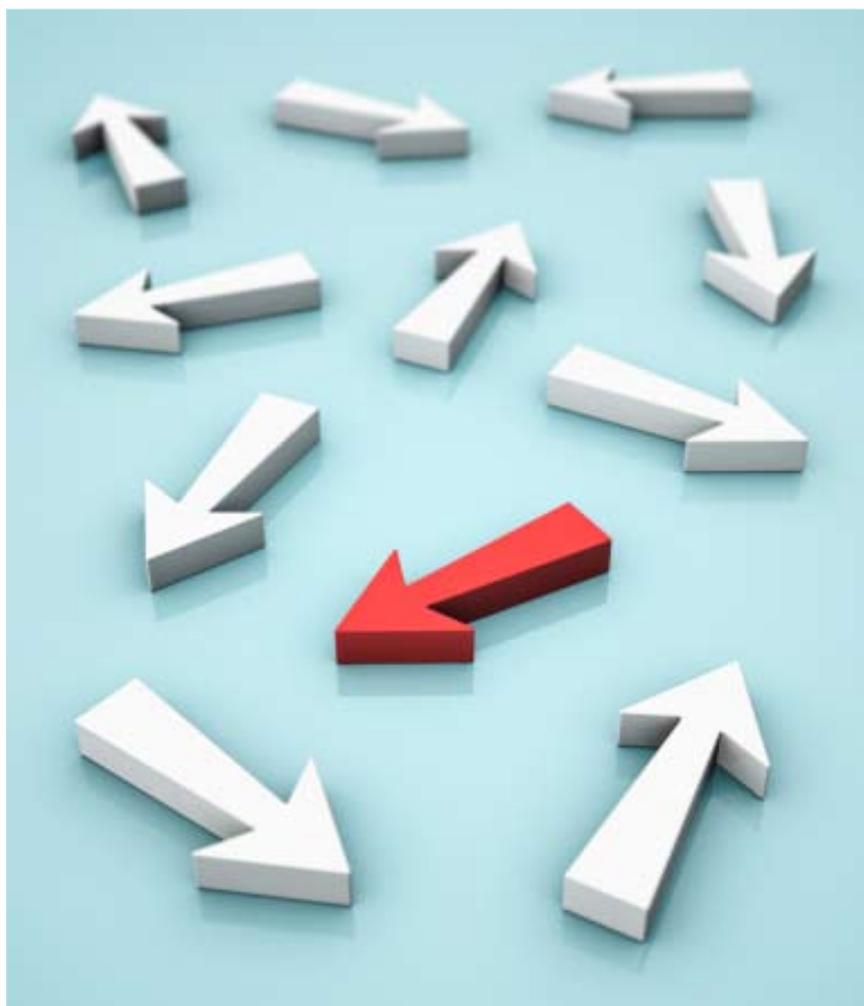




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Ready for Reform? Health Insurance Regulation in California Under the ACA

June 2011

Ready for Reform?

Health Insurance Regulation in California Under the ACA

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

by

Kelch Associates

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This report was researched and prepared for CHCF by **Kelch Associates**, an independent health policy consulting firm based in Sacramento, California. Client services include health policy research and writing, strategic advice and counsel, project management, meeting facilitation, grant writing, and staff and management mentoring and training. Kelch Associates partners with independent experts, consultants, and consulting firms on a strategic and issue-specific basis to meet the needs of clients.

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About the Foundation

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I. Executive Summary

IN CALIFORNIA, REGULATION OF HEALTH care coverage has long been divided between two state departments, currently the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). The departments administer two distinct regulatory frameworks reflecting the history of regulation in California which grew, in part, from aspects of health care financing and delivery unique to California.¹ Yet for many years, having two distinct regulatory frameworks has contributed to consumer confusion, added administrative burdens to government and insurance carriers, and obscured efforts to monitor the products and services being bought and sold in the insurance marketplace.

As part of expanding and transforming health coverage, the federal Affordable Care Act (ACA) enacts sweeping changes to the way health care services are purchased, delivered, and regulated. The ACA seeks to reshape health insurance markets and establishes new federal rules for coverage, competition, and service delivery.

The ACA, and the implementation tasks it imposes, compel a reexamination of how California regulates health coverage. Through the imposition of new federal standards, the ACA will narrow the differences between CDI- and DMHC-regulated health coverage products. Moreover, the ACA will necessitate enhanced accountability and consistency in the oversight and regulation of health care coverage. Maintaining California's regulatory status quo threatens to compromise California's ability to implement and monitor federal reforms of the health insurance market and could frustrate the federal goal

of enhanced transparency of coverage options for consumers.

ACA Health Insurance Market Reforms

Historically, states have assumed primary responsibility for the regulation of health insurance markets, with only limited areas typically under federal oversight. The ACA alters these traditional state and federal roles by establishing new areas of federal regulatory responsibility affecting health care coverage and markets. Despite the new federal roles in health insurance oversight, the ACA contemplates a continuing, active role for states in monitoring and regulating health insurance markets including state responsibilities for enforcing many of the new federal rules and standards.

One year following the passage of the ACA, much remains unknown about how the federal government and the states will share responsibilities for implementation and enforcement of federal insurance market reforms. To illustrate the variety of potential roles and responsibilities states might assume, this report considers in some detail two different ACA requirements that are already in effect: medical loss ratio (MLR) requirements and regulatory review of proposed premium increases. Federal rules carve out different roles for the states in each case.

The role of states in the enforcement of federal health insurance market reforms will likely vary by issue, depending on the specific requirements outlined in the ACA, federal implementation rules or guidance, and individual state laws and authority. For many ACA provisions, effective state enforcement will require changes or additions to California law. Generally speaking, neither DMHC nor CDI can

directly enforce provisions of federal law without specific state authority.

In both state and federal law, the market reforms and the standards for qualified health plans offering coverage through the new health benefit exchanges are intended to apply equally to carriers, regardless of product type or which state agency regulates them.

California's Dual Regulatory System

California's current complex and bifurcated regulatory structure for health coverage means that the task of determining of whether state law meets, exceeds, or fails to comply with the ACA will be more complex than in most other states. For each health reform issue, California will have to evaluate and revise as appropriate, two separate bodies of law, regulation, and practice.

Fundamentally, CDI and DMHC have different statutory standards to enforce and a very different regulatory emphasis. DMHC regulation reflects the historical emphasis in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) on health plans' contractual promise to provide or arrange for health care services. In contrast, CDI's oversight is based upon a traditional insurance regulation model emphasizing the insurer obligation to pay claims consistent with the insurance policy.

The two departments can and do work collaboratively. However, the different histories and statutes yield different regulatory functions and approaches between the departments. Although policymakers regularly mandate coordination and communication, the two departments are different enough that it often proves difficult to match enforcement and oversight activities. Even identical statutory requirements can yield different regulatory or enforcement outcomes.

As just one example, both DMHC-regulated health plans and CDI-regulated health insurers are

subject to state legislation enacted in 2002 to ensure enrollees have timely access to necessary health care services. DMHC and CDI both adopted and enforce access standards, but the standards are not identical. CDI adopted a geographic standard for the proximity of providers to a consumer's residence or place of work, while DMHC adopted requirements that focus on how quickly a consumer must be connected with services and providers. The result is that consumers have different protections related to their ability to access services in a timely manner, depending on whether their health coverage is regulated by DMHC or CDI.

Criteria and Options for Reforming Health Insurance Regulation in California

Health reform's new imperatives and opportunities call for a comprehensive review of how health insurance is regulated in California. This report identifies several criteria for evaluating regulatory reform options in California. It goes on to offer starting points for discussion of specific reform options which could be considered separately or in some combination.

The following criteria may be helpful in evaluating regulatory reform options.

- **Improve the consumer experience.** The most compelling reason to implement regulatory reform is to improve the consumer experience, making it easier for consumers to understand their coverage choices, access health services when they need them, and get timely assistance when there are problems or issues with their coverage. Policymakers should evaluate regulatory reform options accordingly, with a focus on making sure reforms maximize the benefit to consumers. Regulatory improvements should also consider the needs and interests of newly insured

consumers who may be less knowledgeable about their rights and responsibilities under their new coverage plans.

- **Ensure transparency and accountability.** As health reform is implemented, it will be essential to have adequate resources and commitment to monitor and track reform impacts. Policymakers will need accurate and timely information about market trends, the pace of coverage expansions, and the impact of various reforms being implemented at the state and community levels. To this end, transparent, timely, accurate, and understandable data collection and monitoring will be essential.
- **Ensure consistent interpretations of federal law.** At this early stage, it appears that implementation of new federal market reforms will rely heavily on state regulators for enforcement of many provisions. If California's two state regulators interpret or enforce provisions differently, carriers and other stakeholders may seek out or support the regulator with the interpretation most favorable to their business or policy interests. This result has the potential to encourage risk segmentation in the market, diminish the consumer experience, and interfere with the successful operation of California's Health Benefit Exchange (a state-based health insurance exchange mandated by the ACA through which individuals and small employers can purchase coverage). Consistent application and interpretation of state and federal ACA-related requirements will be a critical factor in the effectiveness of regulatory reform.

