground-breaking victory and regaining their rescinded health care coverage. The DMHC's national leadership in this consumer protection issue led to an invitation to testify before Congress, and was influential in getting a ban on rescissions included in the national health care reform provisions.

Improper rescission left consumers uninsured and uninsurable when health plans, instead of underwriting individual policies before issuing them, waited until a large claim was made before investigating the information that the consumer provided on the application form, and then sought errors or omissions. When one was found, the health plan rescinded the coverage, retroactive to when the policy was issued, leaving the enrollee responsible for all of the medical bills.

The DMHC achieved first-of-its-kind settlements with California's five largest health plans through fines totaling nearly $14 million for improperly rescinding coverage after enrollees sought treatment or filed a claim. The DMHC also required major changes in health plan processes to protect future enrollees, such as clearer health history applications, vigorous up-front underwriting, and resolution of all health questions before issuing coverage. The settlements also offered guaranteed issue coverage to the 3,000+ consumers rescinded since 2004, along with an independent arbitration process for receiving reimbursement for out-of-pocket expenses incurred as a result of the rescission.

## Getting Needed Care

The DMHC's enforcement authority has been used to ensure that health plans are ensuring that enrollees receive quality health care services from their providers. The Department's authority to hold health plans accountable for the quality of care rendered to enrollees was challenged shortly after the new Department was established. Health plans challenged the DMHC's authority with tactics ranging from lawsuits, appeals of department orders to simple refusals to comply. Several key court decisions affirmed the authority of the Department to levy fines on health plans and to adopt decisions in IMR appeals.

In 2001, the DMHC levied it's most significant fine up to that point, $1.1 million on a health plan for systemically failing to provide adequate care in it's hospitals. In 2006, the DMHC stepped in to oversee the transition to other facilities of 2,313 HMO patients needing kidney transplants after the health plan's kidney transplant program was closed for significant failures in administrative oversight. In addition, the health plan was fined $5 million for failing to oversee the transplant center arrange timely access to patient care.

# Improving Consumer Access to Quality Care

## Timely Access to Care Regulation

This regulation, also the first of its kind in the nation, became effective January 17, 2010. The major goals are to establish uniform waiting times for appointments with physicians; to provide timeliness for care during an episode of illness, including timeliness for referrals and obtaining other services; and to provide a uniform waiting time for speaking to a physician, registered nurse, or other qualified health care professional who is trained in screening and triage. The health plans licensed by the DMHC have until January 17, 2011, to fully implement the policies, procedures, and systems necessary to comply with the regulation. Quality assurance standards require that enrollees be offered appointments within the following time frames:

- 48 hours for an urgent care appointment for services that do not require prior authorization
- 96 hours for an urgent care appointment for services that do require prior authorization
- 10 business days for non-urgent primary care appointments
- 15 business days for an appointment with a specialist
- 10 business days of a request for an appointment with non-physician mental health care providers
- 15 business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition

## Language Assistance

In 2009, California became the first state in the nation to require health plans to provide consumer materials and translations in additional languages, and to require interpreters at all points of service. In today's complex medical world, it is crucial that patients understand the instructions given by their doctors, and perhaps more importantly, that doctors understand their patients -- which can be nearly impossible when a language barrier prevents them from communicating with each other. The DMHC regulations fully implemented a landmark law which has made a profound, positive change in the way millions of Californians with limited English proficiency communicate with their doctors.

The regulations required California health plans to set up a system where services, materials, and information are provided to enrollees in a language that they speak and understand. As a result of the new regulations, the Help Center saw an 80 percent increase in callers requesting interpreters in the first eight months of 2009.

## Continuity of Care

From 2000 to 2003, more than three million Californians were affected by contract terminations between health plans and providers that resulted in the transfer of large groups of enrollees from a terminated medical group to new providers. In many instances, the provider group was insolvent and closed down abruptly. The DMHC provided critical guidance in more than 500 transfers during that time period, ensuring that patients received the care to which they were entitled.

In order to ensure that consumers had a smooth transition to a new provider or were allowed to continue care with the same provider, the DMHC contributed significantly to the drafting in 2003 of AB 1286/SB 244, the continuity of care legislation. Through consultations with consumer advocates, enrollees, health care lobbyists, provider groups, and attorneys, the legislation was crafted to enhance the rights of Californians faced with a disruption in their established doctor-patient relationships. New protections under the law expanded continuity of care rights to include the terminally ill, all pregnancies, and surgeries or procedures scheduled to occur within six months of the contract termination date or date of new enrollment in a health care service plan.

