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REPORT



Making Sense of Managed Care Regulation in California

November 2001

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Prepared for the
California HealthCare Foundation

by
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Introduction

In California, regulation and oversight of health insurance is split between two state departments. The new Department of Managed Health Care (DMHC) primarily regulates health maintenance organizations (HMOs), while the California Department of Insurance (CDI) has jurisdiction over traditional health insurance.

The 1999 legislation establishing the new DMHC (AB 78) transferred regulatory responsibility for HMOs from the Department of Corporations (DOC) to DMHC.¹ AB 78 also requires DMHC to report to the Legislature by December 31, 2001 on the feasibility of transferring regulatory jurisdiction of CDI-regulated health insurers to DMHC.

The two regulatory models, and their deficiencies and strengths, are the result of history, changing political judgments and circumstances, and sweeping marketplace trends over a half-century. While the differences are rooted in distinct statutory frameworks and generally apply to discrete

product types, there have been many twists and turns along the way. Today, it can be difficult to understand why one regulator rather than another has jurisdiction over a particular product or company.

This report considers the political history, current statutory and regulatory requirements, and the predominant types of health insurance products available in today's market. The goal here is to contribute to an informed discussion and debate as policymakers and stakeholders evaluate the options within the context of the pending AB 78 report.

Research for this report included a review of legislative history and relevant statutes, review of materials provided by DMHC and CDI, review of other relevant research and reports, and key informant interviews with individuals who are particularly knowledgeable regarding the evolution and current status of health insurance regulation in California.

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History of the Knox-Keene Act

The Knox-Keene Health Care Service Plan Act of 1975, the current statutory framework under which HMOs and most managed care plans operate in California, is very directly the result of the history and the times during which it has evolved. This section provides a brief overview of that history and the evolution of prepaid health care and health insurance in California. A detailed chronology appears in Appendix A.

The story of health insurance in California is the story of two systems developing in parallel: *indemnity health insurance*, based on fee-for-service provider payments and broad provider networks, alongside *prepaid health plans, or HMOs*, providing specific services for a fixed monthly fee through more tightly organized and restrictive networks.²

Until the mid-1970s, Blue Cross, Blue Shield, and commercial indemnity business, claimed the lion's share of the California market.³ Over time, cost containment concerns yielded much of the market to the HMOs with their relatively low-cost structures and tighter management of service delivery.

Early Prepaid Health Care

One of the very first prepaid health plans was established in 1929 when the Ross-Loos Clinic, a group practice of physicians, contracted to provide care for workers in the Los Angeles water department.⁴

At about the same time, the Kaiser Permanente Program was emerging out of an effort in the Mojave Desert to bring medical care to thousands of workers laboring on the construction of the Los

Angeles Aqueduct. The physician who established the on-site clinic approached Kaiser Industries proposing to accept a prepaid fixed amount per covered worker to provide medical care for both on-the-job and non-job related injuries. The resulting Kaiser model was expanded to other projects in California and Washington and was ultimately made available to the public in 1945.

Blue Cross and Blue Shield

In the late 1930s, organized medicine and hospital associations around the country helped to establish Blue Cross (hospital coverage) and Blue Shield (coverage for physician services) plans. These plans aimed to shore up revenues dependent on the uncertainties of patient payments and, some observers report, to block more radical changes in medical care delivery such as government health insurance.⁵

Historians dispute the first place in the country where a Blue Cross plan developed, but many put the origins in Dallas, Texas. The first statutory authorization for a California Blue Cross plan came in 1937 legislation creating the new designation of “nonprofit hospital service plan” subject to regulation by the Insurance Commissioner. As a nonprofit hospital service plan, California Blue Cross was exempt from paying the gross premiums tax applicable to other insurers.⁶

In 1939, the California Medical Association (CMA) founded the California Physicians Service (CPS), the nation's first statewide, medical-society–controlled, prepaid plan, which would later be called Blue Shield of California.

In the early 1940s, California's Insurance Commissioner challenged Blue Shield's contention that it was not subject to the Insurance Code. In 1946, the California Supreme Court held that Blue Shield (and prepaid health plans) are not in the business of insurance and are not subject to regulation by the Insurance Code. The decision represented the first distinction in California law between the "promise to pay" (indemnity health insurance) and the "promise to deliver or arrange for care" (prepaid health care).

According to key informants, Kaiser, Blue Cross, and Blue Shield resisted being regulated by CDI in the same way as commercial insurers for philosophical reasons, because they fundamentally believed that they were not in the business of traditional insurance. Several key informants also suggested that these companies avoided CDI regulation because they were concerned about the possibility of having to pay the gross premiums tax.

The Rise of Indemnity Health Insurance

The growth of health insurance (Blue Cross, Blue Shield, and commercial indemnity coverage) was dramatically fueled during World War II when wages were frozen but benefits were not.⁷ Organized labor turned its bargaining strategy to benefits instead of wages.

By the early 1950s, health care became a routine benefit of the workplace, with nearly eight out of ten workers in the private sector covered through employment by some type of voluntary, if limited, health care plan.⁸ In 1958, nearly two-thirds of Americans had coverage for hospital costs, then the most common type of health insurance coverage.

Knox-Mills Act

In 1965, concerned about the lack of any regulatory framework for prepaid health plans in California, and the increasing potential that there would be an effort to license them as insurers, Kaiser, Blue Shield, and Ross-Loos actively supported passage of the Knox-Mills registration program. Knox-Mills required "health care service plans" to "register" with the Attorney General. Much of the language in Knox-Mills continues in the present day Knox-Keene statute.

Knox-Mills was never considered to be a rigorous licensing framework by either the plans or other stakeholders. It was, however, the scandals that emerged in the early Medi-Cal Prepaid Health Plan (PHP) program that prompted the Legislature to consider more substantive regulation of prepaid health plans.

Medi-Cal PHP Scandals

In 1971, Governor Ronald Reagan proposed sweeping reforms in the Medi-Cal program, which included a strong emphasis on prepaid health plans as a means of reducing Medi-Cal costs.⁹

The problems began almost immediately. By mid-1972, the media was reporting misrepresentations by health plan enrollers, poor quality of care, and failure to provide promised transportation to medical offices.¹⁰

Many newly organized PHPs were little more than schemes to funnel Medi-Cal dollars through a nonprofit shell to for-profit corporations owned by the same providers. In some cases, the plans actually sold health plan "shares" to unscrupulous providers who were hoping to reap huge profits in the form of provider payments. Plan owners and

partners siphoned off funds, leaving other providers without payment and the PHP shell in financial disarray.

In response to the complaints, the Legislature passed the Waxman-Duffy Act, which set regulatory standards for Medi-Cal PHPs.¹¹ Despite the new requirements, problems grew.¹²

State and federal legislative investigations revealed that California Department of Health Services (DHS) officials had shown favoritism to plans represented by former DHS staffers and had renewed licenses even where quality of care problems had been documented.¹³ Investigators also uncovered financial and/or political ties between a few legislators and plans, where legislators pressured DHS to approve new contracts or continue existing ones despite evidence of potential abuses. A DHS deputy was even accused of impeding an investigation by the Los Angeles District Attorney's office.¹⁴ The written rules had changed, but the unwritten rules had not.

Federal HMO Act

The term “health maintenance organization” was coined in 1973 with the enactment of the federal HMO Act, an attempt by federal policymakers to stem the “crisis” in health care cost inflation.¹⁵

The HMO Act established comprehensive benefits, community rating requirements, administrative oversight procedures, requirements for financial reserves, annual open enrollments, prohibitions on pre-existing condition limitations, and other requirements. The Act recognized several different models of plans and provided federal start-up grants for nonprofit HMOs to encourage HMO expansion and development.

Under the HMO Act, plans could choose to apply for federal qualification and agree to meet the requirements of the Act. In return, HMOs would be eligible for start-up grants and loans and could market the HMO as meeting federal standards and requirements. In addition, the Act originally required employers of more than 25 workers who already provided health benefits to offer as one choice an available federally qualified HMO. This requirement was phased out in the early 1990s. In the wake of the HMO Act, the number of HMOs grew dramatically. By 1987, at least 16 new HMOs had appeared in California.¹⁶

The Time Is Right for Knox-Keene

In 1975, Governor Jerry Brown appointed the Prepaid Health Plan Advisory Committee to examine the Medi-Cal PHP program. Among other things, the Committee recommended that all Medi-Cal PHPs be required to meet the standards in the federal HMO Act.

At the same time, there was increasing pressure to find a regulatory home for the expanding nonprofit Knox-Mills plans including Blue Shield, Kaiser, and Ross-Loos, which were subject to only minimal regulation under Knox-Mills.¹⁷

The Knox-Keene Health Care Service Plan Act of 1975 transferred regulatory authority from the Attorney General to the Department of Corporations and established the basic framework for regulation of health care service plans that remains today. Knox-Keene was heavily influenced by the failures and inadequacies of the PHP program and also paralleled many provisions of the federal HMO Act. The Act set rules for mandatory basic services, financial stability, availability and accessibility of providers, review of provider

contracts, administrative organization, and consumer disclosure and grievance requirements.

According to key informants, the primary reasons for selection of DOC to regulate Knox-Keene plans were: (1) Department of Health Services was universally viewed as incompetent in the wake of the PHP scandals, and had a reputation as an unmanageable and unwieldy bureaucracy; (2) Legislative staff and other key stakeholders felt that the Department of Insurance was too friendly to the interests of insurers; and (3) Stakeholders believed that DOC could bring financial stability to the health plan industry, given DOC's expertise in financial and investment regulation, while the department could contract for or hire the required health care expertise.