- **Offer potential system costs and savings.** To the greatest extent possible, regulatory reform should result in streamlining administrative requirements and reducing associated administrative costs. Focus should be given to eliminating outdated or duplicative requirements and promoting meaningful, measureable standards and enforcement strategies that improve transparency and access to quality care for consumers. For example, increasing federal requirements and greater standardization may reduce or change the role of up-front state licensing and product approval, permitting streamlining of the process without compromising consumer protections. In addition, policymakers should assess state costs and other impacts that may result from regulatory reform, such as changes to the relative tax burden of different carrier types.
- **Build on the strengths of the existing regulators.** DMHC and CDI have different relative strengths. Given the breadth and extent of the ACA reforms, the state will be best served if it draws on the resident expertise and experience of both departments as California moves to implement federal health reform.

OPTION 1:

Consolidate Regulation in One State Agency

This review found virtually no defenders of the existing complex and duplicative regulatory environment in California. Stakeholders agreed that having two legal frameworks and two regulators as they are currently configured is confusing, costly, and cumbersome. Consolidating oversight into one state department could increase accountability, improve efficiency, and reduce costs.

A full analysis of what it would take to consolidate departments is beyond the scope of the report. To move toward that end would require

analysis and comparison of the legal, operational, and organizational changes necessary to effectively combine regulatory jurisdiction. In addition, there would be political and change management issues to consider and resolve. The full report outlines some of the ACA-related strengths of the two existing departments and highlights potential pitfalls and unintended consequences from any consolidation effort.

If the state moves to consolidate regulatory oversight at the same time it works to implement the ACA, this report suggests that policymakers adopt one or more of the following to mitigate potential unintended consequences and to ensure effective consolidation of regulatory responsibility: phasing in any consolidation; reorganizing oversight by product type; and setting clear lines of authority among all agencies involved in oversight of health coverage, including the California Exchange.

Based specifically on key elements of the ACA, this report highlights for consideration and discussion some of the relative advantages for the state of moving jurisdiction either to DMHC or CDI.

Moving jurisdiction to DMHC. Consolidation within DMHC would disrupt coverage for a smaller number of consumers than consolidation at CDI simply because DMHC has responsibility for the vast majority of covered lives. As the stand-alone state agency with an exclusive focus on health plan licensure, DMHC is in a strong position to dedicate its staff and resources to implementing federal reform. DMHC's statutory emphasis on managed care, and the expertise it has developed in regulating integrated delivery systems, are consistent with some provisions of the ACA, including new payment approaches and care delivery arrangements in ACOs. Key pieces of the ACA address health coverage issues that the DMHC already regulates, including

minimum benefits, access to care, monitoring of quality and quality improvement, and oversight of integrated delivery models with complex risk-sharing and provider contracting arrangements.

Since its inception, DMHC has been mandated to focus on consumer protection, education, and transparency, and has developed an infrastructure for those functions through its Web site, the HMO Help Center, and the Office of the Patient Advocate. As the federally funded lead agency in the state's Consumer Assistance Program, DMHC is well-positioned to expand on its consumer assistance activities. Finally, the placement of DMHC within the state administration creates important opportunities for shared leadership, resources, and collaboration with other state agencies and programs that will be impacted by federal reform.

Moving jurisdiction to CDI. As the state insurance agency, CDI has experience with rate review and rate regulation for other lines of insurance. It has actuarial and legal expertise that will be important in related aspects of ACA implementation, including premium rate review, MLR enforcement, and defining products in the reformed market by their actuarial value.

In addition, CDI is California's representative and sole voting member of the National Association of Insurance Commissioners (NAIC). The NAIC has been given a leadership role in many aspects of reform implementation under the ACA. Thus, CDI has access to national expertise, resources, and relationships that strengthen its ability to analyze and administer key aspects of health reform, and to conduct oversight of national health insurance companies doing business in California. As an NAIC member, CDI will be positioned to translate and interpret insurance market reform terminology and concepts as they are developed by the NAIC and federal agencies.

CDI's licensure and regulation of insurance agents and brokers provides California's Insurance Commissioner with a network of resources in communities that potentially can serve as an early warning system for troublesome market trends and access barriers.

OPTION 2:

Institutionalize Coordination and Consistency

Consolidation of regulation in one agency is the course most likely to maximize efficiency, effectiveness, and uniformity in implementing the ACA market and coverage reforms. However, if California continues to have two separate state agencies regulating health coverage, policymakers should consider policies and strategies to promote and prioritize greater consistency and cooperation between CDI and DMHC. Below are options to accomplish this goal.

Require Regulatory Consistency

One option to formalize collaboration and consultation would be to require by statute that CDI and DMHC work to ensure consistency in the implementation of the ACA. This requirement could be combined with joint reporting on coordination activities and legislative oversight. To emphasize the importance of consistency in implementing guidance and regulations, policymakers could require DMHC and CDI to adopt identical ACA implementation regulations, absent a specific finding that there is a reasonable policy rationale for different standards.

Reinvigorate the Joint Senior Level Working Group

A joint senior level working group of DMHC and CDI still exists, although it is no longer subject to an annual reporting requirement. Health reform implementation tasks and new reporting requirements could be assigned to the working group. If rededicated to collaborative implementation of health care reform, the existing working group, made up of senior staff from both CDI and DMHC, could facilitate legislative and public oversight of ACA mandates, regularly report to policymakers and the public on its joint assessments and activities, and facilitate legislative and public oversight of ACA mandates.

Require Timely Public Reporting

Both DMHC and CDI have been posting their guidance and regulations regarding the ACA on their respective Web sites, but have not always made the operational activities and documents for implementing reform (such as, for example, carrier compliance filings) publicly available. The more transparent the regulatory and enforcement process is, the more likely that there will be an emphasis on consistency and serious oversight by policymakers and stakeholders when differences emerge. Transparency should also apply to the state's activities in federal forums such as the NAIC that have been assigned new responsibility and authority under the ACA. State policymakers could seek to ensure that both DMHC and CDI have regular input and meaningful participation in the NAIC, consistent with their respective state roles, and that CDI seek input from and provide information to policymakers and stakeholders regarding NAIC activities, proposals, and standards.

Improve and Consolidate Data Collection

For decades, it has been difficult and sometimes impossible to get basic data regarding the companies, covered lives, products, and processes regulated by CDI and DMHC. To be fair, the departments individually provide varying degrees of access to information, and data needs have fluctuated as policymakers confront new and different problems to solve. As the state tackles health care reform, good data and consistent information about markets and products will be more important than ever. Clear, specific, and consistent data reporting requirements for DMHC and CDI, in conjunction with the California Exchange, would help ensure that there is reliable information by which to monitor and adjust oversight and implementation of market reforms.

Require Joint Public Reporting on the ACA

One approach to promoting consistency and collaboration between CDI and DMHC could be to require by law that ACA-related postings by both departments be done in a consistent format at a centralized shared Web site, dedicated for that purpose and linked to the state's health reform site. Policymakers could also require that both departments publicize on the common Web site any differences in guidance, regulation, or enforcement when they occur, including the rationale and the meaning for consumers of different requirements or standards. The goal of this option would be to maximize public and stakeholder awareness of the steps each department is taking to implement and enforce the ACA, and to shine a public spotlight on the day-to-day operational impact of having two separate regulators.

Realign Statutes and Regulations

One of the barriers to consistent regulation and enforcement between DMHC and CDI is the very different statutory frameworks under which each functions. Implementation of the new federal rules under the ACA will, at a minimum, require California to review and revise both the Insurance Code and Knox-Keene as appropriate to comply with and incorporate federal insurance reforms. This could also make possible a more thorough statutory overhaul, to both reconcile state law with the new federal requirements, and to reconcile differences between Knox-Keene and the Insurance Code.

A statutory review could also evaluate potential legislative options to encourage and promote voluntary consolidation of products within one agency consistent with the significant changes in the ACA. For example, the review could clarify that any PPO product could be licensed under DMHC, rather than just the PPO products of two companies allowed under DMHC through historical exceptions. This change could result in companies choosing over time to consolidate all of their HMO and PPO products under one regulator, DMHC, given that the ACA requirements already impose consistent benefit, cost sharing, MLR, and rate review standards on all products.

Realigning statutory and regulatory standards could also impose consistent product definitions and permit greater emphasis on model-specific regulation and standards for HMOs, PPOs and EPOs, as well as newly emerging delivery models such as accountable care organizations, rather than department-specific standards.

Mandate Functional Consolidation

Both DMHC and CDI have different relative strengths as regulating agencies. As part of state implementation of the ACA, policymakers could consider voluntary or mandatory functional integration on an issue-specific basis using the relative strengths of each regulator. State implementation planning could require one department to take the lead on specific elements of the ACA, authorize or require memoranda of understanding between CDI and DMHC for that purpose, or mandate joint audits and field surveys related to ACA compliance.

For example, legislation could consolidate at the CDI review of premium rate filings and certification of the actuarial values of products to be sold after 2014. This would build on the CDI's staff and expertise in this area. Alternatively, joint purchasing of independent actuarial expertise or a joint working staff group could be responsible for those activities. DMHC might assume responsibility for ensuring compliance with minimum benefit standards for all carriers subject to the federal essential benefits requirement.

In addition, the California Exchange could require all carriers interested in participating as qualified health plans in the Exchange to have their networks and quality assurance systems reviewed by the DMHC for compliance with federal and state certification standards. Finally, a particular opportunity might arise to develop joint auditing tools and processes for carriers with affiliated companies under the jurisdiction of both departments.

In considering integration of key functions, policymakers would need to ensure that both regulators retained the tools and information to actively monitor and regulate carriers under their jurisdiction. For example, provider access challenges with a health plan often signal solvency issues,

and rate filings can provide information to inform regulatory review of provider payment arrangements.

For comparisons of the two departments, see Tables 3 and 4 of the main report.