# Improving Consumer Access to Quality Care

## Prescription Drug Legislation and Regulation

In the early part of the decade, the DMHC was challenged with many prescription drug coverage issues in a rapidly changing legal climate. Issues raised by patient complaints included coverage for weight-loss drugs, non-formulary drugs, drugs used for both cosmetic and medical purposes, compound medications, and off-label drugs. The changing legal climate included a court decision that put at issue the DMHC's regulatory authority, as well as the validity of its existing regulations on prescription drug coverage. Given these circumstances, SB 842 (Speier) clarified the DMHC's regulatory authority, and addressed the challenge of handling such coverage issues.

## Right Care Initiative

In 2008, the DMHC created the Right Care Initiative (RCI), a public-private partnership of medical groups, health plans, associated businesses, and medical experts, to measurably improve patient outcomes and save lives in California by encouraging the practice of evidence-based medicine.

The Right Care Initiative's goal is to apply scientific evidence and outcome improvement strategies to reduce morbidity and mortality among California's managed health plan enrollees in three key areas: cardiovascular disease, with particular emphasis on hypertension; diabetes, with particular emphasis on heart attack and stroke prevention; and hospital-acquired infections.

The National Center for Quality Assurance estimates that improving California's cardiovascular disease and diabetes measures to the national Healthcare Effectiveness Data and Information Set (HEDIS) 90th percentile standard could save 1,694 to 2,818 lives annually. These improvements would also avoid $118 million in yearly hospital costs, 766,401 sick days and $125.56 million in lost productivity. Additionally, reducing the incidence of hospital-acquired infections can save an estimated 10,000 California lives each year.

Currently, the Right Care Initiative is collaborating with the UCLA and UC Berkeley Schools of Public Health on a pilot project in San Diego aimed at reducing heart attacks and strokes by meeting the national HEDIS control targets for blood pressure and lipids. Progress toward meeting the 2010 performance improvement goals will be announced at the third annual RCI Summit to be held at UC Berkeley in October.

## Health Plan Mergers Create Community Benefits

During the middle of the decade, two very significant mergers of health plans took place. In 2004, the WellPoint and Anthem corporations merged, clearing the way for a change in control of Blue Cross of California. Then in 2005, PacifiCare of California merged with UnitedHealth Group. The DMHC's review process for each of these mergers was thorough, structured, and deliberative. As a result, the DMHC was able to negotiate concessions that would improve the quality and accessibility of health care for Californians, retain administrative oversight activities in California, and hold down administrative costs

The DMHC also secured more than $450 million in community benefits for California consumers through the establishment of community investment programs. These funds have been used to improve the health care information technology infrastructure in rural and underserved communities, give consumers more choice through development of new managed care products, improve medical education in key areas of the state, and provide other investments in health care projects designed to serve low-income populations.

# Sustainability of the Managed Care Delivery System

## Health Care Reform

DMHC staff played a significant role in supporting the development of Governor Arnold Schwarzenegger's 2007 Health Care Reform Proposal. A number of key concepts in the Governor's plan, such as guaranteed coverage, cost controls, and prevention goals are also contained in the new federal health reform plan, and the DMHC will have a significant role in many parts of its implementation.

The Schwarzenegger Administration has applied for California to contract with the federal government to operate the federal high-risk pool for currently uninsured individuals with pre-existing medical conditions alongside the state's existing high-risk pool, using the same governance and operational framework. The Managed Risk Medical Insurance Board will begin providing coverage to Californians in September 2010 – one of first major provisions of federal health reform to be implemented in the state.

The DMHC has been jointly awarded, along with the California Department of Insurance, a grant of $1 million to retain actuarial services and necessary information technology upgrades necessary for reviewing health plan premium rates under the provisions of the federal bill. The DMHC is also competing for a $3.4 million grant to provide consumer assistance on federal health care reform provisions.

In the 2010 session, the DMHC worked closely with the Administration and the legislature in drafting key bills for implementing important provisions of the federal legislation including: SB 1163 (Premium Rate Review), AB 2244 (Pre-existing Conditions for Children), AB 2470 (Rescission of Coverage), AB 2345 (Coverage of Preventive Services), and SB 1088 (Dependent Coverage).

