

Insurance Markets

Regulatory Oversight of Health Insurance in California

June 2003

Introduction

The business of health insurance in California is subject to a complex patchwork of federal and state regulations. Different rules apply depending on whether insurance coverage is purchased directly by individuals or on behalf of a group, as in job-based health insurance. Among groups, rules differ depending on group size.¹ Finally, rules and consumer protections vary based on how employers choose to cover the health costs of their employees, either by paying claims costs directly or by purchasing health insurance coverage through a state-regulated insurance carrier.² This complexity can make it difficult for purchasers and consumers to understand which rules and protections apply to their health coverage.

As a general principle, the business of health insurance is regulated by the states. However, one federal law, known as ERISA, has far-reaching implications that limit when and how states may regulate health coverage provided by private employers. This analysis highlights federal ERISA rules and key California laws regulating health coverage. It also identifies how the different regulatory schemes affect the legal protections available to consumers covered by different types of plans. The overview presented here is a summary of the more detailed findings included

in two prior CHCF reports — *Regulation of ERISA Plans: The Interplay of ERISA and California Law (2002)* and *Making Sense of Managed Care Regulation in California (2001)*.

Federal Law: ERISA

The federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from enforcing state laws relating to private sector employee benefit plans established by employers or other sponsors in order to provide health coverage. However, ERISA allows states to regulate the insurance carriers with which employers (or other sponsors) contract to provide health benefits for their employees. ERISA applies to private sector benefit plans, but does not apply to benefit plans offered by state and local governments or churches; nor does it apply to coverage sold directly to individuals. ERISA's provisions are monitored and enforced by the U.S. Department of Labor (DOL).

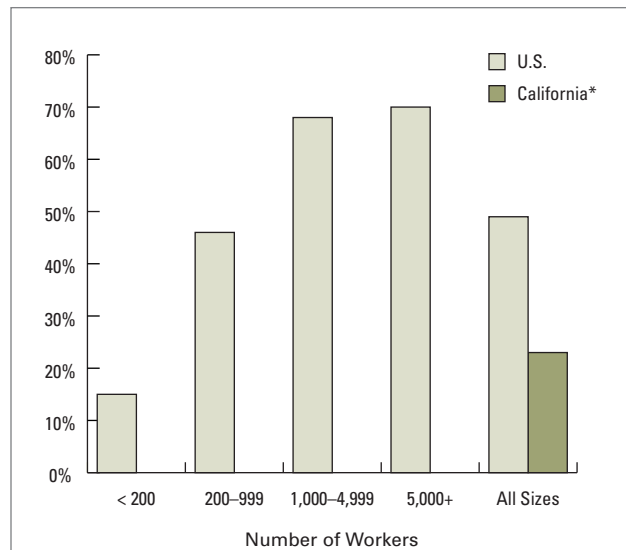
While ERISA specifically “preempts,” or supercedes, state laws directly regulating employee health benefit plans, it also gives states the power to regulate “the business of insurance.” In other words, states are free to apply their own regulatory standards and requirements to the insurance carriers that employers contract with in order to

provide employee benefits. As a practical matter, this means that the application of ERISA depends in part on how the employer chooses to provide the benefits — as a fully insured plan or a self-insured plan. Under a fully insured plan, the employer purchases coverage from a state-regulated insurance carrier, and the carrier assumes the risk for the costs of medical claims. In contrast, under a self-insured plan, the employer retains the risk and covers the costs of medical claims. Because the employer does not contract with an independent insurance carrier, the ERISA preemption applies and the coverage is exempted from state regulatory oversight.

In general, ERISA requirements for employee health benefit plans are less far-reaching than the state regulations that apply to insurance carriers. Since self-insured employee benefit plans are subject only to ERISA, consumers covered by self-insured plans have fewer protections than those covered through fully insured plans.

In 2001, about 3 million Californians were in self-insured plans, and therefore exempt from state regulatory oversight.³ Figure 1 shows how self-insurance varies with firm size. Self-insurance is less prevalent in California than the nation as a whole, in part because of the high market penetration of standardized managed care products in California.

Figure 1. Percentage of Employees in Self-Insured Plans, by Firm Size, 2002



*California data by firm size not available.

