

Consumer Protections Achieved by the DMHC

Background

The California Department of Managed Health Care is the only stand-alone HMO watchdog agency in the nation. It was formed by the legislature in 2000 to unify regulatory and consumer protection functions for HMO patients in California and to enforce the Knox-Keene Act, a vast body of laws affecting nearly 20 million Californians, representing more than half the insured population of the state. This robust enforcement has resulted in more than \$32 million in fines against health plans.

Accomplishments

The crowning jewel of the DMHC is the Help Center, which has assisted more than 1 million consumers since 2000 in resolving complaints and problems with health plans. The Help Center can assist consumers in 148 different languages. The Help Center has also:

- Recovered more than \$11 million for consumers in payments or reimbursements owed by health plans.
- Resolved 5,433 urgent cases within three days to date.
- Facilitated 9,000 cases to the independent medical review (IMR) process to date.
 - In 2008 alone, nearly 60 percent of health plan treatment denials sent to IMR were overturned, resulting in healthcare services being provided to consumers.
- Launched 10 unscheduled investigations of health plans to date into issues such as health insurance cancellations, claims payment and quality assurance problems, resulting in significant improvements in health plan processes and significant fines.

Other key consumer protection efforts

Rescission

- Accomplished a first-of-its-kind settlement 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. Required major changes in health plan processes to protect consumers from having their coverage unlawfully rescinded, such as clearer health history applications, vigorous upfront underwriting and resolving all health questions before issuing coverage.
- Offered guaranteed issue coverage back to more than 3,000 consumers previously rescinded since 2004.
- Created an independent arbitration process to receive reimbursement for out-of-pocket expenses incurred as a result of the rescission.

Balance Billing

- In 2008, passed regulations, among the strongest in the nation, to fully protect consumers from balance billing for emergency services, taking the patient out of the middle of billing disputes between providers and health plans.
- Prior to the passage of the regulations, studies showed that the average balance billed amount was \$1,289, in addition to an average patient cost-sharing amount of \$433.
- In 2007, the California Association of Health Plans reported that 1.76 million enrollees who visited ERs in a two-year period were balance billed by providers for an average of \$300 each – and half of them paid the bill.
- In 2009, the California Supreme Court, in the *Prospect* case, affirmed that balance billing is unlawful under the Knox-Keene Act.

Language Assistance

- 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 2009, regulations went into effect with relatively few implementation problems or consumer complaints.
- Eighty full-service and specialized health plans are subject to the regulations, each submitting an implementation plan based on the needs of its own enrollees.
- In the first eight months of 2009, as a result of the new regulations, the Help Center saw an 80 percent increase in callers requesting interpreters.

Timely Access to Care

- Beginning January 17, 2010, California became the first state to set standards to shorten the time a patient has to wait to see a doctor.
- Prior to the new standards, a recent study had found that the average wait time for new patients to see a family practice physician in Los Angeles is 59 days.
- Key elements of the new regulation include:
 - Triage or screening by telephone 24-7.
 - Waiting time for telephone triage no longer than 30 minutes.
 - During normal business hours, waiting time to speak to a plan's customer service representative can be no longer than 10 minutes.
 - Most urgent primary care appointments available within two days.
 - Appointments for non-urgent primary care visits available within 10 business days.
 - Non-urgent appointments with a specialist available within 15 business days.
 - The obligation to comply with the law is on the health plan, not the doctor.

Kaiser Kidney Center

- In 2006, the DMHC stepped in to oversee the transition to other facilities of 2,313 Kaiser Foundation Health Plan patients needing kidney transplants after the health plan's kidney transplant program was closed for significant failures in administrative oversight.
- Fined the plan \$5 million for failing to oversee the transplant center arrange timely access to patient care.

Discount Health Plans

- Ordered 18 fraudulent discount health card companies to cease operations or become licensed. Five discount health plans or products are now licensed.
- Since 2003, the Help Center has assisted more than 1,000 consumers with questions or problems with unlicensed discount health entities.
- The DMHC has proposed new regulations to license discount health entities with full consumer protections such as strict advertising restrictions, measurable discounts, verifiable provider contracts and uniform cancellation policies.

Right Care Initiative

- Launched in 2008 to improve clinical quality improvement in three areas which take the lives of thousands of Californians each year: cardiovascular disease (with particular emphasis on hypertension), diabetes, and hospital-acquired infections.
- The DMHC is committed to lowering barriers to the right care in these areas, by promoting cost-effective technologies, creating culturally-appropriate patient healthy behavior incentives, and developing team-based interventions among health plans and medical groups.
- The goal is to bring California health plans to the 90th percentile rankings in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) scores, a tool used by most U.S. health plans to measure performance on important dimensions of care and service.
- According to the NCQA, by improving scores to the 90th percentile levels, the lives of more than 2,000 Californians will be saved annually.

Mental Health Parity

- Required California health plans to make major improvements in services under the landmark 2001 Mental Health Parity law. Plans are now required to provide after-hours hotlines and reduce long waits for appointments.
- Striving to improve the entire system of care for autism treatment by gaining clear diagnoses, evaluations and treatment plans.
- Ensuring that health plans pay for key treatments such as speech, physical and occupational therapy, as required by law.

Office of the Patient Advocate (OPA)

- The sister agency to the DMHC, the OPA was created in 2000 to promote transparency and quality of health care by providing educational material for consumers and by publishing an annual Quality of Care Report Card.
- The Report Card rates the largest HMO and PPO health plans and more than 200 medical groups in California according to a set of national standards for quality of care.
- The Report Card also shows how members rate the care and services received from their HMOs.
- The Web-based Report Card served 65,000 website visitors in 2008.

The OPA:

- Provides one-on-one outreach about the DMHC's Help Center services and patient rights to 100,000 consumers annually.
- Promotes timely consumer health care information to general market, Spanish-language, and Asian-language media, resulting in hundreds of earned media placements.
- Promotes health care tools and resources through digital communications, including social media releases and social media platforms such as YouTube, Facebook, Twitter and Flickr.
- Distributed more than one million printed 'How to Use Your Health Plan' guidebooks to date.

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