The Act required all Knox-Mills plans to seek Knox-Keene licensure and, according to key informants, more than 100 plans applied for and received the new license.¹⁸ In addition, the new law required Blue Shield to become a Knox-Keene plan but gave it and several specialized plans (dental and mental health) three years to *reduce* (but not eliminate) the portion of their business that “substantially indemnified subscribers.”¹⁹ Blue Shield was essentially being told to look more like a prepaid health plan and less like an indemnity carrier,²⁰ although the company retained the ability to offer products paying for services delivered by some providers not under contract.²¹

Rising HMO Enrollment and the Development of PPOs

In 1982, faced with rising Medi-Cal costs, the Legislature enacted the selective hospital contracting program in Medi-Cal. Private insurers argued that hospitals would shift costs to the private sector

when their Medi-Cal revenues declined, prompting the Legislature to repeal the Freedom of Choice provisions in the Insurance Code and authorize insurers to negotiate and enter into contracts with providers at “alternative rates of payment.”²² The statute provides no further definition or detail on what that means. The Act also permitted carriers to limit claims payment to providers charging the alternative rates.

The resulting preferred provider organization (PPO) model of indemnity insurance—where individuals have reduced out-of-pocket costs if they use providers on the insurer's preferred list—meant that indemnity carriers could move to be more price competitive with Knox-Keene licensed HMOs. PPOs implemented utilization review and other cost containment strategies in an effort to compete with the lower priced HMO plans. By 1985, there were 60 PPO plans with nearly 4 million covered lives in California.²³

California's health care market became intensely competitive. By 1990, there were more than 35 HMOs in California with nearly 10 million enrollees,²⁴ all but six of which had been formed since passage of the 1973 HMO Act.

HMOs Become Increasingly For-profit

In 1979, the federal HMO Act was amended to permit conversion of nonprofit plans to for-profit status. While Knox-Keene permitted both nonprofit and for-profit plans since its inception, most of the HMOs that were developing around the country, including in California, were nonprofit. This was primarily because of the availability of federal grants and loans for nonprofit HMOs under the federal HMO Act. In the early 1980s,

federal grants and loans were discontinued, prompting many HMOs to pursue for-profit conversions in the search for capital. As a result, a wave of conversions of California HMOs occurred through the 1980s and into the 1990s.

Blue Cross Moves to Knox-Keene

Blue Cross of California (BCC) continued to operate as a nonprofit hospital service plan under the Insurance Code throughout the 1970s and 1980s.²⁵ In the early 1990s, a complex combination of political and economic events prompted BCC to seek Knox-Keene licensure. One issue, according to key informants, was the concern among insurers that BCC's poor financial condition at the time might result in BCC insolvency and become a drain on the new health insurance guarantee fund at CDI. This concern led to the requirement in the legislation establishing the Health Insurance Guarantee Fund that BCC apply for Knox-Keene licensure by 1991.²⁶

In 1993, BCC obtained multiple Knox-Keene licenses for health, pharmacy, and dental business. BCC also submitted an initial proposal for “restructuring” of assets that included BCC ownership of a large for-profit subsidiary, Wellpoint Health Networks, which in turn owned three nonprofit Knox-Keene licenses.

The ultimate restructuring of BCC was legally and technically complex, controversial, and heavily debated in legal, legislative, and public forums. After a prolonged legislative and regulatory struggle, BCC reached agreement with policymakers and DOC (as its regulator) to dedicate major corporate assets to charitable purposes and to maintain a single license as a for-profit health care service plan.

BCC was granted specific statutory authority under Knox-Keene, similar to the original authority provided for Blue Shield, allowing BCC to continue offering PPO products.²⁷

The New Department of Managed Health Care

As providers, consumers, and consumer advocates witnessed the dramatic changes in health care delivery precipitated by the growth in managed care, they increasingly sought legislative and regulatory changes in how HMOs operate and are regulated. Throughout the 1990s, Knox-Keene (and to a large extent the Insurance Code) was amended to include a series of additional benefit and provider mandates, new provider contracting and claims payment requirements, and changes to coverage and contract requirements.

In 1997, the statutorily mandated Managed Health Care Improvement Task Force put forward a series of reform recommendations. These included the need for a new agency to regulate Knox-Keene plans, and phased-in regulation of other entities, including other health insurance carriers and organized medical groups.

In 1999, the Legislature passed a series of managed care reforms, including AB 78, which created the new Department of Managed (Health) Care. In addition, 20 other bills, referred to by consumer advocates as the “Patient Bill of Rights,” were enacted in 1999:

- Guaranteed coverage for second opinions;
- Time limits on utilization review and mandated disclosure of the criteria health plans use in denying coverage;

- Independent external medical review to resolve disputes related to denials, delays, or modifications of coverage;
- Improvements in the external review system for coverage of experimental treatments;
- Consumer right to sue an HMO for damages related to denials or delays in care;
- Standards to assure the solvency of medical groups under contract with health plans; and
- Specific mandated benefits, such as mental health parity, contraception, hospice, cancer screening, and coverage for diabetes supplies.

In July 2000, the new Department of Managed Health Care (DMHC) opened its doors. DMHC is currently divided into teams: the HMO Help

Center, Enforcement, Legal Services, Health Plan Oversight, Administrative Efficiency, Technology and Innovation, and Staff Leadership.²⁸

Three boards advise DMHC: the Advisory Committee on Managed Care, the Clinical Advisory Panel, and the Financial Solvency Standards Board. The meetings of these boards and their subcommittees are open to the public.

The Advisory Committee on Managed Care is currently considering the regulation of health plans and indemnity insurers in response to the AB 78 requirement that DMHC study the feasibility of transferring the regulation of health insurance from CDI to DMHC. The report is due to the Legislature in December 2001.

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Uncovering the Differences in Regulatory Frameworks

Although both departments regulate carriers providing health coverage, DMHC and CDI approach regulation very differently, primarily because the various carriers they regulate, and the statutory authority under which they regulate, are very different. At the heart of the distinction between “disability insurers”²⁹ and “health care service plans”³⁰ is the “promise to pay” versus the “promise to deliver care.”

Under Knox-Keene, health care service plans (commonly referred to as HMOs) actually arrange for and organize the delivery of health care and services through contracted or owned providers and facilities. Disability insurers protect against (indemnify) the expenses or charges (losses) associated with illness or injury. A disability insurance policy, or indemnity policy, provides coverage for defined benefits related to the insured event—accident, illness, or other covered health condition or situation. This is the traditional concept of indemnity insurance, and applies generally to all forms of insurance, including a home destroyed by fire or an automobile destroyed in a collision.

Another inherent difference between a health care service plan and a disability insurer is the nature of the protection afforded consumers under each coverage type. Knox-Keene HMOs assume the risk and pay for all medically necessary covered services for one monthly, prepaid payment; insurers pay medical expenses or a portion of medical expenses according to the specific coverage under the contract. In effect, under Knox-Keene, consumers are not financially affected by variations in either cost or utilization, outside of specified copayments or

other contract cost-sharing provisions. This is because the health plan provides (or contracts for) the *services*, rather than making payments to cover a specific dollar loss (charges), or percentage of the loss, as in indemnity insurance.

Providers may look to their patients with indemnity coverage to pay costs or charges regardless of whether or how much the insurer indemnifies (reimburses the patient) for the services. However, contracts between Knox-Keene HMOs and providers must specifically prevent the providers from seeking payment directly from enrollees *for covered services* if the health plan fails to pay.

Marketplace Changes Blur the Distinctions

Over time, the differences between these two models of health coverage have been obscured or blurred for many observers and stakeholders. There are two primary reasons for this.

First, there have been two significant exceptions made in law and regulation in the types of carriers regulated as Knox-Keene plans. Through the historical and statutory authorizations described above, both Blue Cross and Blue Shield are licensed as health care service plans, but along with several specialized plans are able to also offer PPO contracts, a type of contract otherwise subject to CDI licensure and more commonly associated with indemnity insurance.³¹

Second, over the past several decades, the Legislature has authorized both health plans and insurers to offer new types of policies and contracts

that appear more similar than different. Insurers have increasingly offered PPO policies with what look like delivery systems, where a published list of “preferred” providers offer their services at discounted rates, reducing out-of-pocket costs for consumers who use the PPO network to obtain health care. Health care service plans (HMOs) are now able to offer point-of-service (POS) contracts, allowing enrollees to receive some services outside of the network of contracted or employed providers, if they are willing to pay increased out-of-pocket costs for these choices.

Moreover, virtually all health coverage today (whether health plan or disability insurance carrier) has some elements of “managed care” including, for example, prior authorization, coverage limited to medically necessary care, and utilization review. These hybrid products have in some respects blurred the distinctions between health plans and insurers for consumers, policymakers, and other key stakeholders.

Key Informant Impressions

Key informants interviewed for this project offered the following opinions and observations about the two models of health coverage and the respective regulation by each department. Appendix E lists the key informants who were interviewed.

Current System Is Confusing to Consumers

Since the department of jurisdiction for different health insurance products is based in part on history and legal technicalities, the differences are invisible or too complex for consumers to recognize. As a result, the dual regulatory system is difficult for consumers to navigate when they have problems with their health care.

Key informants agreed that DMHC, in existence for little more than one year, is seen as more consumer oriented than the entity that previously regulated health plans, the Department of Corporations. Some key informants also felt that CDI was potentially less consumer friendly because CDI’s consumer complaint system is generally more limited than DMHC’s system. This is because DMHC has a statutory mandate to review and resolve complaints related to the quality of health care services while CDI does not.

Departments Have Different Strengths and Weaknesses

Each department regulates in a fundamentally different way. Consequently, key informants viewed DMHC’s emphasis on insuring quality of care as generally more burdensome for health plans in the regulation of adequacy of in-network care, benefit design, consumer complaints, and quality review. Virtually all key informants viewed CDI as stricter in the application of financial and claims payment standards and a more rigorous enforcer of financial solvency and reserve requirements.

Consumer Recourse Is Different

The two types of coverage result in very different relationships between consumers and carriers and between consumers and providers.

An individual covered by an insurance product independently selects and deals directly with the provider, is generally responsible for payment and, if not satisfied, can exercise the option to change providers. An insured can register complaints with CDI, but CDI does not have the statutory authority to become directly involved in resolving consumer complaints about medical services or providers. CDI does enforce laws and regulations related to claims, underwriting, and rating practices. According to CDI, by enforcing

these requirements, the department is able to ensure that consumers are paid for the medical services necessary for their treatment.