Source: *Employer Health Benefits 2002 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, and Kaiser/HRET 2002 California Employer Health Benefits Survey.

THE EMPLOYER PERSPECTIVE: Why Self-Insure?

For employers and other health insurance sponsors (for example, labor trusts and associations), self-insuring may be attractive for several reasons. Self-insured plans:

- Allow an employer to provide a consistent benefit package in all locations, even if employees reside in several states. Under fully insured plans, the carrier is subject to state-specific benefit mandates and other regulatory requirements that vary from state to state.
- Are not subject to state insurance premium taxes.
- Allow employers to maintain control of funds until health care costs are incurred and paid. Although there are financial risks associated with unpredictable health care costs, employers may benefit from the cash "float" that self-insurance provides.

Large businesses are more likely than small businesses to have financial reserves that would enable them to bear the risk of uncertain health care costs. They are also more likely to have employees in multiple states. As a result, larger businesses are more likely to provide coverage on a self-insured basis than are smaller businesses.

The ERISA preemption is complex and has been subject to numerous court challenges to determine its scope and applicability.⁴ The Department of Labor has not clarified the exact definition of “self-insurance.” Many existing insurance arrangements are hybrids between fully insured and fully self-insured. As a result, courts have determined whether the ERISA preemption applies on a case-by-case basis. For example, many self-insured employers buy stop-loss insurance to reduce their risk of paying unexpectedly large medical claims. Federal courts have found that the ERISA preemption limits the ability of states to regulate medical stop-loss policies purchased by employers in these cases, even if a regulated insurer sells the policy.⁵

Some self-insured employers contract with insurance carriers to administer their ERISA plans through third-party administrator (TPA) arrangements. TPAs pay claims, conduct utilization review, and process prior authorizations. Individuals covered under these self-insured employee benefit plans through TPAs may incorrectly believe they are covered by the carrier administering the benefits and that they have the protection of state regulation, when in fact their coverage is subject only to the more limited protections of ERISA.

California Law and Agency Jurisdictions

In California, regulation and oversight of fully insured employee health benefit plans is split between two state departments—the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).⁶ DMHC primarily regulates health maintenance organizations (HMOs) under the Knox-Keene Health Care Service Plan Act, but also has jurisdiction over some Preferred Provider Organization

(PPO) plans. CDI has jurisdiction under the California Insurance Code over all other types of health insurance, including plans that offer traditional health insurance products, such as indemnity plans, and some PPO plans.⁷ Many more Californians with health coverage fall under the jurisdiction of DMHC than CDI, as shown in Table 1.

Table 1: Covered Californians in Full-Service Health Plans by Regulatory Jurisdiction, 2002

REGULATORY AGENCY	COVERED CALIFORNIANS	
	Number	Percentage
Department of Managed Health Care	23,400,000	85.7%
California Department of Insurance	3,900,000	14.3%

Source: California Department of Insurance, Accident and Health Covered Lives 2002.