Conclusion

The purpose of this report is to jumpstart a conversation among policymakers, insurers, regulators, and the public about health insurance regulation in California and the future policies and structures that will be needed under health reform. Fulfilling new obligations and seizing new opportunities under the ACA require enhanced accountability and consistency in California's regulation of health insurance. Retaining California's bifurcated system could seriously limit the impact of the federal reforms in the state.

Reforming and improving California's health insurance regulatory structure will take serious discussion, analysis and planning among all stakeholders. Most of the ideas included here would require state legislation to implement and effective legislative oversight to ensure success.

The time leading up to full implementation of the ACA is short. The conversation about regulatory reform needs to begin in earnest now, leading to consideration of potential legislation by early 2012, in order to ensure that California has a highly effective and efficient regulatory system in place to support full implementation of the ACA beginning in 2014.

II. Introduction

CALIFORNIA FACES A UNIQUE CONTEXT for implementation of health care market reforms under the federal Affordable Care Act (ACA). For more than 70 years, responsibility for the regulation of health coverage in California has been divided between two different state agencies, most recently between the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). In a 2001 report published by the California HealthCare Foundation (CHCF), *Making Sense of Managed Care Regulation in California*, the authors outlined the history of the two regulatory programs and highlighted the legal and statutory differences between DMHC and CDI at that time.²

As part of its expansion and transformation of health coverage, the ACA enacts sweeping changes to the way health care services are purchased, delivered and regulated.³ The ACA seeks to reshape health insurance markets and establishes new federal rules for coverage, competition, and service delivery. The ACA alters traditional state and federal roles by establishing new areas of federal regulatory responsibility affecting health care coverage and markets. Historically, states have assumed primary responsibility for the regulation of local health insurance markets while oversight by the federal government has been limited.⁴ Despite the new federal roles in health insurance oversight, the ACA contemplates a continuing, active role for states in monitoring and regulating health insurance markets including state responsibilities for enforcing many of the new federal rules and standards.

The ACA, and the implementation tasks facing California, compel a reexamination of how California regulates health coverage. The changes anticipated by

the ACA are unprecedented in scope, and effective and efficient state oversight of health insurance is a critical factor in its success. Unfortunately, the status quo for health insurance regulation in California threatens to impede many of the core goals of reform. At the same time, sensible reform of the current bifurcated regulatory system has the potential to reduce costs, improve quality, and increase accountability.

The purpose of this report is to inform and advance a policy conversation about health insurance regulation in California through a focus on the policies and structures needed to implement the ACA. The report reviews key provisions of the ACA affecting health coverage products, provides background on the structure and responsibilities of CDI and DMHC, and identifies considerations and options for updating and strengthening California's regulatory context in light of ACA requirements.

III. Background: The Historical Context

IN THE 2001 *MAKING SENSE* REPORT, THE authors described how California's two different regulatory regimes developed over decades based on policy, political, and marketplace dynamics. As a consequence of that history, CDI and DMHC today have different statutory underpinnings and different administrative structures.

California's regulation of health coverage and managed health care has been characterized by increasing state standards and regulatory authority as the market for health coverage products grew and evolved. Until the mid-1970s, two nonprofit companies, Blue Cross and Blue Shield, and commercial indemnity business claimed the lion's share of the California market. Over time, cost-containment concerns yielded much of the market to HMOs with their relatively low-cost structures and tighter management of service delivery.⁵

Managed care organizations, especially HMOs, and HMO contracting provider and payment arrangements, became increasingly complex and sophisticated. At critical turns, California expanded and updated the regulatory structure for managed care. Managed care oversight progressed from the simple registration of prepaid health plans with the Attorney General in 1965, to passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), under the auspices of the state Department of Corporations (DOC), following adoption of the Federal HMO Act of 1973.⁶ Ultimately, policymakers created the DMHC in 1999 as a stand-alone state agency dedicated entirely to the regulation of managed health care plans.⁷

Managed care continues to dominate California's health coverage marketplace. In 2010, commercial

coverage was 53 percent HMO coverage and 24 percent PPOs, with the remaining 23 percent in self-insured plans not subject to state oversight.⁸

The Legal Context

The legal context for two different regulating agencies in California has its roots with the 1946 California Supreme Court case which held that California Physicians' Service (doing business as Blue Shield of California) was not in the business of insurance and not subject to the jurisdiction of the Insurance Commissioner.⁹ The ruling meant that Blue Shield and other prepaid health plans such as Kaiser Permanente, followed the path from limited oversight of the Attorney General to Knox-Keene licensure by DMHC, while indemnity health insurers continued to be subject to the jurisdiction of CDI. The current statutory and regulatory approaches of DMHC and CDI remain grounded in the legal distinctions which emerged from that early case.

CDI administers the traditional insurance regulation model emphasizing the insurer obligation to pay claims consistent with the insurance policy. This approach has been referred to as "the promise to pay."¹⁰ Insurance regulation at CDI has focused on assessing and monitoring the insurer's financial solvency, claims payment practices, and the insurer's adherence to the policy terms.

By contrast, DMHC administers a regulatory program based on the prepaid health plan model, embraced nationally in the early 1970s as the HMO concept. In that construct, health plans agree to provide or arrange for covered services, in exchange for "prepayment," a fixed monthly fee or premium. This approach has been referred to as "the promise

to provide care.” Health care services generally must be accessed through providers employed by or under contract with the health plan. In addition to solvency and contractual oversight, Knox-Keene incorporates review of provider networks, provider payment arrangements, and plan administrative structures to ensure that enrollees have adequate access to services, and that medical decision-making is not unduly influenced by financial considerations.

As a practical matter, DMHC and CDI no longer regulate starkly different products as originally articulated in the 1946 ruling. Along the way, key state policy choices and market changes lessened the distinctions.

Initially, Knox-Keene alone regulated managed care arrangements, but in 1982, California amended the Insurance Code to authorize health insurers under CDI to contract with providers in preferred provider organization (PPO) and exclusive provider organization (EPO) arrangements.^{11,12} In addition, because of historical exceptions for Blue Shield and Blue Cross of California (now Anthem Blue Cross) to sell PPO plans under Knox-Keene, PPO coverage products are sold under both DMHC and CDI jurisdiction.¹³ Moreover, 1993 amendments to Knox-Keene authorized health plans to offer point-of-service (POS) plans. POS plans are similar to PPO coverage, in that they allow some services by noncontracted providers, but under POS plans, contracting providers are generally paid capitation payments as in many HMOs.¹⁴

In the marketplace, products have changed so that consumer cost sharing for HMO, POS, and PPO products has risen substantially in recent years. Many HMO products, particularly those offered in the individual market, now have relatively high annual deductibles and copayments more comparable to PPO plan cost sharing than to the early HMO products, which had only minimal consumer cost

sharing. Today’s HMO products are more likely than those in the past to provide coverage for a portion of costs, such as a percentage of the negotiated fee for inpatient services, where earlier HMO products typically required enrollees to pay a fixed copayment amount.

At the same time, the statutory and regulatory frameworks administered by the two departments, while still quite different in many respects, include a growing number of parallel or similar requirements imposed on health carriers. Over time, specific legislative mandates and regulatory requirements have been added through legislation in both the Insurance Code and Knox-Keene so that similar provisions routinely apply to products regulated by both agencies. For example, both CDI and DMHC are required to operate independent medical review programs for consumers who wish to appeal a denied health care service.

The Reform Context: Creation of the DMHC

In the middle and late 1990s, a wave of managed care reforms became law in California. As part of those efforts, policymakers created the Managed Health Care Improvement Task Force in 1998 which made sweeping recommendations for changes to the regulation and oversight of managed care. Following legislative hearings and review in the wake of the Task Force findings, legislation transferred regulation of Knox-Keene plans from the DOC to the newly created DMHC in 1999.^{15,16} The enabling legislation declared that “it is in the public interest that the administration and enforcement of the Knox-Keene Health Care Service Plan Act of 1975, as amended, be undertaken by a department of state government devoted exclusively to the licensing and regulation of managed health care.”¹⁷ That same legislation required the new department to undertake a study on the feasibility and benefit of consolidating within

DMHC the regulation of health insurance, including some or all of the products under the jurisdiction of the CDI.¹⁸

The resulting report released in December 2001, authored by J. Clark Kelso (former interim insurance commissioner for several months in the Summer of 2000 and currently serving as federal receiver of California Prison Health Services) included a review of the history of health insurance regulation in California. It assessed the relative strengths and weaknesses of each regulator, and analyzed potential options for reform of regulatory jurisdiction over health insurance. The Kelso report stopped short of making a specific recommendation and suggested instead that, while there might be marginal improvements in regulatory consistency resulting from consolidation, moving all health insurance to DMHC could potentially overburden what was then a very new department (see sidebar).¹⁹

The report also noted that:

“In light of bureaucratic stasis and political reality, substantial organizational and regulatory change in government usually must take place opportunistically, for example because of one or more flash points (such as a major scandal in an industry or an agency), because political considerations make organizational change possible during a brief period of time, or because of a carefully cultivated consensus for change.”

California’s implementation of the federal ACA reforms represents another critical juncture for health insurance regulation as the ACA requirements reshape and reform the state’s health insurance markets. ACA implementation may present an opportunity for “substantial organizational and regulatory change” that, as the Kelso report noted, is most likely to occur during limited windows of policy and political opportunity.