In contrast, a person covered by an HMO contract has less flexibility in changing providers, is subject to greater plan involvement in the delivery of services, but can seek assistance from the plan in resolving issues relating to a provider or the quality of care. Consumers are required to use the health plan grievance system but can go to DMHC if the plan does not resolve the issue or act in a timely manner.

Products and Companies Are Different

Companies operating health care service plans, as a general rule, have a business focus on health coverage. However, for many companies offering disability insurance, health is just one small portion of their overall business, which typically also includes life insurance and may include multiple other forms of individual and corporate insurance. Large indemnity insurers with multiple lines of insurance have a different corporate culture that reflects the business of insurance, not health care.

Traditional indemnity health insurance regulated under CDI represents a decreasing portion of the overall health coverage market, with key informants estimating that indemnity represents only 5 to 10 percent of the total health coverage market.³²

Comparing Statutes and Regulations

This section includes an overview of the statutory and regulatory differences between disability insurers and health care service plans. Table 1 summarizes the differences, which are discussed

more fully below. Appendix B contains a detailed statutory comparison.

Initial Licensure

Health care service plans apply for and obtain a Knox-Keene license prior to operating in California. Disability insurers obtain a certificate of authority from the Insurance Commissioner for the specific line(s) of business they intend to offer prior to conducting insurance business in the state.

In applying for licensure, a health care service plan must submit for review and approval all of the types of plan contracts (policies) it will offer, standard provider contracts and payment methods, proposed advertising and marketing materials, audited financial statements, administrative structure, projections of financial viability, actuarial analyses, and specific proposed service areas.

The CDI certificate of authority review process involves a detailed operational and financial review. The application process includes review of the company's financial stability, available capital and assets, competency and integrity of ownership and management, claims payment procedures, actuarial certifications, and financial projections. Insurers submit their policy forms for review and are subject to specific "market conduct" (claims handling) requirements and procedures often referenced as the Fair Claims Practices rules.

While both health care service plans and insurers are required to demonstrate administrative capacity and financial solvency, a health care service plan must also provide a detailed outline of the proposed delivery system for in-network care and demonstrate network adequacy. There is generally little or no specific review of the adequacy of networks for insurers, regardless of the type of plan or product they are offering.

Table 1: Comparing the Functions of CDI and DMHC

Area of Oversight	CDI Requirements	DMHC Requirements
Primary Focus	Ability to pay claims.	Ability to deliver care.
Benefits	Specific mandated benefits but no minimum benefit package.	Specific mandated benefits plus “basic health care services.”
Quality	No oversight of medical care. Disclosure and standards for utilization review and utilization management.	On-site medical surveys, including on-site provider reviews, and mandatory internal quality assurance system. Disclosure and standards for utilization review and utilization management.
Provider Accessibility	No accessibility standards enforced.	Providers must be “readily available and accessible,” subject to DMHC review.
Provider Payments	Provider payments limited to fee-for-service and negotiated discount rates.	In addition to fee-for-service and discount rate options, plans may share risk with providers (e.g., capitation).
Consumer Protection	Same as those applicable to all lines of insurance: consumer disclosure, Fair Claims Practices Act (market conduct). Complaints can be filed with CDI. Independent Medical Review for denials of care.	Consumer disclosure requirements, complaints handled through internal plan grievance system with DMHC intervention if necessary. Independent Medical Review for denials of care.
Financial Reserves	Reserves based on the greater of: \$5 million statutory minimum capital or 200 percent of the Risk-Based Capital standards developed by the National Association of Insurance Commissioners. Generally higher than reserve requirements for Knox-Keene plans. Insurers required to join Guarantee Association. Association will assess member insurers to pay the claims of an insolvent insurer.	Reserves (tangible net equity) calculated based on the greatest of: 2 percent of premium revenues; minimum of \$1 million; or specified percent of expenditures. DMHC can require other plans in an area to assume care of an insolvent plan’s enrollees.
Fee and Tax Structures	Licensing fees and other filing fees. Gross premiums tax (in lieu of other corporate taxes): 2.35 percent of total premiums annually, regardless of profit.	Annual “per enrollee” assessments. No gross premiums tax. Subject to applicable corporate taxes.

Benefits

All health care service plans, including PPOs regulated by DMHC, must offer basic health care services: physician services, inpatient and outpatient hospital services, diagnostic lab and radiology, therapeutic radiology, home health, preventive health services, emergency services, and hospice care. In contrast to Knox-Keene requirements for health care service plans, there are no minimum or basic benefits required in the Insurance Code. However, both the Insurance Code and Knox-Keene contain numerous mandatory benefit or coverage provisions requiring that carriers offer or provide specific services and/or specific providers. Examples are listed in Appendix C.

Knox-Keene basic health care services can be subject to copayments and deductibles, but DMHC has regulatory authority to review cost-sharing arrangements and other limitations to ensure that the contract requirements are “fair, reasonable, and consistent with the objectives of the chapter” and are not held to be objectionable by the director.³³

By contrast, disability insurers have enormous flexibility to develop alternative benefit packages, with variations on covered services, copayments and deductibles, and annual and lifetime maximums. Policies can be written to cover limited medical expenses, exclude specific services not mandated in statute, cover primarily catastrophic expenses, or include significant consumer cost-sharing requirements not subject to regulatory oversight. In addition, disability insurers are able to develop specialized and supplemental policies such as disease-specific coverage, short-term health insurance, and coverage for copayments and deductibles from another policy. These types of supplemental policies would not meet Knox-Keene basic benefit requirements.³⁴

Key informants reported that the flexibility in benefit design under the Insurance Code is one of the primary reasons that many Knox-Keene licensed plans also maintain a disability insurance certificate of authority. Reportedly, the insurance certificate allows them to respond to purchaser and marketplace demands for different products, such as low-cost high-deductible plans, greater choice of out-of-network providers, or lower-cost benefit plans that do not include all of the basic benefits under Knox-Keene and are not subject to other Knox-Keene Act provisions.

For example, instead of offering their point-of-service products³⁵ entirely under their Knox-Keene license, some Knox-Keene HMOs offer the equivalent of a point-of-service through a combination of an HMO contract for in-network services and a CDI indemnity “wraparound” for out-of-network services.³⁶

Quality Assurance and Quality Monitoring

Health care service plans are required to have internal quality assurance and utilization review programs, directed by providers, to document and improve the quality of care. The regulations require a written plan, regular meetings of the quality assurance committee(s), and supervision by a plan medical director. DMHC is required to conduct on-site medical surveys of all licensed health plans, including review of patient medical records, at least every three years.

Insurers are not subject to comparable quality assurance requirements. CDI does conduct on-site review and regulatory examination of claims, financial records, and rating and underwriting practices of all licensed insurers.

Utilization Review and Utilization Management

Both disability insurers and health care service plans are subject to similar statutory requirements applicable to their utilization review process.

Carriers must have written policies, develop criteria using health professionals consistent with clinical principles, make decisions within specified time-frames, and disclose the criteria being used. The requirements apply to approvals, modifications, delays, or denials of services prior to, after, or at the time of services being rendered.

Health care service plans must designate or employ a medical director to set the policies and oversee the decisions, and their programs and policies are subject to review during the on-site medical survey. Disability insurers must have a medical director only if the number of California insureds is 50 percent or more of their total national health care business. Violations by either carrier type are subject to fines and penalties.

Provider Accessibility

Health care service plans must ensure that services are “readily available and accessible to enrollees.” Except for contracts specifically allowing for some out-of-network providers (PPOs, EPOs, and POS), all participating providers must be under contract or employed by the health plan. Regulatory guidelines include specific physician-enrollee ratios and distance standards for the location of providers to enrollee residences and workplaces.

As a general rule, disability insurers are not subject to similar accessibility standards. There are state insurance regulations applicable to exclusive provider organizations (EPOs)—where payment is limited to providers who have agreed to accept discounted rates—that require consumer disclosure of available providers and contain availability and accessibility standards nearly identical to

Knox-Keene. According to CDI, the regulations do not require that EPOs submit provider contracts or adequacy and accessibility information. According to CDI, the department will inquire into adequacy of provider networks and will “ensure that the policy is not inconsistent with standards of good health care.” CDI is not required to and does not track the number of EPO policies but concurs with key informants that there are very few currently in the marketplace.

Provider Payments

Disability insurers are limited to paying fee-for-service claims and to negotiating discounted rates of payment as in a PPO arrangement. Health care service plans may pay fee-for-service or discounted fee-for-service, and in addition, may execute provider contracts that pay providers either a capitation payment—a monthly flat rate per enrollee—or some other arrangement where the provider shares in the risks related to costs and utilization of health services.

While the rates paid to providers contracting with Knox-Keene plans are not subject to DMHC review and approval, health plans must submit the payment method. In the case of capitation arrangements, plans retain legal responsibility for ensuring that the provider has the administrative and financial capacity to handle the contract. In addition, the plans must have “a mechanism to detect and correct under-service” by providers assuming financial risk in treating the plan’s members. In the wake of several highly visible medical group bankruptcies, DMHC is currently implementing new provider financial reporting requirements.

Consumer Protection

Health care service plans are required to maintain an internal plan grievance system to respond to consumer complaints. DMHC established the

“HMO Help Center” (continuing the toll-free consumer complaint hotline originally established at the Department of Corporations in 1995) and expanded the hotline hours to 24 hours per day, 7 days per week. After normal business hours, an external contractor trained by DMHC responds to hotline calls. The contractor answers basic questions and is able to send out information, including complaint forms. Help center staff have the ability to page DMHC staff nurses or consulting nurses or physicians, 24 hours per day, for assistance with medical care issues.

There is no similar requirement that insurers maintain an internal grievance or complaint system. CDI also operates a consumer hotline that predates the DOC hotline (for all lines of insurance, not just health insurance), which is available 10 hours per day, 8:00 a.m. to 6:00 p.m. CDI has voice mail and email systems allowing consumers to register complaints after hours. CDI staff then respond to those complaints during regular business hours.

Both departments are legislatively mandated to develop an independent medical review (IMR) system where doctors and other professionals outside of the health plan or insurer review coverage and medical care decisions made by the carriers. DMHC contracted with the Center for Dispute Resolution to conduct the reviews and CDI agreed to use the same organization for consistency and clarity across programs.