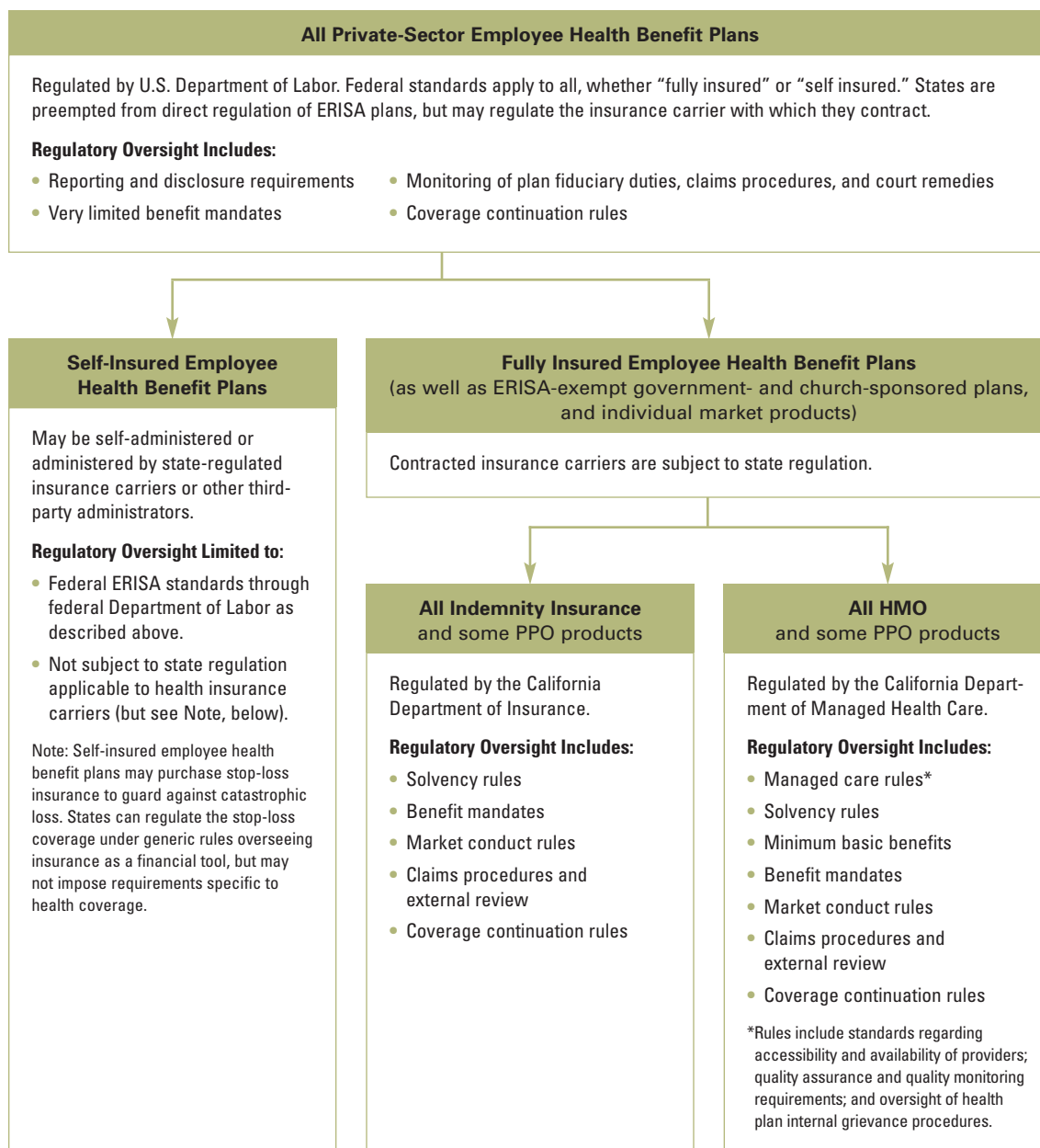
The two departments approach regulation from different legal and regulatory perspectives. DMHC focuses on the accessibility and adequacy of health plan provider networks; internal quality systems; health plan financial solvency; consumer rights and disclosure requirements; and complaint resolution, including complaints related to the adequacy of the care provided. CDI focuses on the financial ability of insurers to pay claims; market conduct; consumer rights and disclosure requirements; and consumer complaints, primarily related to the payment of claims. CDI has no legal authority to resolve complaints related to quality of care.

The division of regulatory authority between the two departments has a complex political history. A key distinction between the two regulatory approaches is that the Knox-Keene regulatory framework is based on direct involvement of the health plan in providing or arranging for the delivery of health services. The insurance regulatory framework, in contrast, focuses primarily on a system of payment or reimbursement

for services once they have been delivered. Distinctions among health coverage types, and the respective jurisdiction of the two departments, have blurred over time. For example, both departments currently regulate

some PPO products, where consumers can use any licensed provider but pay less if they use the plan's list of contracted providers. Figure 2 illustrates California's regulatory environment.

Figure 2. Regulation of Health Coverage under Federal ERISA and California Law



Impact of the Different Regulatory Frameworks

In California, then, there are essentially three relevant regulatory frameworks for health insurance — state regulation of health plans by DMHC, state regulation of insurers by CDI, and regulation of self-insured employee health benefit plans by the federal Department of Labor. All privately sponsored coverage, whether self-insured or fully insured, is subject to ERISA requirements. In addition, fully insured employee health benefit plans are also subject to either DMHC or CDI oversight.

This section highlights several key regulatory areas and the primary differences among the three frameworks. State requirements are more stringent than ERISA in most areas, including solvency standards, mandated benefits, and dispute resolution.