Findings of the 2001 Kelso Report

Regulatory Jurisdiction of Health Insurance Products in California: DMHC and DOI, by Professor J. Clark Kelso Kelso (then Director of the Capitol Center for Government Law and Policy at the McGeorge School of Law) was commissioned by the DMHC. The legislation creating the new department called for the DMHC to study and report to the legislature on whether regulation of all health insurance should be transferred to the new stand-alone agency.

The report analyzed in detail the historical, legal, and administrative differences between CDI and DMHC, and evaluated the pros and cons of several reform options.

Despite the enactment of numerous important legislative changes since the 2001 Kelso report, the basic structure, legal foundation, and relative strengths of each department outlined in the report remain.

The report found that DMHC and CDI perform many similar bureaucratic and regulatory activities but have somewhat different strengths. Professor Kelso cited DMHC’s comparative strengths as its exclusive focus on health care, a robust consumer complaint and grievance program with specified timelines for dispute resolution, monitoring of quality care, consumer health care education programs, and administration of the independent medical review program (which CDI now separately administers for its enrollees). He cited CDI’s comparative strengths as its financial surveillance programs, insurance expertise to inform consumer inquiries, and its national connections to other state insurance regulators.

The report is available at: www.hmohelp.ca.gov.

IV. ACA Health Insurance Market Reforms

SIGNED INTO LAW IN MARCH 2010, THE ACA is expected to fundamentally reshape the nation’s health care system. After the law is fully implemented in 2014, estimates are that nearly 96 percent of documented, non-elderly California residents will be insured, either through their employer, a new exchange market, or expansions in public coverage programs.²⁰

To accomplish the goal of making coverage more accessible, the ACA:

- Imposes a mandate on individuals to have health insurance coverage;
- Expands eligibility and federal funding for public coverage programs such as Medicaid (Medi-Cal in California);

- Establishes state-based health insurance exchanges through which individuals and small employers can purchase coverage;
- Provides federally funded subsidies for qualifying individuals and small groups purchasing through an exchange; and
- Imposes new requirements on health insurance issuers related to private individual and group health coverage. (In California, health plans and insurers are collectively referred to as “carriers”; see Table 1 for more on terminology.)

The ACA reorganizes, amends, and adds to the provisions of the Public Health Services Act (PHS Act) relating to group health plans and health

Table 1. Defining a Health Plan: Comparing Terminology in State and Federal Law

FEDERAL LAW	KNOX-KEENE	CALIFORNIA INSURANCE CODE
<p>Group health plan: An employee welfare benefit plan established by an employer, or an employee organization such as a union, under the federal ERISA law.²¹ May be a self-insured plan or may contract with licensed health insurers to provide the coverage and assume the risk.</p> <p>Health insurance issuer: A company, service, or organization (including an HMO) licensed under state law to engage in the business of health insurance.</p> <p>Qualified health plan: A health plan that is sold through a health insurance exchange established under ACA.</p>	<p>Health care service plan: An entity licensed by DMHC that arranges to provide or to pay for health care services in exchange for a prepaid or periodic charge.</p> <p>Group health plan: A health plan contract purchased by and covering groups, such as an employer group buying coverage for its employees.</p> <p>Individual health plan: A health plan contract purchased by and covering individuals who buy coverage separately.</p> <p>Qualified health plan: References federal law.</p>	<p>Disability insurer: A company certificated by CDI to sell disability insurance, which includes health insurance, long-term care insurance, workers’ compensation, credit disability, and travel insurance.</p> <p>Health insurance: An individual or group policy that provides coverage for hospital, medical, or surgical benefits.</p> <p>Health insurer: Term used in the Insurance Code but not defined.</p> <p>Group health policy: A health insurance policy sold to groups.</p> <p>Individual health policy: A health insurance policy sold to individuals.</p> <p>Qualified health plan: References federal law.</p>
	<p>Carrier: An all-inclusive term used in both Knox-Keene and the Insurance Code in limited circumstances (e.g., small employer coverage reforms) to reference both health plans under DMHC and health insurers under CDI.</p>	

insurance issuers in the group and individual health insurance markets. The federal Department of Health and Human Services (DHHS) is issuing regulations in phases in order to implement the ACA changes to the PHS Act, and in some cases, has issued regulations jointly with the federal Departments of Labor and Treasury.

Reforms of the health insurance market will take place over time starting in 2010 and leading to full implementation of all provisions by 2014. (See “Health Insurance Reforms in the ACA” on page 15 for more detailed reform provisions organized by year of implementation.)

The Role of States

One year after the passage of the ACA, there are still many unknowns about how the federal government and the states will share roles and responsibilities relative to implementation and enforcement of federal insurance market reforms. The ACA includes some specific roles for the states, such as establishment of health insurance exchanges and review of health insurance rates, as well as new federal responsibilities regarding health insurance regulation and enforcement.

In California, through the imposition of new federal standards, the ACA has the potential to narrow the differences between CDI- and DMHC-regulated health coverage. For example, the ACA changes the types of coverage that can be made available by any issuer. The ACA requires all issuers, except for grandfathered plans, selling individual and small group coverage to cover minimum essential benefits as defined by the federal DHHS, bans lifetime and annual benefit limits, standardizes benefit and coverage disclosures, and imposes data and quality reporting mandates. Federal law requires these and other reforms to eventually apply equally to

all issuers. (See Appendix A for a comparison of early ACA insurance reforms with state law.)

The ACA will also lead to the establishment of the California Health Benefit Exchange. The Exchange is intended to be a competitive marketplace where qualified health plans meet standard criteria and performance measures. The state and federal requirements for participation in the Exchange are designed to ensure that carriers compete primarily on the basis of price and quality, rather than other factors such as the health risks of the people they choose to cover. (See Table 2 on page 16 for a summary of requirements that will be imposed on qualified health plans participating in the Exchange.)

In both state and federal law, the new standards and exchange participation requirements are meant to apply equally to all issuers, regardless of which state agency regulates them.

Issue-Specific State and Federal Roles

Early rules and guidance issued by DHHS provide for specific state roles in implementing and enforcing the provisions of the ACA with early effective dates. To date, the federal approach to state responsibility seems to depend on the reform topic and the specificity of the ACA related to each topic. To illustrate the variety of potential roles and responsibilities states might assume, it may be helpful to consider two ACA requirements that are already in effect: medical loss ratio requirements, and regulatory review of proposed premium increases.

Medical Loss Ratio Requirements

Medical loss ratios (MLRs) measure the percentage of premiums spent on medical care. The ACA imposes greater transparency and accountability on issuers by requiring that they publicly report spending of health insurance premium dollars and meet federal MLR standards. The ACA requires issuers that do not

Health Insurance Reforms in the ACA

2010:

- Prohibits lifetime benefit limits.
- Restricts and gradually phases out annual benefit limits until they are prohibited in 2014.
- Prohibits pre-existing condition exclusions for children under age 19 and requires an issuer to cover a child regardless of health status (“guaranteed issue”).
- Allows children to remain on their parents’ health coverage until age 26.
- Prohibits rescission of health care coverage except in cases of fraud or intentional misrepresentation.
- Requires coverage of specified preventive health services without enrollee cost sharing.
- Prohibits prior authorization for emergency services, allows enrollees to choose any available primary care physician in the issuer’s network, and ensures access to pediatricians and obstetrician-gynecologists as primary care physicians.
- Extends to non-grandfathered fully-insured group health plans the existing prohibition against self-funded plans discriminating in favor of highly compensated individuals based on wages or salaries.
- Requires issuers to report specified data and information to DHHS for use in the federal Internet portal of health insurance options for consumers.
- Allows individuals to retain “grandfathered coverage,” defined as coverage under a group health plan, or provided by a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010, and establishes different timelines for application of health insurance reforms. To remain grandfathered, plans cannot make significant coverage changes that reduce benefits or increase costs, including reducing the employer contribution to a plan.

2011 – 2013:

- Requires annual review of unreasonable premium rate increases starting January 1, 2011.
- Requires issuers to implement grievance and external review procedures in compliance with NAIC model guidelines or state laws that meet NAIC standards (July 1, 2011).

- Requires issuers to report medical loss ratios (MLRs; percentage of premiums spent on medical care) and to meet specific standards (no less than 85 percent for large group coverage and no less than 80 percent for small group and individual coverage.) Starting with the 2011 plan year, if an issuer fails to meet the MLR standard, the issuer must provide rebates to enrollees starting in 2012.
- Requires DHHS in consultation with stakeholders to develop by September 23, 2011 a methodology to measure health plan value, including overall cost to enrollees, quality of care, efficiency in providing care, relative risk of enrollees compared to other plans’ actuarial value or other comparative measure of the covered benefits, and other relevant factors.
- Requires issuers to implement federal uniform explanation of coverage documents and standardized definitions within 24 months of enactment of the ACA.
- Requires issuers to report annually on quality improvement benefits.

2014:

- Prohibits annual benefit limits and waiting periods of more than 90 days.
- Eliminates pre-existing condition exclusions and requires guaranteed issue of coverage, regardless of health status, for adults.
- Limits rating factors to age, family size, geography, benefits, and tobacco use with rate bands of 3:1 among age groups.
- Limits deductibles in small group coverage and out-of-pocket maximums in group and individual coverage.
- Requires non-grandfathered issuers that offer coverage in the individual or small group market to cover essential health benefits. “Essential health benefits package” means coverage that offers specified benefits, limits cost-sharing, and provides coverage at the bronze, silver, gold, or platinum level (based on actuarial value);
- Requires states to implement risk adjustments, charging assessments to issuers with low-risk enrollees, and making payments to issuers with high-risk enrollees.
- Requires issuers to participate in state-established temporary reinsurance.