Financial Reserve Requirements

Both health care service plans and disability insurers are subjected to financial reporting requirements, review, and monitoring of their financial capabilities, including on-site reviews, and must meet specific financial reserve requirements.

Disability insurers are required to maintain reserve levels at the greater of either: (1) a minimum of \$5 million or (2) 200 percent of the Risk-Based Capital standards developed by the National Association of Insurance Commissioners.

Insurance industry representatives report that reserves under this formula are 50 to 100 percent higher than the reserves required of Knox-Keene licensees.

In addition, the Insurance Code requires all life and disability insurers to belong to the California Life and Health Insurance Guarantee Association. The Guarantee Association is structured so that all insurers share the risk in the event of a carrier’s financial insolvency. Assessments on all carriers then cover the losses (expenses) of people insured by the insolvent carrier. This system is designed to protect the ability to pay claims.

Under Knox-Keene, health plans are required to maintain financial reserve levels, referred to as tangible net equity (TNE), at the greatest of: (1) a minimum of \$1 million; (2) 2 percent of premium revenues; or (3) specified percentages of expenditures. In addition, PPO and point-of-service plans are subject to higher TNE requirements in light of their increased liability from out-of-network services.

In the event of an insolvent health plan, DMHC has the authority to proportionately assign the members of the insolvent plan to other Knox-Keene plans in the service area. The neighboring plans are required to assume responsibility for delivering health care to the assigned members. Under Knox-Keene contracts, providers are not statutorily protected from the risk of lost payments in the event of plan insolvency.

Fee and Tax Structures

Health care service plans pay an annual assessment, as specified in statute. The amount of the assessment is based on the size of the health plan and the specific number of health plan members (enrollees). Health plan assessments support the regulatory and enforcement program at DMHC. By contrast, insurance fees are assessed for each type of filing or regulatory request and are not in any way based on the number of people an insurer covers. CDI fees support CDI operations. CDI does not track or require insurers to report the number of covered lives or insureds.

Knox-Keene plans are subject to all taxes applicable to the particular corporate and tax status of the plan. Insurers pay a gross premiums tax based on the total dollar amount of premiums sold, regardless of profit, in lieu of other state or local taxes.

It is difficult to compare and contrast the very different types of assessments and reserve formulas applicable to each carrier type since they are based on distinct formulas and requirements. The relative burden and protection afforded by the reserve requirements, fees, and tax structures between health care service plans and disability insurers may warrant further review.

4

Understanding the Products in the Health Coverage Marketplace

Much of the confusion about the two different departments and their jurisdictions—and the driver behind recent interest in possibly combining or overhauling jurisdictions and regulatory responsibilities in some way—results from the overlap and similarities between the products under each department’s jurisdiction.

Specifically, as indemnity insurers have developed networks of providers at discounted rates, and as health care service plans have developed some products where consumers can go out-of-network, it increasingly appears as though both departments are regulating the same types of carriers and products. One way to begin to organize and analyze the products in today’s market is to understand the prevalence of similar products and the regulatory jurisdiction applicable to these products.

Identifying Products and Regulators

HMOs under Knox-Keene

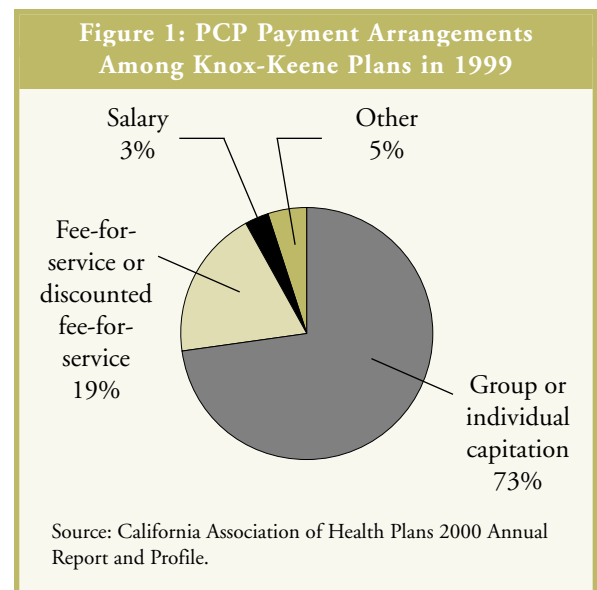
As stated earlier, HMOs under Knox-Keene provide all services through plan operated or contracted providers (except for point-of-service products as discussed below).

There are three models of HMOs: group model, staff model, and independent practice association (IPA) or “network” model plans. In California, Kaiser Permanente is the only group model plan, where one group provides, on an exclusive basis, virtually all of the medical care for plan members in an area. Staff model plans, where the plan employs the providers, are increasingly rare and primarily limited to relatively small, nonprofit

community clinic-based or county owned or operated plans. Most of the HMOs in California are IPA/network model plans, or what the California Association of Health Plans calls “mixed model” plans that provide coverage through a combination of large multi-specialty medical groups and more loosely organized IPAs—private physicians in their own offices who belong to an association for contracting purposes.

Unlike insurers, HMOs under Knox-Keene are permitted to execute provider contracts that shift some of the risk to the providers while the health plan retains legal responsibility to ensure that the providers have the ability to manage and assume the risk.

According to the California Association of Health Plans (CAHP), in 1999 some 73 percent of Knox-Keene plans paid primary care providers by group or individual capitation, while 19 percent paid



fee-for-service or discounted fee-for-service, 3 percent salary, and 5 percent other.³⁷ Among specialists, 40 percent are paid by capitation and 47 percent by fee-for-service. According to key informants, in the past two years there has been a gradual erosion of plans paying providers by way of capitation arrangements.

PPOs and EPOs under Knox-Keene

The PPO model of health coverage, where the carrier offers a list of providers who have agreed to accept reduced payment, and the EPO model, where payment is limited to providers on the list, are generally not allowable under or subject to the Knox-Keene Act. However, as discussed, two significant exceptions continue to complicate analysis of the regulatory framework for health coverage—Blue Shield and Blue Cross.

According to the California Association of Health Plans, in 2000, approximately 4.6 million Californians, or 20 percent of those enrolled in Knox-Keene plans, were in PPOs, 73 percent in HMOs, and approximately 5 percent in point-of-service plans.³⁸

Both Blue Cross and Blue Shield plans have a specific statutory or historical exemption from the requirement that all services be delivered by participating providers. Both companies are otherwise subject to the provisions of Knox-Keene, including the requirement to provide all basic health care services, to establish internal quality monitoring systems, to meet availability and accessibility standards for in-network providers, and to submit plan contracts, advertising, and marketing materials for prior approval to DMHC.

Historically, DOC, and now DMHC, have allowed for considerable flexibility in PPO design—copayments, deductibles, annual

maximums—so that the Blue Cross and Blue Shield PPO products more closely resemble other PPO products in the marketplace. In addition, out-of-network providers and services, with no direct affiliation to the plans, are not subject to the same quality assurance requirements as in-network providers. The statutory authorization applicable to the Blue Cross and Blue Shield plans allows them to have some portion of their business that “substantially indemnifies subscribers” and both companies also offer limited EPO contracts under the Knox-Keene license.

Point-of-Service Contracts under Knox-Keene

In 1992, legislation authorized Knox-Keene health care service plans to begin offering plan contracts that include both an HMO delivery system and the option for enrollees to choose providers outside of the plan’s network, for some services. POS contracts are subject to all Knox-Keene standards, except for the providers and services delivered out-of-network. There are statutory limits on the copayments and deductibles that can be charged for out-of-network services, restrictions on the amount of out-of-network care that a health plan can experience, and increased financial reserve requirements. As of 2001, DMHC reports that eight Knox-Keene plans offer point-of-service contracts under the POS provisions of Knox-Keene.

Based in part on the statutory constraints applicable to Knox-Keene POS contracts, several Knox-Keene plans offer purchasers a POS equivalent that is regulated under both departments—the previously mentioned HMO contract for in-network care, with a disability insurance “wrap-around” for out-of-network care.

PPOs under the Insurance Code

The 1982 selective contracting legislation (authorizing disability insurers, for the first time, to negotiate with providers for “alternative rates of payment”) was a significant departure for indemnity health coverage because the Insurance Code had since 1937 protected the right of an insured to choose any licensed health care provider.

This “alternative payment” language is the basis for development of what became known as insurance PPOs.³⁹ Key informants in this project consistently reported that virtually all of the current indemnity policies for full coverage health insurance in California include a PPO network through which consumers can access services at reduced cost.

Key informants indicated that many insurers “lease or rent” PPO networks from corporations that are in the business of organizing the networks, negotiating rates, and executing provider contracts. These companies also make their PPO networks available to large, self-insured employers. The contracted PPO may also perform other functions such as prior authorization or utilization review for employers and insurers. The PPO networks and companies themselves are not subject to any licensing or regulation under California law. PPO network companies are regulated in some other states, complicating state-to-state comparisons of how “PPO products” are regulated.

EPOs under the Insurance Code

The Insurance Code also allows insurers to limit payment to providers agreeing to alternative rates. Exclusive provider organizations require individuals to receive all services from providers who agree to accept reduced payments from the insurer.

These products are subject to increased consumer disclosure regulations monitored through CDI

scrutiny of policy forms. CDI does not track the number of EPO policies it approves, but CDI agrees with key informants that there are very few EPO plans being offered by disability insurers.

Traditional Indemnity Insurance under the Insurance Code

Insurance companies that offer health insurance under the Insurance Code may offer an open panel product allowing insureds to seek services from licensed providers with no network limitation or discounted network offering. These products are subject to statute and regulations applicable to disability insurers generally.

These “traditional” indemnity policies typically have annual deductibles and pay for services when a bill is received. The policies generally cover physician and hospital services and medical tests. They may cover prescription drugs but are typically limited in coverage of preventive care services. The insurer generally pays a specified percentage of the “usual and customary fees” (often 80 percent) while the insured pays the remaining amount, known as “coinsurance.”