## Prompt Claims Payment

In January of 2001, the legislature enacted AB 1455 (Scott). This legislation set legal requirements for prompt payment of provider claims by health care service plans, with interest, and, in some cases, penalties for delayed payments. It also directed the DMHC to promulgate regulations requiring streamlined provider claims payment processes, and to establish a dispute resolution system.

These regulations created a definition of unfair payment patterns and led to the establishment of the Provider Complaint Unit (PCU) by Director Ehnes. This unit is devoted to responding to the needs of providers. It also tracks provider complaints to determine whether any health plans are engaged in demonstrable and unjust payment patterns, and if so, seeks appropriate remedies. The efforts of this unit have resulted in the recovery of more than $22 million in payments owed to physicians and hospitals.

## Financial Solvency of Medical Groups

In 1999, SB 260 (Speier) established the Financial Solvency Standards Board (FSSB) to serve in an advisory capacity to the Director on matters of financial solvency that affect the delivery of health care services, and to recommend financial solvency requirements and standards relating to health plans and providers. More specifically, this bill placed certain financial standards on risk-bearing organizations (RBOs), and required the DMHC to adopt regulations establishing "a process for reviewing or grading risk-bearing organizations based on specified criteria." Generally speaking, these risk-bearing organizations are medical groups or Independent Practice Associations that have been delegated risk, and that pay claims on behalf of health plans.

Regulations developed by the DMHC through the FSSB require RBOs to meet a number of financial standards and to submit data on a quarterly and annual basis that demonstrate their compliance with the specified solvency criteria. The DMHC established the Office of Provider Oversight (OPO), charged with monitoring compliance with the regulations. Information supplied by these RBOs provides

# Sustainability of the Managed Care Delivery System

the OPO with an early warning signal of possible financial difficulties. As a result of this financial oversight system, insolvency of RBOs is now a relatively rare occurrence.

## Innovation

During the past decade, the DMHC has continually evaluated its business processes, looking for new ways to deliver services to all customers in a timely, efficient, and professional manner. The Office of Technology and Innovation (OTI) has been recognized as a leader within state government for its commitment to finding innovative solutions to complex technical issues.

Beginning in 2003, the OTI developed an e-filing system that allowed all health care service plans to submit their required reports and licensing documents via an electronic document management system. Previously, documents were submitted in hard copy and stored in traditional paper filing systems. This e-filing innovation has saved countless hours of transmission time, as well as staff review time, and has substantially reduced the amount of paperwork required for health plans to comply with state reporting laws.

Another unique development occurred in September 2004, when the Provider Complaint System was deployed to enable health care providers to submit individual complaints electronically through a secured web portal. This system has allowed the DMHC to resolve claims payment issues on behalf of providers, giving them a fast and free way to have claims paid fairly and on time.

In 2009, another staff collaboration produced a streamlined Financial Examination System to provide additional information to the public and give examiners enhanced tools for detecting negative financial trends. One impressive accomplishment of this project was that most of the work was completed in-house, saving a significant amount in outside contracting costs.

Innovation never stops at the DMHC, and current projects include a new web portal to help evaluate a health plan's network adequacy in cases of contract termination with medical groups and hospitals. This will give the DMHC a faster way to verify that a sufficient number of providers are available to treat patients in a certain geographic area.

## Collaborating with Stakeholders

The DMHC is tasked with the regulation of a dynamic industry. During this decade, it has endeavored to address key issues through a collaborative stakeholder input process that ensures maximum public transparency. By convening representatives across the spectrum of stakeholder groups, the DMHC has ensured that its policies and regulations include the perspective of the stakeholders involved in the provisions and delivery of managed health care.

Significant stakeholder input shaped the DMHC's policies and regulations with respect to the most significant issues of the past decade. These include language assistance, timely access to care, recission, discount plan oversight, balance billing, and continuity of care. DMHC staff regularly participate in the Industry Collaboration Effort (ICE) projects to develop standardized procedures and tools for assisting health plans and providers. ICE mobilizes health care stakeholders to streamline, simplify, and standardize the regulatory policies and procedures governing the provision of health care services. The Consumer Participation Program, enacted in 2003, is designed to increase consumer participation in rulemaking by awarding fees to any person or organization that represents the interests of consumers, and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees. To date, almost $437,133 has been awarded to consumer advocacy groups.


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