Table 2. California Health Benefit Exchange: Federal and State Requirements for Qualified Health Plans, 2014

Marketing and enrollment	<ul style="list-style-type: none"> • Comply with marketing requirements and practices as required by DHHS. • Use a uniform enrollment form based on criteria developed by the National Association of Insurance Commissioners (NAIC). • Use a standard format developed by DHHS for presenting health benefits and coverage options.
Provider network	<ul style="list-style-type: none"> • Ensure a sufficient choice of health care providers based on standards developed by DHHS. • Contract with essential community providers. • Contract with hospitals (50+ beds) only if they meet specified quality criteria set by DHHS, including patient safety and specified discharge planning requirements; and with other providers only if they implement federal mechanisms to improve quality. • Contract with providers implementing quality improvement mechanisms as required by DHHS. • Make an electronic directory of contracting providers available to the Exchange, and regularly update it.
Quality	<ul style="list-style-type: none"> • Meet certification requirements for performance on clinical quality measures and quality assurance. • Implement market-based strategies for quality improvement. • Provide information on quality measures of health plan performance. • Report annually to DHHS on pediatric quality measures.
Licensure	<ul style="list-style-type: none"> • Obtain licensure by state regulatory agency; California: “respective regulatory agency” (added in state law by the California Patient Protection and Affordable Care Act of 2010).
Rates	<ul style="list-style-type: none"> • Submit justifications for premium increases which will be taken into account when certifying a qualified health plan. • Charge the same premium rate inside and outside of the Exchange for each product.
Products	<ul style="list-style-type: none"> • Cover all essential health benefits as defined by DHHS. • Fairly and affirmatively offer at least one product in each of the five actuarial levels (bronze, silver, gold, platinum, and catastrophic-only) developed by DHHS (state requirement added by the California ACA). • California Exchange may standardize products and/or require participating carriers to offer additional products in each of the five coverage levels outlined in federal law (added by California law).
Disclosure	<ul style="list-style-type: none"> • Submit to the Exchange, DHHS, and the state Insurance Commissioner, and publicly disclose, specified information such as claims payment policies and practices, number of claims denied, enrollment and disenrollment, enrollee rights, etc. • Allow individuals to learn the cost sharing under a plan for a specific item or service by a participating provider, through a Web site, upon request.
Risk and risk pools	<ul style="list-style-type: none"> • Create common risk pools across all enrollees in non-grandfathered plans in individual products or in small group products, regardless of whether the product is sold in or outside of the Exchange. • Contribute to temporary reinsurance program and participate in risk adjustment.
Outside the Exchange	<ul style="list-style-type: none"> • Fairly and affirmatively market and sell all of the company’s products made available in the Exchange to individuals and small employers outside the Exchange (added by California law). • Offer at least one standardized product that has been designated by the Exchange in each of the four levels if the carrier does not participate in the Exchange (added by California law). Prohibits carriers not participating in the Exchange from offering the fifth level of coverage: catastrophic-only coverage.

meet the federal MLR standards set by the DHHS to provide rebates to enrollees beginning in 2012.

The MLR interim final rule (IFR) issued by DHHS in December 2010 requires issuers to submit specified MLR data and information directly to DHHS for products offered by the issuer in each state, based on detailed standards recommended by the National Association of Insurance Commissioners (NAIC).²² The DHHS will be responsible for direct enforcement of the MLR reporting and rebate requirements. The IFR provides for the imposition of federal civil monetary penalties if issuers fail to comply with the reporting and rebate requirements.²³

The IFR also outlines possible state roles and responsibilities. States are permitted to establish more stringent MLR requirements than the ACA, as long as the state requires issuers to also submit the MLR data directly to the state.²⁴ States can request the DHHS to adjust the MLR requirement for a specific state if that state determines an 80 percent MLR will destabilize the state's individual market, and authorizes DHHS to approve the adjustment based on standards recommended by the NAIC. DHHS may also, at its discretion, accept the findings of audits conducted by state regulators on the validity and accuracy of the MLR data issuers submit, if specified conditions are met.

Notably, the overview section of the IFR highlights the role of states related to solvency and rate oversight. It recognizes "the historical role that states have had in regulating insurance." Further, it says, "[I]t is appropriate for the States to have an oversight role with respect to the [MLR] reporting provisions, even though the statute gives DHHS direct enforcement authority." Finally, the overview notes, "As DHHS and the states develop greater experience and expertise in conducting these audits, it is likely that the states' role will increase."²⁵

Premium Rate Review Requirements

By contrast, the ACA and federal regulations for premium rate review provide for a more immediate, direct state role in and responsibility for reviewing premium rate increases.²⁶ The ACA directs the DHHS, in conjunction with states, to establish a process for annual review of "unreasonable increases in [health insurance] premiums."²⁷ This requirement does "not preempt or supplant any existing state laws governing the review of insurance premiums," deferring to standards in state law.²⁸

In this regard, regulation of health insurance rates varies dramatically from state to state.²⁹ Some states have authority to disapprove rate increases, while others (including California) review rates and the justification for them, but do not have the authority to disapprove an increase.

In California, carriers under both DMHC and CDI have been required since 1993 to submit rates for products sold to small employers (those with 50 or fewer employees) for review of compliance with specific rating rules (age bands and geography, for example).³⁰ CDI-regulated carriers must file rates with the Insurance Commissioner, who can review them and ensure that they are in compliance with state law, but has no authority to reject excessive premium increases. Carriers under DMHC must file premium rates for review under new ACA requirements and state implementing legislation which applies to products under both departments.

In response to the ACA's rate review mandate, the DHHS issued a final regulation with a comment period on May 23, 2011 that would require review of proposed rate increases of 10 percent or more (alone or in combination with other prior increases in the preceding 12-month period) in the individual and small group markets. The federal rule contemplates that state-specific thresholds (to be developed by DHHS in consultation with states)

will replace the 10 percent threshold in 2012. No specific methodology is specified for setting state-specific thresholds, but in comments on the proposed rule, the NAIC recommended that states be given maximum flexibility to determine a state threshold triggering review.³¹

The federal rule requires that states review all rate increases that exceed the threshold, or, as the overview states, DHHS would review rate increases “in the small number of states that do not have an effective [rate review] process in place.” The federal rule provides that so long as a state can conduct an effective review of rate increases that meet or exceed the applicable threshold, based on proposed criteria outlined in the rule, DHHS will adopt the state determinations.

The factors for determining whether a state’s rate review process is effective are: (1) whether the state receives sufficient data and documentation from health insurance issuers to determine whether a rate increase is unreasonable; (2) whether the state effectively reviews the data and information submitted; (3) whether the state examines the reasonableness of the assumptions used in developing the rate; and (4) whether the state applies a standard set forth in a statute or regulation in making the determination of reasonableness.³²

Importantly, the final rule provides that DHHS will accept a state’s determination as to whether a rate increase is unreasonable (if the process meets the minimum criteria above). The rule does not impose a federal standard or definition of “unreasonable” on state rate review processes but rather includes definitions and criteria for “unreasonable,” “unjustified,” or “excessive” rate increases, only for those cases in which the DHHS, not the state, does the review. The specific rule defers to state rules for what issuers must file, and to state definitions of

individual and small group markets, to the extent the state law includes such definitions.

Ongoing Monitoring of States’ Role in ACA Implementation

These two illustrations suggest that as additional federal implementation guidance and regulations are issued, and new ACA requirements are phased in by 2014, states will need to examine the ACA and the implementing federal rules on an ongoing basis to identify and clarify state roles and responsibilities. States will also need to evaluate (and potentially revise) existing state laws and regulations issue by issue, to avoid or eliminate duplication, inconsistency, or lack of compliance with federal law and regulation.

Much of the legal and analytical work on the role of states in enforcing the ACA is occurring through the NAIC. The ACA assigned NAIC to develop specific definitions, guidance, and recommendations for ACA implementation. In addition, NAIC has been continuing its historic practice of developing model state laws for many of the ACA provisions.

The ACA states that it should not be construed to “preempt any state law that does not prevent the application of the provisions of Title I [of the ACA].”³³ According to the NAIC, this means that on the effective date for each health insurance provision, any state law that does not meet the federal standard will be preempted and the federal DHHS will assume regulatory authority for enforcing the federal requirement.³⁴ If the existing state law, or a subsequent change to state law, meets the federal standard, the state will be able to enforce it. The NAIC preemption analysis also points out that the ACA preempts state law in a few specific areas (such as grandfathered plans), allows states to have additional flexibility in some areas, and authorizes

states to seek waivers of other specified federal requirements.

As of this writing, additional federal guidelines and regulations are pending in many areas. Based on early experience, the exact role of states in

implementing and enforcing federal health insurance market reforms will likely vary depending on the specific requirements of the ACA and federal implementation rules, combined with state authority in existing or newly enacted statutes.