Key informants consistently reported that there are very few “pure” indemnity products remaining in today’s market. CDI does not track information on the extent of availability of any product type under its jurisdiction, including traditional indemnity coverage.

What Is a Health Insurance Product?

Individuals can obtain protection from the costs of health care services through multiple product strategies, not just traditional health insurance products. The traditional health insurance

products discussed in this report, regulated by DMHC or CDI, constitute a subset of the different strategies available. Strategies include:

Full coverage health insurance, which generally covers hospital, medical, and surgical services and may include coverage for ancillary services. Knox-Keene plans, both HMOs and PPOs, will cover at least the basic health care services and distinguish products primarily by the different levels of patient cost sharing. Among disability insurers, the types of services covered, including the extent to which they cover preventive care, and variation in patient cost-sharing levels, may distinguish products.

Catastrophic or high-deductible health insurance, which covers health care costs above a relatively high fixed-dollar amount and may also include policies that cover only high-cost items such as major medical or hospitalization. In today's market these policies may be sold in combination with a Medical Savings Account (MSA), a savings account dedicated for health care expenses and organized under federal tax laws establishing MSAs as a tax-deductible option. Both Knox-Keene plans (primarily the PPOs) and disability insurers have developed these types of products.

Cash benefit plan, which provides lump sum or periodic cash payments related to specific events such as hospitalization, accident, defined disability, catastrophic illness, or illness out of the country. These plans do not reimburse for health services but pay cash payments when the insured event occurs. The payments can be used to pay for health care or for other expenses. These products

are exclusively offered by disability insurers and are not permissible under Knox-Keene.

Elements of a Health Insurance Product

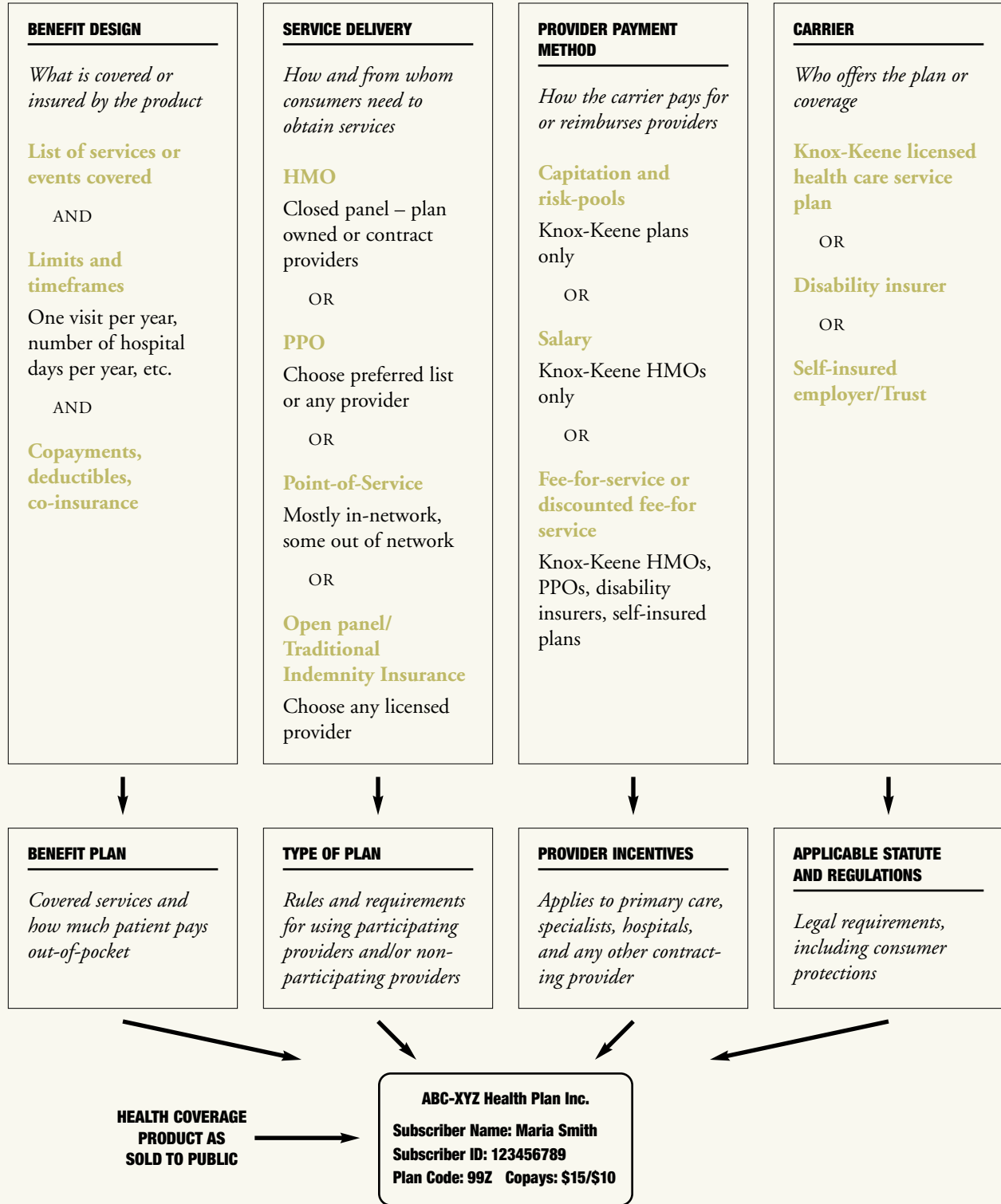
Each full coverage health insurance product can be viewed as a combination of four key elements: (1) the benefit design—what is covered or insured; (2) the service delivery approach, if any—how and from whom the consumer must obtain services to receive benefits under the contract; (3) the method of provider payment—how the carrier pays providers; and (4) the specific company or carrier type offering the coverage. Benefit design, which contains several elements that are not mutually exclusive, is the area of most variability product to product. Figure 2 provides an illustration of health coverage product components.

What has made the dialogue about health coverage products and companies so complicated, and often confusing, is that in the marketplace, products are typically referred to more by the service delivery type—HMO, PPO, and POS—than by any other element of the product design. And yet there can be substantial variation among these products and, as the comparison of the two licensing schemes reveals, very different regulatory requirements depending on the carrier offering the product.

This section shows that breaking down the components of any product helps to identify the regulatory framework and specific requirements that govern that product. Appendix D contains an overview of the different products licensed and regulated in California, which serves to illustrate the complexities inherent in regulation.

Figure 2: Elements of a Health Insurance Product

These four elements combine to form a health coverage product as sold to purchasers. Consumers may not always be familiar with or aware of all the elements that make up a health coverage product.



Conclusion

The intent of this report has been to provide the reader with a contextual framework through which to examine the difficult issue of whether the regulation of health coverage in California should be altered or consolidated.

What this report reveals is that public policy choices and shifting political inclinations over more than a half-century have resulted in two very different statutory and regulatory frameworks. The existing differences between the two departments, and their respective regulatory personalities, are firmly rooted in both history and statute. These choices have also had profound effects on the health coverage market in California.

The report also suggests that as long as there are two different departments regulating health coverage, and two distinct statutory frameworks, there will be important differences in how carriers are regulated, distinct departmental cultures, and disparate views of their respective roles and responsibilities toward consumers, providers, and carriers.

When properly channeled, and when there is effective collaboration and communication between departments, the differences can serve as learning tools, presenting an opportunity to build on success. Many key informants interviewed reported that the information exchange resulting from the AB 78 review of the respective departments and frameworks has resulted in many such desirable effects. At the same time, it is also possible, under dual regulation, for the two departments to become competitors vying for recognition and acknowledgement of the soundness of their regulatory performance.

Dual regulation also invites carriers to design products to fit within the regulatory structure most conducive to their business and marketplace needs. Allowing carriers discretion as they develop and license products may have the desirable consequence of greater flexibility in product design but also the potentially undesirable consequence of avoidance of some types of oversight.

Finally, among consumers, stakeholders, and policymakers, dual regulation means that there will always be the potential for confusion, misunderstanding, and misinformation.

This project has led the authors to conclude that any policy change in this area necessitates clearly articulated goals and objectives along with open discussion of both intended and unintended consequences. This means carefully analyzing how statute, regulation, and department styles and strategies may combine such that the actual impact of various policy choices may ultimately differ from the original intent.

The following questions offer just two examples of possible proposed changes and consequences:

- If all health coverage were moved to DMHC and made subject to Knox-Keene basic benefits requirements, would that reduce or eliminate affordable options for some consumers?
- Would consolidating consumer complaint functions result in lower levels of expertise or competence by complaint handlers who might not understand specific statutory and real world differences among carriers and licensing requirements? How could that be avoided or mitigated?

A deliberate process has been put in place to study the ramifications of change, giving policymakers and stakeholders the opportunity to carefully investigate all options before making changes to the current statutory and regulatory environment. The complexities of the regulatory environment as outlined in this report warrant that level of thoughtful scrutiny.

Simpler and more understandable regulatory requirements, combined with consistent enforcement, increase the likelihood that the system will function to bring consumers affordable, high-quality care. Given the high number of uninsured Californians, and increasing consumer anxiety over health care quality, high-quality care at affordable prices should be the ultimate objective of policy change.