Solvency Standards

Solvency standards are intended to ensure the financial stability of insurance carriers and to protect consumers from losing access to health care in the event of a carrier's bankruptcy. There are two elements to solvency regulation: monitoring and corrective action.

There are virtually no solvency protections applicable to self-insured employee health benefit plans. However, the federal Department of Labor has the authority to enforce broad fiduciary responsibilities and could intervene, for example, if benefit plan funds were being diverted for other purposes.

Both of California's regulatory agencies are responsible for monitoring and enforcing solvency, but the agencies approach solvency oversight differently. DMHC enforces minimum financial reserve standards through

what are known as “tangible net equity” requirements. DMHC conducts regular on-site financial audits and health plans must submit monthly and quarterly financial reports. If a health plan becomes insolvent, DMHC has the authority to allocate its enrollees to other health plans in the area. In the event of an insolvent health plan, health care providers are at risk for lost payments. In the past five years, DMHC has placed nine health plans under state conservatorship.

Most observers agree that CDI imposes more rigorous financial standards than DMHC.⁸ CDI applies nationally developed “risk-based capital” standards to ensure that insurers have adequate financial reserves to cover claims liabilities. Most state insurance departments have adopted these standards, which are based on formulas that take into account each company's assets, premiums, reserves, and management practices. CDI conducts extensive financial examinations of insurers originating in California and exchanges information with regulators in other states. If a health insurer licensed by CDI becomes insolvent, the California Life and Health Insurance Guaranty Association, funded by assessments on all CDI regulated life and health insurers, can help to pay claims. CDI has not experienced widespread solvency problems with health insurers under its jurisdiction.

Mandated Benefits

Mandated benefits are specific services or coverage that carriers are legally required to offer or include in their health plans. It is only within the last few years that benefits have been mandated under ERISA. Now ERISA includes three mandates: equal treatment of mental health coverage (mental health parity) by employee health benefit plans with 50 or more

employees, reconstructive surgery following mastectomy, and minimum length of hospital stays for maternity patients (48 hours).

California imposes dozens of benefit mandates on insurance carriers. Most mandates apply both to health plans regulated by DMHC and to insurers regulated by CDI. In addition, all Knox-Keene licensed plans must provide a set of basic minimum benefits: inpatient and outpatient care, physician services, preventive services, lab and radiology, home health, hospice, and emergency services. Pharmacy coverage is not required under Knox-Keene, but plans that offer drug coverage are subject to a series of statutory and regulatory requirements specifying what must be covered, such as pain medicine for terminally ill patients and prescription contraceptive methods. There are no basic benefits applicable to plans regulated by CDI.

Dispute Resolution

Dispute resolution allows covered individuals to seek redress in coverage, payment, and quality of care disputes. ERISA requires every private-sector employee benefit plan, insured or self-insured, to provide:

- Adequate notice of any claims denial, along with the reasons for the denial; and
- An opportunity for a full and fair review of the denial by the plan.

THE EMPLOYEE PERSPECTIVE: What Happens When Problems Arise?

Most Californians with health insurance coverage obtain it through the workplace. When coverage problems arise, consumer recourse differs depending on the health insurance arrangement the employer has chosen. As illustrated below, consumers with private sector employment-based health coverage obtained under different arrangements (a fully insured HMO, a fully insured PPO, and a self-insured PPO) have different protections.

Independent Medical Review

Suppose that consumers covered under each arrangement believe that care has been inappropriately denied.

- **Fully Insured HMO:** Health plans must provide a process for appeal of disputes to an external, independent medical review program. Consumer has recourse through DMHC.
- **Fully Insured PPO (CDI regulated):** Insurers must provide a process for appeal of disputes to an external, independent medical review program. Consumer has recourse through CDI.
- **Self-Insured PPO:** External review is not required. Consumer has limited regulatory recourse under ERISA claims regulations. DOL may provide limited assistance in discussing disputes with the plan administrator.

Access to Providers

Suppose that consumers covered under each arrangement are concerned that a geographically convenient provider is not available in the carrier's managed care network.