Early Implementation of ACA Insurance Market Reforms in California

In 2010, The Legislature passed, and the Governor signed, multiple bills to implement some of the earliest ACA reforms applicable to health insurance issuers in California under both DMHC and CDI. California also became the first state to enact legislation to create a state health insurance exchange under the ACA.³⁵

Other bills passed in 2010 to conform California statute to federal law included:

1. Eliminating pre-existing condition exclusions for children under 19;³⁶
2. Allowing adult children to stay on their parents' coverage until age 26;³⁷
3. Prohibiting rescission of coverage except in instances of fraud or intentional misrepresentation;³⁸
4. Mandating coverage of prevention services without cost sharing;³⁹ and
5. Requiring California health plans and insurers to submit rate increases to their respective regulators, DMHC or CDI.⁴⁰

California did not enact legislation related to all of the early ACA requirements. For example, Governor Schwarzenegger vetoed legislation that, among other things, would have imposed MLR standards for health plans and insurers as required by the ACA.⁴¹ In the absence of a specific state statutory MLR standard, CDI continues to use MLR regulations first established in the 1960s based on an Insurance Code provision requiring disability insurance benefits to be reasonable in relation to the premiums paid.⁴² CDI updated the MLR regulations in 2007 to impose a 70 percent lifetime loss ratio on individual health insurance policies.⁴³

In January 2011, CDI promulgated emergency regulations adding the federal MLR standards to the existing MLR regulations affecting group and individual health insurance under its jurisdiction. As of this writing, CDI-regulated insurers will be subject to enforcement of the federal MLR requirement by both federal DHHS and CDI, along with the state-only lifetime MLR referenced above. DMHC indicates that it will review MLR compliance as part of its overall review of health plan financial and legal compliance, but DMHC does not currently have specific state authority to enforce the federal MLR or to require health plans to report and file federal MLR data directly to DMHC.

Federal ACA Implementation Grants for California Market Reforms

In 2010, California applied for and received three federal grants to support implementation of the health insurance reforms in the ACA for the purposes of implementing premium rate review, consumer assistance programs, and a health insurance exchange.

Rate Review

The DMHC and the CDI jointly applied for and received a \$1 million federal grant to implement a premium rate review process for carriers in California. The proposal specified the departments would use the grant funds for: (1) information technology (IT) changes in each department, including upgrades to support electronic filing of rates by carriers through the national system developed by the NAIC; and (2) actuarial expertise to review rate filings submitted to DMHC and CDI. In the implementing state statute, California incorporated the requirement already in state law in the Insurance Code so that individual carrier rate filings are subject to independent actuarial review.

Consumer Assistance Programs

DMHC separately applied for and received a \$4.1-million grant to expand consumer assistance programs operated by the DMHC Help Center and the Office of the Patient Advocate, a sister agency to DMHC. The stated goal in the grant proposal is to provide a seamless Consumer Assistance Program (CAP) as a single point of entry for California consumers to obtain needed information about and assistance with health care coverage, regardless of the source of that coverage. As of this writing, the CAP funds will be used to:

- Promote a toll-free consumer assistance number and statewide Web site to help consumers with questions and complaints regarding health coverage, enrollment, and federal health care reform;

- Assist consumers with filing complaints and grievances, including referrals to appropriate state and federal agencies;
- Partner with community-based organizations in communities to provide assistance and information to individuals who are uninsured or enrolled in self-insured plans; and
- Conduct data collection, tracking, and evaluation of the consumer assistance program for reporting to state and federal policymakers.

Health Benefits Exchange

The California Health and Human Services Agency secured a \$1-million planning grant for California to begin implementation of the California Exchange. The Exchange Board has been constituted and has begun the process of implementation. The planning grant is supporting an intense year of planning, data gathering, and public and stakeholder engagement and education. Consistent with the grant proposal, CHHS is providing initial logistical and administrative support for the Exchange planning process and development of the Exchange infrastructure, along with temporary space and logistical support, until the Exchange board and staff are fully operational. The Exchange is developing a Level I federal establishment grant to obtain additional funding that will support continued planning and early implementation activities through June 2012.

V. California's Unique Context for ACA Implementation

LIKE OTHER STATES, CALIFORNIA WILL need to conduct an ongoing assessment of its role in enforcing ACA health insurance reforms as federal law and regulations are phased in over time. California is unique, however, in having two separate state agencies with authority to independently regulate and oversee different health coverage products, even to the point of PPO coverage products being regulated by two departments.

Forty-one states assign regulation of health coverage to the state insurance department or similar agency. As shown in Appendix A, 14 states have more than one department engaged in some oversight of health coverage products, but generally speaking, regulatory authority is delineated by functional area and combined with at least some oversight by the state insurance department. Dual regulation most often applies to managed care plans, including commercial and/or Medicaid HMOs. In 2004, Rhode Island established a new Office of the Health Insurance Commissioner and separated regulation of health insurance from oversight of other insurance lines under the Department of Insurance.

In California, because the CDI and the DMHC enforce different statutes, determining whether state law meets, exceeds, or fails to comply with federal law will be more complex than in most other states. For each issue and area of health reform, California will have to evaluate two separate bodies of law, regulation, and practice.

Those involved in state implementation of the ACA will also encounter terminology that is used inconsistently across state and federal law and between California's two regulatory agencies, as Table 1 on page 13 illustrates. These language

differences complicate the process of enacting and implementing consistent statutory provisions for similar product types. They also reduce consumer understanding of the different types of insurance products and the carriers offering them.

The Knox-Keene Act (enforced by the DMHC) includes statutory provisions and regulations that are similar to many, but not all, of the ACA requirements. California's Insurance Code (enforced by CDI) has some similar provisions to Knox-Keene and to the ACA, but in many cases there is no comparable state requirement that applies to carriers under CDI, such as a minimum set of basic benefits carriers must cover. At the same time, the Insurance Code has general provisions that apply to all lines of insurance, including health insurance, which are incorporated throughout law and regulations (e.g., the Fair Claims Settlement Practices regulations).⁴⁴ This means it can sometimes be difficult to determine what Insurance Code requirements apply to health insurance products under CDI.

Generally speaking, neither DMHC nor CDI can directly enforce provisions of federal law without state authority, but in some instances the departments may have related, similar, or broad state authority to enforce individual federal requirements. For many ACA provisions, effective state enforcement will require changes or additions to California law. This is also true for many other states.⁴⁵

In addition to CDI and DMHC regulations, other requirements and oversight may apply to carriers operating in California depending on the types of coverage they offer. For example, carriers that participate in publicly funded programs, such

as Medi-Cal managed care, must meet additional contracting requirements monitored by the Department of Health Care Services (DHCS). The Managed Risk Medical Insurance Board administers state and federal requirements specific to the Healthy Families Program (California’s Children’s Health Insurance Program) through contracts with licensed carriers.

All of these state laws, regulations, and contracting standards will need to be considered and should inform the implementation of the ACA in California.

Profiles of DMHC and CDI

DMHC regulates health plans covering 21.6 million lives, about eight times the number regulated by CDI (see Figure 1). In 2009, direct commercial enrollment constituted more than half of the lives covered by DMHC-regulated plans (11.8 million lives, or 55 percent); with the remainder enrolled in plans contracted with Medi-Cal and other public programs.

By comparison, the entire 2.6 million covered lives under CDI jurisdiction are in commercial health insurance products. CDI regulates the majority of the individual market in California—65 percent of an estimated 2 million Californians with individual health coverage—while DMHC regulates the majority of the insured group market—67 percent of the small group market (those with 50 or fewer employees) and 96 percent of the large group insured market. (See Figure 2.)

Enrollment data reveals that 93 percent of the covered lives under CDI are enrolled in health insurance products sold by eight national companies. These eight companies also have affiliates with some products licensed under the DMHC.

Note: DMHC enrollment may reflect double-counting of about 4 percent, due to Medi-Cal

Figure 1. Number of Covered Lives in Coverage Regulated by DMHC and CDI, 2005–2009

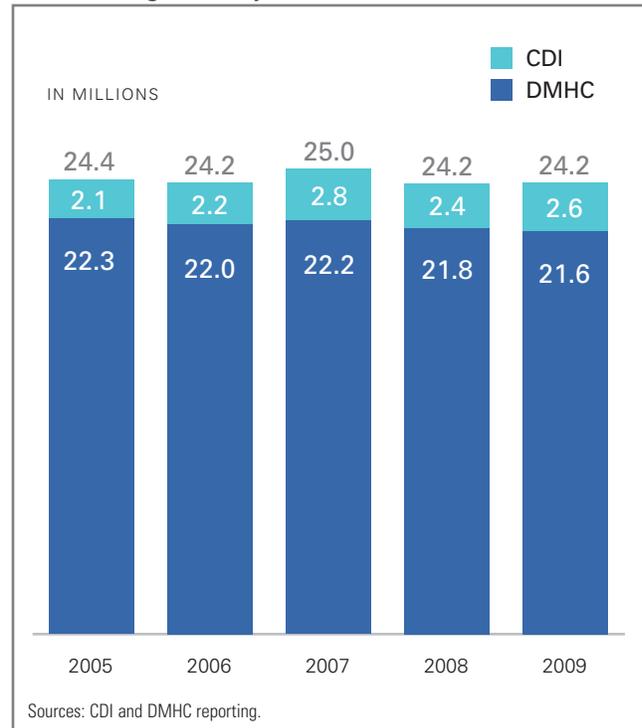
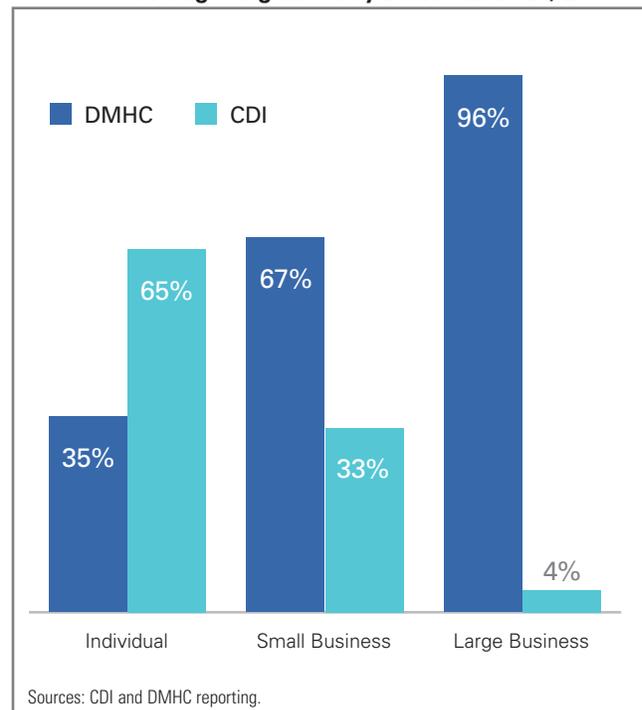


Figure 2. Share of Commercial Covered Lives in Coverage Regulated by DMHC and CDI, 2009



managed care reporting conventions. For example, the 2009 figure overstates enrollment by approximately 820,000.