Appendices

Appendix A: History of the Knox-Keene Health Care Service Plan Act of 1975

- 1929** Ross-Loos Clinic opens in Los Angeles. First prepaid contract with a group practice of physicians provides medical care for workers in the city's water department.
- 1937** Chapter 11A of the Insurance Code enacted, authorizing first Blue Cross hospital insurance in California as a nonprofit hospital service plan subject to the Insurance Code. (Chapter 881, Statutes of 1937)
- 1938** California Medical Association votes to create California Physicians Service (CPS) (later Blue Shield). CPS provides coverage for medical and surgical services to employee groups who receive care from "professional [physician] members" of CPS "on a periodic budgeting basis." CPS does not seek state licensure.
- 1941** Blue Shield registers as a health service plan under Civil Code Section 593a (legislation sponsored by Blue Shield), requiring a service plan to obtain a certificate from the Board of Medical Examiners. General supervision placed with the Attorney General but funds are not budgeted for implementation.
- 1945** Permanente Health Plan (later Kaiser Permanente) opens public enrollment in the nonprofit prepaid health plan originally developed for employees of Kaiser Industries. Kaiser Permanente is a group practice model HMO where a Permanente Medical Group provides services on an exclusive basis to Kaiser enrollees in an area. The health plan also has an exclusive contract with Kaiser Foundation Hospitals for hospital services.
- 1946** *CPS v. Garrison*. California Supreme Court rules that CPS (Blue Shield) (and other prepaid health plans) is not in the business of insurance and is not subject to the jurisdiction of the Insurance Commissioner.
- 1954** The local medical society establishes the Foundation for Medical Care in the Stockton/San Joaquin Valley area. FMC is an early prototype of the IPA-model HMO, providing health care services through non-exclusive contracts with community physicians, who are paid discounted fees for the services provided.
- 1959** Congress passes the Federal Employees' Health Benefits Act, which establishes health coverage as a benefit for federal employees.
- 1961** The Family Health Plan (later FHP, Inc.) opens in Southern California as a nonprofit staff-model HMO. Salaried physicians provide health services to enrolled members. FHP owns and operates its own hospitals, pharmacies, and laboratory facilities.
- 1965** Knox-Mills Health Plan Act requires health care service plans to register with the California Attorney General. (Chapter 880, Statutes of 1965) Ultimately more than one hundred plans registered, including specialized plans such as dental and mental health plans, including Kaiser, Ross-Loos, Blue Shield, and FHP.
- Kaiser Health Plan enrollment reaches 1 million members.

Appendix A: History of the Knox-Keene Health Care Service Plan Act of 1975 (continued)

- 1971** AB 949, put forward by then Governor Ronald Reagan, enacts significant Medi-Cal reforms, including authorizing “prepaid health plans” to serve Medi-Cal beneficiaries, on a capitated basis, under contract with the Department of Health Services (DHS).
- 1972** Innovative Health Systems of Los Angeles signs first non-pilot PHP contract. By December 1972, some 22 PHP contracts with 132,668 Medi-Cal enrollees are in effect, mostly in Los Angeles County.
- Within months, the public press, most notably the *Los Angeles Times*, reports serious PHP abuses. The *Times* reports enrollment fraud and abuse, substandard care, and lack of physicians available during business hours.
- PHP enrollers indicted in Los Angeles for forging the names of Medi-Cal recipients on PHP enrollment forms. Los Angeles District Attorney initiates criminal investigation into Los Angeles-based PHPs.
- Waxman-Duffy Prepaid Health Plan Act sets standards for Medi-Cal PHPs, under the oversight of DHS, including minimum patient-physician ratios, conflict of interest limitations, and onsite reviews. (AB 1496, Chapter 1366, Statutes of 1972)
- 1973** California Auditor General’s follow-up report documents serious failures in oversight by DHS and violations of law by some participating PHPs.
- Office of the Legislative Analyst issues scathing report on the administration of the PHP program by DHS. Report details financial schemes where “nonprofit” health plans channel Medi-Cal payments into for-profit subsidiary provider corporations.
- Congress passes the Federal Health Maintenance Organization Act of 1973. (42 U.S.C. 300 et seq.) The HMO Act establishes comprehensive benefits, community rating requirements, administrative procedures, financial reserves, annual open enrollments, prohibitions on pre-existing condition limitations, and other requirements, and provides federal grants for start-up of nonprofit HMOs seeking federal qualification. The phrase “health maintenance organization” is coined for the first time. The Act also requires employers of more than 25 workers who are already providing health benefits to offer as one choice an available federally qualified HMO (later repealed).
- Assembly Health Committee holds a series of investigatory hearings on PHP abuses. Topics include enrollment, marketing procedures, and quality of care.
- Chapter 11A of the Insurance Code (nonprofit hospital service plans) is amended to allow for development and regulation of nonprofit HMOs, and their licensure as nonprofit hospital service plans. Health Net and Take Care are licensed as nonprofit hospital service plan HMOs, originally as subsidiaries of Blue Cross.
- 1974** Third Auditor General Report reveals that among 15 PHPs investigated (14 in Los Angeles), only 48 percent of funds paid to the plans over a two-year period went for services to Medi-Cal recipients. The remaining funds went to administrative costs and profits to contractors and subcontractors.
- California Attorney General Younger repudiates Knox-Mills, refuses to administer the Act, and urges the Legislature to enact tougher regulation of health plans.

Appendix A: History of the Knox-Keene Health Care Service Plan Act of 1975 (continued)

- 1974** Congress enacts the Employee Retirement Income Security Act of 1974 (ERISA). ERISA supersedes or preempts all state laws related to employee health benefits provided by self-insured employers.
- 1975** U.S. Senator Henry Jackson convenes congressional oversight hearings on the California PHP program. *Hearings on Prepaid Health Plans before the Permanent Subcommittee on Investigations of the Senate Committee on Government Operations, 94th Congress.*
- Knox-Keene Health Care Service Plan Act of 1975 transfers regulation of health care service plans from the Attorney General to the Commissioner of Corporations. (Assembly Bill 138, Chapter 941, Statutes of 1975) Enacts standards related to basic health care services, administrative and financial systems, marketing and advertising, forms for plan contracts issued, etc. The bill requires the transfer of Blue Shield from Knox-Mills to Knox-Keene licensure, giving them three years to reduce (but not completely eliminate) their indemnity model business.
- 1979** Congress amends Federal HMO Act to permit for-profit plans to seek federal qualification.
- 1982** California Legislature passes selective contracting for disability insurers. Insurers authorized to negotiate and enter into contracts with providers at alternative rates of payment and permitted to limit claims payment to services received from providers charging alternative rates. (AB 3480, Ch. 329 of 1982) Paves the way for PPO products to be offered by carriers licensed as disability carriers under Department of Insurance.
- 1983** Legislation transfers from the Attorney General to the Department of Corporations authority for administering conversions of health care service plans. Federal HMO Act start-up grants and loans for nonprofit HMOs discontinued.
- 1984** California Legislature adopts a renewed emphasis on PHP contracts in the Medi-Cal program but continues to require Knox-Keene licensure or licensure as a nonprofit hospital service plan as a pre-condition for a PHP contract.
- 1990** Legislation establishes the Health Insurance Guarantee Fund for disability insurers and requires Blue Cross of California to seek Knox-Keene licensure within one year. Includes statutory authority for BCC to continue some portion of business as indemnity model coverage. (SB 785, Chapter 1043, Statutes of 1990)
- 1992** Small employer group access legislation reforms the market for small employer health coverage. Similar provisions apply to Knox-Keene and disability insurers. (AB 1672, Chapter 1128, Statutes of 1992)
- Legislature eliminates door-to-door marketing for Medi-Cal Prepaid Health Plans, effective January 1994. (AB 3463, Ch. 1056 of 1992)
- Legislature expands DHS authority to enter into contracts for Medi-Cal managed care resulting in implementation of the Medi-Cal Two-Plan Model. Limits PHP contracts to Knox-Keene licensees, with certain limited exceptions. (SB 485, Ch. 722 of 1992)

Appendix A: History of the Knox-Keene Health Care Service Plan Act of 1975 (continued)

- 1993** Legislature authorizes Knox-Keene plans to develop point-of-service plan contracts. SB 1221, Ch. 987 of 1993, allows plans to offer contracts where subscribers can go outside of the plan network for specified services, while incurring higher out-of-pocket costs.
- Blue Cross of California licenses four health care service plans, including dental and pharmacy plans, and proposes a controversial corporate restructuring plan.
- 1995** Consumer hotline enacted. Legislation requires DOC to establish a toll-free number to receive consumer complaints and inquiries. (SB 689, Ch.789 of 1995)
- Blue Cross of California reaches agreement with DOC and the Legislature to dedicate substantial assets to charity and move forward as a for-profit health care service plan.
- 1996** Legislature repeals the nonprofit hospital service plan law since there are no remaining licensees. (SB 1866, Ch. 484 of 1996)
- Legislation requires DOC to establish HMO Ombudsperson to resolve and respond to consumer complaints and problems with their health plan. (SB 1936, Ch. 1095 of 1996)
- Legislature creates the Managed Health Care Improvement Task Force to report on the status of health care coverage and the extent to which health care service plans are meeting the goals of cost containment, quality, and access, and to make recommendations on the appropriate role of government in oversight and regulation of managed care. (AB 2343, Ch. 815 of 1996)
- 1998** Managed Care Improvement Task Force releases final report. Recommends the creation of a new state department for regulation of health care service plans and phasing in regulation of medical groups and other provider entities that bear substantial risk for health care services.
- 1999** California Legislature passes Patient Bill of Rights. The 21-bill package sponsored and supported by consumer advocacy groups becomes law. AB 78 creates the new Department of Managed Care and transfers authority for health care service plans to the new agency.
- 2000** New Department of Managed Health Care opens for business July 1, 2000. The DMHC constitutes a new Advisory Committee on Managed Care, a Clinical Advisory Panel, and a Financial Solvency Standards Board, consistent with requirements of AB 78 of 1999.
- 2001** DMHC contracts with independent consultant for a feasibility study regarding transferring the regulation of health insurance from the California Department of Insurance (CDI) to the new DMHC. Report due to the Legislature December 2001.