- **Fully Insured HMO:** DMHC reviews proposed health plan networks and providers for compliance with geographic accessibility standards and enforces enrollee-to-provider ratios. Consumers have recourse through DMHC in the event there are insufficient providers in the area.
- **Fully Insured PPO:** To date, CDI has not monitored or regulated the adequacy of provider networks or access to services, since all types of insurance regulated by CDI pay for services from both in-network and out-of-network providers. Consumer has no regulatory recourse.
- **Self-Insured PPO:** Consumer has no regulatory recourse.

Federal regulations prescribe timeframes for internal appeals and require employee benefit plan administrators to consult with medical professionals when reviewing matters of medical judgment. ERISA allows for applicability of state dispute resolution laws to insurance carriers but limits court-awarded damages in some cases. The Department of Labor has very limited staff and authority for resolving consumer complaints.

Both California regulatory agencies have greater authority to respond to and resolve complaints than the DOL. State law requires health plans under DMHC jurisdiction to have an internal grievance process. CDI has interpreted the existing statute as requiring that insurers under its jurisdiction also have some type of internal review process for utilization issues. DMHC has broader statutory powers than CDI to adjudicate complaints related to quality of care. Both departments have toll-free consumer complaint hotlines and staff for resolving consumer complaints.

Independent Medical Review. All California insurance carriers, whether regulated by DMHC or CDI, must provide a process for appeal of certain benefit disputes to an external, independent medical review program. California's independent medical review law includes specific timeframes, which must be expedited in urgent situations, for submitting review requests and obtaining resolution. (For more information, see the CHCF reports *Independent Medical Review Experiences in California, Phase I and II* available at www.chcf.org.) There is no similar independent external review required under ERISA.

Conclusion

Californians obtain health coverage through a variety of arrangements that are subject to complex state and federal regulation. Under the provisions of ERISA, consumers who are covered by self-insured private-sector employee benefit plans have fewer protections than consumers whose employer purchases coverage from a state-regulated carrier. Given the variety and complexity of employer-provided health insurance arrangements, the differences may not be readily apparent to consumers. California's split regulatory authority, where two separate departments have responsibility for regulation of segments of the health insurance industry, makes it even more difficult for consumers to understand which protections apply in their circumstances, and which agency is responsible for oversight.

Acknowledgments

This summary was prepared by Deborah Reidy Kelch, an independent health researcher and president of Kelch Associates Consulting. *Regulation of ERISA Plans: The Interplay of ERISA and California Law* (2002) was written by Patricia A. Butler and Karl Polzer. *Making Sense of Managed Care Regulation in California* (2001) was written by Debra L. Roth and Deborah Reidy Kelch. Both reports are available at www.chcf.org.

ENDNOTES

1. For more information about California market rules, see two companion Trends & Analyses documents: “Rules Governing California’s Small Group Health Insurance Market,” and “Rules Governing California’s Individual Health Insurance Market,” both available at www.chcf.org.
2. In this document, “insurance carrier” or “carrier” is used generically to refer to both health plans regulated by the Department of Managed Health Care (DMHC) and insurers regulated under the California Department of Insurance (CDI).
3. Butler, P.A. and Karl Polzer. *Regulation of ERISA Plans: The interplay of ERISA and California law*. Prepared for the California HealthCare Foundation. Oakland: June 2002. Available online at: www.chcf.org.
4. For additional information on ERISA and the ERISA preemption, see Butler and Polzer.
5. National Association of Insurance Commissioners. *Fourth Circuit U.S. Court of Appeals holds that ERISA preempts state stop-loss insurance regulation: American Medical Security, Inc. vs. Bartlett, F.3d, 1997 (WL 16989 [4th Cir., Md.]*). Available on-line at: www.naic.org.
6. In addition to licensure and regulation through the DMHC and the CDI, health plans that participate in the Medi-Cal Managed Care program are subject to regulation and oversight by the state Department of Health Services.
7. For a detailed description of the California regulatory environment, see Roth, D.L. and Deborah R. Kelch. *Making Sense of Managed Care Regulation in California*. Prepared for the California HealthCare Foundation. Oakland: November 2001. Available online at: www.chcf.org.
8. Roth and Kelch.

Future editions will identify trends in California’s insurance markets, analyze regulatory and policy issues, and provide industry updates. Analyses will be posted as they become available at the California HealthCare Foundation’s Web site at www.chcf.org.

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