Table 3 presents a profile of the two departments on key measures. Table 4 compares the two departments on select functional activities.

Table 3. Agency Profiles: Department of Managed Health Care and California Department of Insurance

	DMHC	CDI
Primary responsibility	Established in 2000 within the Business, Transportation and Housing Agency to take over jurisdiction of health plans from the Department of Corporations. Licenses and regulates full-service health plans offering comprehensive health coverage, as well as specialized health plans covering specialized services such as dental or vision services. Also oversees specific requirements related to medical groups contracted to provide services to plan enrollees on a capitation basis.	Licenses and regulates the rates and practices of 26 lines of insurance. Disability insurance covering health is one focus of a department with a broader scope of responsibility, including oversight of life insurance, workers' compensation, automobile insurance, and homeowners' insurance. Licenses insurance agents and brokers, including health insurance agents and brokers.
Statutory authority	Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code §1340 et seq).	California Insurance Code.
Governance	Director appointed by the Governor. Director serves in the administration with multiple levels of internal review and input on health policy and regulatory decisions. In ten years, two appointed directors and two acting directors during transition periods.	Since 1991, independent elected commissioner is the single arbiter on insurance policy and regulatory decisions. In 20 years since Commissioner became an elected position, there have been seven Commissioners, four elected. Of the elected Commissioners, none have served two consecutive terms, but one Commissioner served two terms, eight years apart. There have also been two appointed commissioners for interim periods totaling three years.
Licensees	Licenses 125 health care service plans, 70 full-service health plans, and 55 specialized health plans (behavioral, dental, vision, chiropractic, and Medicare) (April 2011). ⁴⁶	Issues certificates of authority to 1,500 insurance companies, including approximately 105 companies selling hospital, medical, and surgical reimbursement policies (7 percent of all companies) (2009). Licenses 340,000 agents and brokers of all types.
Covered lives	21.6 million lives covered by full-service health plans (2009).	2.6 million lives covered by major medical coverage (hospital, medical, or surgical) (2009).
Staffing	349.0 authorized positions (2010–11).	Estimated 1,204 personnel years, across all business lines, including health insurance. Includes 14 positions dedicated to gross premiums tax collection (2010–11). CDI staffing is not dedicated or allocated by type of insurance. ⁴⁷
Consumer complaints	50,000 consumer assistance contacts handled by the HMO Help Center, including 10,000 referrals to other state and federal agencies, such as CDI (2010).	19,000 health-related calls handled by Consumer Hotline, including approximately 4,000 referrals to DMHC (2010).

Table 3. Agency Profiles: Department of Managed Health Care and California Department of Insurance, *continued*

	DMHC	CDI
Independent medical review cases	<p>1,779 resolved in 2010:</p> <ul style="list-style-type: none"> • Experimental/investigational: 464 • Medical necessity: 920 • Emergency: 69 • Reversed by plan prior to IMR: 326 	<p>428 resolved in 2010:</p> <ul style="list-style-type: none"> • Experimental/investigational: 144 • Medical necessity: 275 • Withdrawn: 9
Department funding	<p>Estimated total expenditures: \$48.8 million (2010–11).</p> <p>No state General Fund support: Revenues are from licensing fees, annual health plan assessments, recoveries, and federal grants when available.</p>	<p>Estimated total expenditures: \$208 million (all lines of business) (2010–11).</p> <p>No state General Fund support: Revenues are from licensing and filing fees, examination fees, and recoveries and fines.</p>

Sources: DMHC and CDI staff and Web sites; Governor’s 2011–12 budget documents.

Table 4. Comparing Select Regulatory Functions of DMHC and CDI

	DMHC	CDI
Regulatory emphasis	Ability of the plan to provide or contract for services accessible to consumers.	Ability of the insurer to pay claims consistent with the policy.
Benefits	Specific mandated benefits plus “medically necessary basic health care services.”	Specific mandated benefits but no minimum benefit requirements.
Quality	<p>Routine medical surveys conducted by health professionals, including onsite reviews every three years to assess quality assurance programs including comprehensive reviews of utilization review, provider site reviews, enrollee grievance and appeals processes, and access to timely care.</p> <p>Required filings of utilization review processes and guidelines.</p>	<p>No oversight of the quality of medical care services or review of contracting providers.</p> <p>Similar language to Knox-Keene requiring insurers with utilization review programs to file the processes and guidelines being used.</p>
Provider accessibility	Plan must meet geographic accessibility standards and time-elapsd standards for access to services and providers.	Insurers contracting with providers in a PPO or Exclusive Provider Organization arrangement must meet geographic accessibility standards.
Provider arrangements	In addition to fee-for-service and discount rate options, plans may have risk-sharing arrangements with providers (e.g., capitation), subject to DMHC oversight and approval.	Provider payments limited to fee-for-service and negotiated discount rates. Oversight of provider payments limited to complaints.

Table 4. Comparing Select Regulatory Functions of DMHC and CDI, *continued*

	DMHC	CDI
Consumer complaints	<p>Health plans are required to have an internal grievance and complaint process that meets specified criteria to resolve enrollee grievances and appeals within 30 days, unless the issue is more urgent.</p> <p>After 30 days in the plan grievance process, or in cases DMHC determines warrant earlier review, consumers can appeal to DMHC, which must resolve and provide written disposition to consumers within 30 days.</p> <p>Independent medical review is available for medical necessity, experimental/investigational, and emergency services claim denials. Enrollee must complete health plan’s grievance process, except in more urgent cases.</p>	<p>Same as those applicable to all lines of insurance: consumer disclosure and required response times for claims communications under the Fair Claims Practices Act (market conduct).</p> <p>Complaints can be filed with CDI whether filed with the insurer or not. There is no time limit on CDI resolution, except that CDI must notify consumers within 30 days of resolution. If an insurer contests (denies) a claim it must notify the insured that it can appeal to CDI.</p> <p>Independent medical review for denials of care (language assumes an internal grievance process that is not otherwise specified in Insurance Code).</p>
Premium rates	<p>Effective January 1, 2011, plans must submit proposed rate increases in the individual and small group market 60 days prior to the effective date, including specified information and an independent actuarial analysis of the justification for the rates. Requires DMHC to publicly disclose the proposed rate increases.</p> <p>Prior to January 1, 2011, plans were only required to submit small employer rates for review of compliance with small group rating rules in state law.</p> <p>DMHC does not have the authority to reject a proposed rate increase.</p>	<p>New rate filings and public disclosure for proposed increases the same as DMHC.</p> <p>Prior to January 1, 2011, insurers were required to submit rates and rate increases for individual and small group coverage, subject to review by CDI actuaries, primarily for the purpose of ensuring compliance with regulatory medical loss ratio requirements of 70 percent for individual coverage and compliance with small group rating rules in state law. CDI actuaries also may raise issues with actuarial assumptions for a proposed rate increase and insurers may voluntarily adjust rates as a result.</p> <p>CDI does not have the authority to reject a proposed rate increase.</p>
Financial solvency	<p>Health plans must meet minimum required tangible net equity (TNE) based on the greatest of: \$1 million; 2 percent of premium revenues; or up to 8 percent of medical expenditures pursuant to a regulatory formula. Plans must also maintain restricted cash deposits of at least \$300,000 for full-service plans, or \$50,000 for specialized plans; or even higher, based on their exposure to non-contracted providers or when offering riskier products (POS). Health plans must also demonstrate to DMHC that they have a financially viable operation.</p>	<p>Insurers must have 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 under Knox-Keene.</p>
Fee and tax structures	<p>Annual “per enrollee” assessments and filing fees support DMHC operations.</p> <p>Health plans do not pay gross premiums taxes but are instead subject to applicable corporate and local taxes, such as the state bank and corporations tax (8.84 percent of profits). Nonprofits are exempt from bank and corporations tax.</p>	<p>Licensing fees, fines, and other filing fees support CDI operations.</p> <p>Insurers pay gross premiums tax (in lieu of other state and local taxes): 2.35 percent of total premiums annually, regardless of profit. One hundred percent of the revenues from the tax go to the state General Fund.</p>

Sources: DMHC, CDI, Joint Senior Level Working Group Annual Reports (multiple years).