**Appendix B: Comparison of Statutory and Regulatory Requirements
Department of Managed Health Care and California Department of Insurance**

Activity or Function	Department of Managed Health Care	Health and Safety Code	California Department of Insurance	Insurance Code
JURISDICTION	Licenses and regulates all “health care service plans.” Regulates all HMOs and two companies that offer PPO plans under statutory and/or regulatory waivers.	Sec. 1345(f): Health care service plans “undertake to arrange for the provision of health care services, ... or to reimburse for any part of the cost of services, in return for a prepaid or periodic charge, paid for by or on behalf of the subscribers or enrollees.”	Regulates health insurers as life, disability and property and casualty insurers. Carriers commonly referred to as “indemnity” health insurers or disability insurers.	Sec 106: Defines disability insurance as “insurance appertaining to an injury, disablement or death resulting from accidents... or sickness.”
Exemptions	Insurers, unless they directly provide services through contracted or owned providers and /or facilities. Life care facilities for the elderly Long-term care demonstration programs Public ambulance services Joint labor management trusts	Sec. 1343(e) Includes other very narrow and specific exemptions. Sec. 1343(e) Sec. 1343.1 Sec. 1349.1, 1349.3 Sec. 1349.2	Knox Keene plans exempt from regulation under the Insurance Code Section 791.02(k). Presumption of Insurance Department jurisdiction unless entity is licensed by another agency.	Sec. 791.02(k) Sec. 740(a) Entities providing coverage for medical, surgical, hospital, chiropractic, physical therapy, mental health, dental, speech pathology, audiology, optometric . . .
Anti-trust	Limited state anti-trust exemption related to provider negotiations. Legislative intent supporting the formation of groups or combinations of providers and purchasing groups.	Sec. 1342.6	Insurers have similar limited exemption from anti-trust. Similar legislative intent. Permitted to negotiate for “alternative rates of payment.”	Sec. 10133.6
Specialized Plans	Licenses and regulates specialized health care service plans, that is, contracts for health services in a single specialized area such as dental, mental health, or vision.	Sec. 1345(o)	Carriers covering the same types of services are subject to Insurance regulation but there is no special category of insurer.	Sec. 740(a)
Other Entities	Administers other very narrow and/or obsolete exemptions from licensure in statute and regulation.	1345, 1349.1 CCR § 1300.43-1300.43.15	Multiple employer welfare arrangements (MEWAs) must obtain a certificate of authority.	Sec. 742.20-742.44

**Appendix B: Comparison of Statutory and Regulatory Requirements
Department of Managed Health Care and California Department of Insurance (continued)**

Activity or Function	Department of Managed Health Care	Health and Safety Code	California Department of Insurance	Insurance Code
BENEFIT DESIGN Basic Benefits	Basic health care services include physician, hospital inpatient and outpatient, diagnostic, home health, preventive, emergency, and hospice.	Sec. 1345(b)	No similar provision.	None
Mandated Benefits	Mandated benefits specified in statute.	See Appendix C.	Mandated benefits specified similar to health plans.	See Appendix C.
Copayments, Deductibles and Other Cost-sharing Components	Reviews proposed cost-sharing and may require changes in the plan contract to ensure contracts are “fair, reasonable and consistent with the objectives of the chapter.”	1367, CCR Title 28 §1300.67.4: Benefits cannot be subject to “exclusion, exception, reduction, deductible, or copayment that renders the benefit illusory.”	No authority to review or revise benefits or cost sharing in an insurance policy.	None
QUALITY ASSURANCE Internal Quality Review	Reviews internal procedures of plan to continuously review quality of medical care, performance of providers, etc.	1370	No similar requirement.	None
Medical Survey	On-site medical survey at least once every three years; results made publicly available; reviews enrollee medical records.	1380, 1380.1	No similar requirement. CDI does conduct on-site review and regulatory examination of claims, financial records, and rating and underwriting practices of all licensed insurers.	None
Utilization Management/ Utilization Review (UR/UM)	Reviews UR/UM policies and procedures related to review and approval of requests for health care services. Disclosure requirements and standards for utilization review.	1363.5, 1367.01	Required policies and procedures related to UR/UM. Similar disclosure requirements and standards for utilization review.	10133(d), 10123.135
Independent Medical Review (IMR)	External independent medical review of plan coverage decisions.	1374.30, 1370.4	Identical requirement for IMR.	10145.3

**Appendix B: Comparison of Statutory and Regulatory Requirements
Department of Managed Health Care and California Department of Insurance (continued)**

Activity or Function	Department of Managed Health Care	Health and Safety Code	California Department of Insurance	Insurance Code
Separation of Medical and Administrative	Reviews plan process to separate medical decisions from fiscal / administrative management.	1367(g)	No similar requirement.	None
ACCESSIBILITY OF SERVICES	Monitors and reviews specific guidelines for availability and accessibility of providers (i.e., 1 primary care physician for every 2,000 enrollees, provider within 30 minutes or 15 miles). Not applicable to out-of-network services of Knox-Keene PPOs.	1367(e)	Accessibility regulations for EPOs, no filings of networks required and limited oversight beyond policy disclosure. EPO products rare or non-existent.	10133.5
PROVIDER NETWORKS	Plans required to receive prior approval of networks in each geographic region. Not applicable to out-of-network services.	1351(k)	No similar requirement.	None
REGULATORY FILINGS Material Modifications	Plans must obtain prior approval for plan contracts, service areas, and other major changes.	1351, 1352, 1352.1	CDI has 30 days to disapprove policy forms, rating changes, and other required filings.	900, 10970, 717, 1011, 10290, 10270.9, 10291.5(f), 10293, 1215-1215.16.
PROVIDER RELATIONSHIPS AND ARRANGEMENTS Payment Methods	Reviews provider contracts (not rates of payment) and health plan policies and procedures for ensuring providers can assume risk of the contract. Risk contracts with providers permissible, subject to limitations.	1344, 1370, CCR Title 28 § 1300.70(b)(H) 1348.6, 1349.3, 1375.6	Disability insurers limited to negotiation for “alternative rates of payment.” At-risk provider contracts not permissible.	10133
Economic Profiling	Must make publicly available policies and procedures related to economic profiling—reviewing providers based on costs or utilization.	1367.02	Same as Knox-Keene.	10123.36

**Appendix B: Comparison of Statutory and Regulatory Requirements
Department of Managed Health Care and California Department of Insurance (continued)**

Activity or Function	Department of Managed Health Care	Health and Safety Code	California Department of Insurance	Insurance Code
Provider Dispute Resolution	Reviews plan provider dispute resolution system.	1367(h)	No similar requirement.	None
CONSUMER PROTECTIONS Internal Grievance Procedure	Reviews plan's internal grievance procedure, reviews results on appeal by enrollee, reviews consumer complaints during on-site survey.	1351(i), 1368, 1370.2, 1380(f)	No similar requirement.	None
Toll-free Consumer Hotline	Operates the HMO Help Center, 24 hours per day, 7 days per week. After-hours answering service can page DMHC health professionals.		Operates consumer complaint line for all lines of insurance weekdays 8 a.m. until 6 p.m.	
FINANCIAL SOLVENCY	Plans must meet tangible net equity requirements. Regular financial filings and on-site financial review.	1376, 1381, 1382	Carriers subject to minimum reserves and National Association of Insurance Commissioners (NAIC) risk-based capital requirements. Regular financial filings and on-site financial review.	700-700.5, 10489.1-10489.95, 730, 739-739.12
Plan for Insolvent Carriers	Director may assign enrollees of an insolvent plan to plans in the area with sufficient capacity and financial resources. Plans must provide care for transferred members.	1394.7	Carriers must belong to the Life and Health Insurance Guarantee Association, which will assess members to pay the claims of an insolvent insurer.	1067-1067.18
FEES	Annual assessment based on number of enrollees. Plans reimburse cost of licensing application.	1356	Regulatory filing fees based on type of filing. No assessment based on number of insureds.	Various

Appendix C: Sample of Benefits Mandated by Knox-Keene and Insurance Code

Benefit / service	Knox-Keene (Health and Safety Code)	Insurance Code
Alcoholism treatment	1367.2	10123.6
Breast cancer coverage	1367.6	10123.8
Cervical cancer screening tests	1367.66	10123.18
Comprehensive Preventive Services for Children	1367.3, 1367.35	10123.5– 10123.55
Diabetes equipment and supplies	1367.51	10176.61
General anesthesia and associated hospitalization for dental procedures, under specified circumstances	1367.71	10119.9
Home health care	Basic health care service – 1345 and 1374.10	10123.10
Laryngectomy, prosthetic devices	1367.61	10123.82
Infertility treatment	1374.55	10119.6
Mammography, diagnostic or screening	1367.65	10123.81
Mastectomies and lymph node dissections, covered hospital stay	1367.635	10123.86
Maternity, including 48-hour inpatient hospital stay	1367.62	10123.87
Orthotic and prosthetic devices	1367.18	10123.7
Osteoporosis diagnosis, treatment, and management	1367.67	10123.185
Phenylketonuria treatment and testing	1374.56	10123.89
Prenatal diagnosis of genetic disorders	1367.7	10123.9
Reconstructive surgery	1367.63	10123.88
Severe mental illness and serious emotional disturbance of children	1374.72	10144.5
Special footwear related to disfigurement	1367.19	10123.141

Appendix D: Distinguishing Among Product Types

Product	Delivery Model	Physician Base Compensation	Benefits	Service Structure
<p>HMO <i>IPA/Network Model</i> Regulated by DMHC</p>	<p>Care provided by contracting physicians in loose affiliation (independent practice association and/or more than one large multi-specialty medical group).</p>	<p>Physician compensation based on one of the following:</p> <ol style="list-style-type: none"> 1. Salary paid by the medical group which receives a lump sum monthly payment per enrollee (capitation); 2. Risk contract, i.e., flat monthly rate per person assigned to the doctor, paid directly by the plan or large medical group; or 3. Discounted fee-for-service. 	<p>Minimum: basic health care services under Knox-Keene. DMHC regulates and limits copayments, deductibles, and other cost sharing components so that contracts are “fair, reasonable and consistent with the objectives of the chapter.” Generally annual or lifetime maximums prohibited.</p>	<p>Care directed by “primary care physician.” Most services must be obtained with a referral or authorization by the primary care physician.</p>
<p>HMO <i>Group Model</i> Regulated by DMHC</p>	<p>Care provided by one large multi-specialty medical group under exclusive contract with the plan. Kaiser Permanente is the only group model HMO in California; it contracts with The Permanente Group in Northern California and the Southern California Permanente Medical Group.</p>	<p>Salary paid by medical group, which receives a lump sum monthly payment per enrollee (capitation).</p>	<p>Same as above.</p>	<p>Same as above.</p>
<p>HMO <i>Staff Model</i> Regulated by DMHC</p>	<p>Care provided by physicians employed by the plan in the plan’s medical offices. Increasingly rare and primarily limited to relatively small, nonprofit community clinic-based or county-owned or operated plans.</p>	<p>Physician receives salary as employee of health plan.</p>	<p>Same as above.</p>	<p>Same as above.</p>
<p>Point of Service (POS) Regulated by DMHC</p>	<p><i>In network:</i> The majority of care is provided through the HMO model of the health plan, e.g., IPA/network, group or staff model. <i>Out of network services</i> are those from providers not employed by or under contract with the health plan or services obtained without getting the required referral or authorization.</p>	<p><i>In network:</i> paid according to the HMO’s regular payment system (IPA/network, group, staff). <i>Out of network:</i> Based generally on a percentage of charges.</p>	<p>Minimum: basic health care services under Knox-Keene. Out-of-network services have higher cost sharing, i.e., copayments, deductibles, annual maximums. DMHC regulates cost-sharing components. Generally annual or lifetime maximums prohibited, except may be applied to out-of-network services.</p>	<p>Enrollee care, except for out-of-network services, is directed by the enrollee’s primary care physician. In-network services must generally be obtained with a referral or authorization by that primary care physician.</p>

Appendix D: Distinguishing Among Product Types (continued)

Product	Delivery Model	Physician Base Compensation	Benefits	Service Structure
<p>Preferred Provider Organization (PPO) Regulated by DMHC (by specific exemption, Blue Cross and Blue Shield are the only DMHC plans authorized to offer a PPO product)</p>	<p>Enrollee can receive services from any licensed provider. Selecting providers from the “preferred provider” list reduces out-of-pocket costs (copayments, deductibles, co-insurance). Refers to Knox-Keene “full service” (medical) plans.</p>	<p>Physicians paid on a fee-for-service or discounted fee-for-service basis. Risk contracts with providers prohibited under the Insurance Code.</p>	<p>Minimum: basic health care services under Knox-Keene. DMHC regulates cost sharing components. Generally annual or lifetime maximums prohibited but may be applied to out-of-network services.</p>	<p>No primary care provider assignment. Referral not needed in order to see specialist, but some services may be subject to prior authorization by the health plan.</p>
<p>Indemnity Preferred Provider Organization (PPO) Regulated by CDI</p>	<p>Same as above.</p>	<p>Same as above.</p>	<p>No statutory minimum services, except specific mandated benefits. No regulatory review or limits on out-of-pocket costs such as copayments, deductibles, or annual and lifetime maximums.</p>	<p>Same as above.</p>
<p>Traditional Indemnity Plan Regulated by CDI</p>	<p>Insured can receive services from any provider without network limitation or discounted network offering.</p>	<p>Typically a percentage of usual and customary fees.</p>	<p>No statutory or regulatory minimums or requirements, except specific mandated benefits. No regulatory review or limits on out-of-pocket costs such as copayments, deductibles, or annual and lifetime maximums.</p>	<p>Not applicable.</p>

Appendix E: Key Informant Interviews

Warren Barnes
Supervising Counsel
Department of Managed Health Care

Beth Capell
Legislative Advocate
Health Access

Joe Criscione
Senior Consultant
Blue Shield of California

Emery “Soap” Dowell
Former Member, Managed Risk Medical
Insurance Board
Former Vice President of
Government Affairs
Blue Cross of California

Anne Eowan
Vice President
Association of California Life and Health
Insurance Companies

Richard Figueroa
Deputy Secretary, Legislative Affairs
Governor’s Office

Maureen O’Haren
Legislative Advocate
Hyde, Miller, Owen & Trost
Former Executive Vice President
California Association of Health Plans

Paul Press
Former Chief Consultant
Assembly Health Committee

Shelley Rouillard
Program Director
Health Rights Hotline

Herb Schultz
Deputy Director for External Affairs
Department of Managed Health Care

Jeff Shelton
Vice President, Government Affairs
Health Net

Lyle Swallow
Chief Legal Counsel
Blue Shield of California

Steve Thompson
Vice President
California Medical Association

Barbara Yonemura
Deputy Director and Chief Counsel
Department of Health Services
Former Legal Advisor
to the Office of the Director
Department of Managed Health Care

Steve Zatkin
Senior Vice President
Government Relations
Kaiser Permanente

Walter Zelman
President and CEO
California Association of Health Plans

Staff members at the California Department of Insurance and the Department of Managed Health Care provided extensive amounts of background information and materials. CDI was invited to participate in key informant interviews, but chose instead to respond to written technical questions and to provide extensive written and oral comments from a team of staff members.

Notes

- ¹ AB 78, Chapter 525, Statutes of 1999.
- ² *The Future of California's Health Care: Solving the Safety Net Puzzle in the New California Context*. California Forum for Critical Health Issues, Institute for the Future (IFTF). (1997)
- ³ Ibid.
- ⁴ Ibid.
- ⁵ Falkson, JL. *HMOs and the Politics of Health System Reform*. American Hospital Association. Chicago, Illinois. (1980)
- ⁶ In California, separate Blue Cross plans originally emerged in the north and south, ultimately becoming one company.
- ⁷ Institute for the Future.
- ⁸ Ibid.
- ⁹ In the Prepaid Health Plan program, health plans enroll Medi-Cal beneficiaries as members and agree to provide all medically necessary Medi-Cal services for a fixed monthly fee.
- ¹⁰ Ibid.
- ¹¹ AB 1496, Chapter 1366, Statutes of 1972.
- ¹² Chavrin, DF and Treseder, A. *California's Prepaid Health Plan Program: Can the Patient Be Saved?* Hastings Law Journal. Vol. 28: 685-760. (January 1977)
- ¹³ Ibid.
- ¹⁴ Ibid.
- ¹⁵ Falkson, JL. *HMOs and the Politics of Health System Reform*. American Hospital Association. Chicago, Illinois. (1980)
- ¹⁶ Institute for the Future.
- ¹⁷ In his oral history, Howard Hassard (then chief counsel to the CMA and counsel for Blue Shield) reported that, as Blue Shield's membership grew, staff at the Department of Insurance felt increasingly uncomfortable with the lack of a regulatory forum for dealing with consumer complaints about the plan. *Fifty Years in Law and Medicine: Howard Hassard An Oral History*. (1985)
- ¹⁸ Knox-Keene applies to two types of health care service plans: full-service plans (medical) and specialized plans such as dental, vision, and mental health. Many of the plans that moved over in the early days were specialized plans. This paper focuses on full-service health care service plans.
- ¹⁹ AB 138, Chapter 941, Statutes of 1975.
- ²⁰ This report uses the term "carrier" to refer generally to entities offering health care coverage, regardless of the license or regulating agency.
- ²¹ Except for the limited exceptions of Blue Shield, and a few other specialized plans like Delta Dental, Knox-Keene otherwise requires that all providers be employed by or under contract with the health plan.
- ²² The Full Freedom of Choice Act of 1937 provided that insureds with policies under Insurance Department regulation had the right to choose their own health care provider.
- ²³ Institute for the Future.
- ²⁴ Under Knox-Keene, health plan members are referred to as enrollees or subscribers, and under the Insurance Code, as insureds.
- ²⁵ The only other nonprofit hospital service plans ever licensed were two nonprofit HMOs, Health Net and Take Care, both of which were originally

subsidiary companies of Blue Cross. The non-profit hospital service plan statute was amended to allow for their licensure and development in the 1970s. Health Net and Take Care ultimately became Knox-Keene HMOs and later converted to for-profit status.

²⁶ SB 785, Chapter 1043, Statutes of 1990.

²⁷ California Health and Safety Code §1396.5.

²⁸ *Fact Sheet: The California Department of Managed Health Care*, National Health Law Program, November 28, 2000, obtained online, August 2001 (<http://www.healthlaw.org>).

²⁹ Insurers offering health insurance are often referred to in policy discussions using the category of “disability insurer” in the Insurance Code. According to CDI, insurers of any type (life, property, or casualty) authorized to offer the “class” of disability insurance could offer health insurance coverage. For purposes of this report, we use the term disability insurer to refer to carriers authorized to offer the class of disability insurance.

³⁰ Licensed Knox-Keene plans are legally referred to as “health care service plans.” The phrase health maintenance organization (HMO) was coined in the federal HMO Act, and continues to be the commonly used name for health plans that provide or deliver services through contracted or employed providers, but is generally not used in California statute. For purposes of this report we use the term “health care service plan” or “health plan” to refer to Knox-Keene licensed full-service (medical) plans.

³¹ Since the PPO lines of business under Knox-Keene are there by special authorization, it is sometimes difficult to discuss clearly and easily “Knox-Keene regulation.” Although the two companies offering PPOs under Knox-Keene are subject to all relevant Knox-Keene provisions, including providing basic health care services, they do have greater flexibility in product design and out-of-network services are not subject to the

same level of quality assurance and delivery system requirements applicable to HMOs lines of business.

³² CDI does not track numbers of insureds or types of policies written by type of coverage, including health insurance, so it is not possible to easily determine exactly how much of the health insurance market is insured through CDI regulated policies.

³³ Health and Safety Code Section 1367(h) and 1367(i). In addition, California Code of Regulations, Title 28, §1300.67.2(3)(A) provides that co-pays and other limitations cannot “render the benefit illusory.” This concept is not further defined in regulation or policy. Several key informants report that DMHC has recently become more aggressive in limiting consumer cost sharing under this broad regulatory authority.

³⁴ However, Knox-Keene plans are specifically authorized to (and do) offer Medicare supplement products.

³⁵ A point-of-service plan allows consumers to access some services from out-of-network providers at higher levels of cost sharing.

³⁶ This allows the plans to avoid the Knox-Keene limits on cost sharing, out-of-network expenses, and the higher TNE requirements on Knox-Keene plans offering POS.

³⁷ California Association of Health Plans 2000 Annual Report and Profile.

³⁸ *Ibid.*

³⁹ The term “preferred provider” or “preferred provider organization” (PPO) is generally not used in the Insurance Code but is referenced in one section clarifying that an insurer contracting with preferred providers is subject to CDI jurisdiction. The product term “PPO” is commonly used in the marketplace.



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