Efforts to Maximize Collaboration, Consistency, and Coordination

There have been varying levels of informal collaboration and coordination between DMHC and CDI over time, and those efforts continue today. Observers report that many of the successful collaborations resulted from the initiative of department leaders with the support and cooperation of individual staff, or because of effective legislative oversight and focused advocacy. As early implementation of federal health reform progresses in California, DMHC and CDI report that they regularly communicate with each other and share information on reform implementation activities.

Policymakers have tried over the years to create more formal opportunities and expectations to encourage as much regulatory consistency and cooperation as possible. In 2002, for example, legislation required DMHC and CDI to establish and maintain a joint senior level staff working group and to report to the legislature annually.⁴⁸ The working group met and publicly reported on a number of issues including: consumer protection and outreach; independent medical review; statutes affecting internal grievance procedures; benefit disclosure; and arbitration processes. According to both departments, the working group still exists but the public reporting requirement ended after five years. Another example is the CDI- and DMHC-focused exams of carriers subject to the jurisdiction of both departments, which were conducted collaboratively by the departments to investigate potentially improper or illegal carrier rescissions of coverage.

Even with a mandate for coordination and communication, however, the two legal frameworks and approaches of DMHC and CDI are different enough to make joint efforts difficult. For example, in 2005, the joint senior level staff working group

studied companies with licenses from both DMHC and CDI to determine whether collaborative market conduct examinations by the two departments might be productive. The working group concluded that the two departments' examination processes were not comparable and that a collaborative market conduct examination would "require special effort."⁴⁹ Specifically, the work group reported that CDI and DMHC used different data collection and analysis methods in their market conduct processes and applied different standards for review of claims and claims practices making collaboration difficult. This example is illustrative of the inherent challenges in looking for opportunities for better coordination between CDI and DMHC.

California has also increasingly enacted parallel statutes applicable to carriers regulated by both departments, and has sought to formalize collaboration in legislative mandates for the two departments to consult on policy development and implementation. Managed care legislation—including the 1999 Patient Bill of Rights, the 2002 Provider Bill of Rights, and dozens of bills over the last decade—has increasingly included provisions applicable to health coverage under both the Insurance Code and Knox-Keene.^{50,51}

However, even identical statutory requirements can yield different results. As just one example, both health plans and health insurers are subject to state legislation enacted in 2002 to ensure enrollees have timely access to necessary health care services.⁵² CDI first adopted regulations that mirrored the long-standing geographic access standards which already applied to Knox-Keene health plans, for example, requiring that specialists be available within 60 minutes or 30 miles of an enrollee's residence or place of work. In 2010, DMHC adopted regulations implementing the 2002 law adding to its regulations a more rigorous time-elapsing standard: a health plan

must offer an appointment to a specialist within 15 days of an enrollee request. As a consequence, PPOs licensed under DMHC must meet both Knox-Keene geographic standards and the elapsed-time standards, whereas PPOs offered under the Insurance Code must only meet the geographic access standards. Under the DMHC standards, carriers may need to have more providers in the network to monitor and comply with the more rigorous DMHC access standards than carriers under CDI.

VI. Health Reform as a Catalyst for Making Sense of State Regulation

THE FEDERAL REFORM GOALS IN THE ACA present significant challenges that will necessitate enhanced predictability, reliability, accountability, and consistency for health insurance regulation in the state. The subsections below highlight some of the key goals of ACA insurance reforms and discuss the implications for insurance oversight in the state.

Consumer Choice

As one of its core principles, the ACA seeks to make the process of buying health coverage easier for consumers and purchasers. The ACA includes provisions designed to maximize transparency and disclosure, and to provide consumers with consistent, standardized information “in plain language” about their health coverage options. In order to facilitate informed consumer choice, policymakers, administrators, and clinicians must educate and engage consumers in a consistent and effective manner.⁵³ The ACA seeks to give consumers better information in specified areas through, among other things, federal definitions and standards for minimum essential health benefits and uniform disclosure requirements.

In California, however, application of any federal standards in day-to-day state oversight could be *interpreted or enforced* differently among products and companies between CDI and DMHC. For example, when California passed implementing legislation to require dependent coverage for children up to age 26, CDI initially required insurers to comply as of January 1, 2011, the effective date of the state legislation, while DMHC required plans to comply in any contract beginning or renewing on or after September 23, 2010, the effective date in federal law.

Ultimately, both departments adopted a consistent implementation date of September 2010, but the example illustrates how federal and state laws can be interpreted differently by the two departments.

Consumer Protection

The ACA establishes standards for benefits, coverage, and appeals intended to apply uniformly across all carriers and products. In the early days of California’s dual regulatory environment, CDI and DMHC regulated different types of coverage. As outlined in the section on the historical development of the two departments, both departments now regulate PPO and EPO product offerings, depending on which carrier is offering the product and the choice of regulator the carrier makes. Blue Shield of California and Anthem Blue Cross are able (but not required) to seek licensure for PPO/EPO products at DMHC and other carriers submit PPO and EPO offerings to CDI. Even though PPO/EPO products in the market are based on the same general approach to coverage, the PPO products regulated by CDI differ in the scope of benefits and coverage from the ones regulated by DMHC, due to the legal differences inherent in the two agencies and their legal foundations. This is true even for similar services such as coverage for hospital care.

For example, CDI-regulated PPO products covering hospital services can currently include specific dollar or day limits on covered hospital services, while DMHC-regulated products must cover medically necessary hospital services with no such limits. Carriers offering PPO coverage must also comply with different standards for provider access and waiting times, different consumer

complaint procedures, and other distinct regulatory requirements. These types of behind-the-scenes, fine-print differences are unlikely to be fully visible to or understood by consumers. In a consumer-oriented health care market as is contemplated under the ACA, all consumers selecting a similar product, such as PPO coverage, should be able to compare offerings and expect they will have the same basic legal protections and state oversight.

Product Compatibility

As stated earlier, the ACA includes numerous health insurance reforms that will reduce and eliminate many of the differences that currently exist between products under CDI and DMHC. These federal changes would significantly reduce the potential for major disruptions in product offerings were California to restructure its regulatory approach.

In past discussions about health insurance regulatory reform in California, policymakers and stakeholders were concerned that consumers would lose coverage choices if, for example, all health insurance products were moved to DMHC regulation (as was evaluated in the DMHC-commissioned Kelso report) and required to cover the minimum benefits under Knox-Keene, likely resulting in higher premiums for the transferred products.⁵⁴ For example, today many products under CDI do not cover maternity benefits but under current law DMHC carriers, including those offering PPO products, must cover maternity as medically necessary basic care. Under the ACA, however, maternity coverage must be offered by all carriers once reform is fully implemented. As another example, prior to the ACA, CDI-regulated carriers could impose lower annual and lifetime benefit limits than DMHC-regulated carriers were able to impose. Lifetime limits on essential health benefits are now

prohibited and annual limits will be phased out by 2014.

Efficiency

The ACA includes provisions that could reduce the administrative costs of health coverage, helping to make it more affordable for consumers to acquire and keep. Such provisions include establishing health insurance exchanges to lower marketing and distribution costs, and reforming underwriting rules to eliminate carrier costs associated with screening applicants for health coverage based on health status or pre-existing conditions.

California's two separate regulatory departments with different filing and licensing requirements, including assessments and other fees imposed on carriers to support the regulatory functions, results in duplicative and potentially unnecessary administrative costs for carriers subject to both regulators. Although carriers with business under both CDI and DMHC do not typically have two entirely different compliance units, complaint systems, contract templates, or utilization management programs to meet state standards, they are required to submit different regulatory filings and are subject to distinctly different regulatory reviews. Given that eight national companies cover 93 percent of the lives at CDI, and also have affiliated companies licensed by DMHC, most of the purchasers of health coverage in California today bear the costs of dual regulation.

Fair Competition

If state and federal regulations, licensing requirements, and enforcement are not consistent, the carriers or products subject to fewer requirements or less rigorous enforcement could have an unfair competitive and price advantage. In California, carriers regulated by CDI are subject to less stringent

provider access rules, have fewer requirements related to quality improvement and utilization review, and are not subject to oversight that is analogous to the DMHC medical survey. In addition, DMHC-regulated carriers must directly contract with or employ providers (except for out-of-network providers in PPO or POS plans), and have those provider contracts reviewed by DMHC. In contrast, CDI carriers may lease provider networks from other carriers or PPO companies, potentially reducing their administrative costs.

Establishing comparable standards and requirements for all carriers will be important to promote fair competition based on price and quality as envisioned in the ACA.

Risk Spreading

The current voluntary health insurance market, especially the market for individually purchased coverage, creates strong incentives for insurers to avoid high-cost and high-risk enrollees.⁵⁵ Fears of adverse selection (enrollment of high-cost and/or high-risk individuals) and the natural drive to maximize revenue, cause carriers to implement strategies in the pursuit of low-cost, healthy enrollees. In the past, these strategies have included limiting coverage for pre-existing medical conditions, imposing waiting periods before coverage becomes effective, or refusing to cover some individuals at all.

The ACA seeks to eliminate risk segmentation through mandating coverage for individuals, eliminating pre-existing condition limitations, requiring carriers to accept all applicants regardless of health status, and eliminating rating based on health risk or health status. In addition, the ACA requires carriers to treat all of the individual policies both inside and outside of an insurance exchange as one risk pool for rating purposes, eliminating product

pricing based on the risk and costs associated with individuals who buy one specific product.

Another way for insurers to attract healthy persons is through design of benefit packages that selectively appeal to low-risk persons, such as coverage with higher deductibles, higher limits on out-of-pocket costs, tighter provider networks, and caps on benefits.⁵⁶ Healthier individuals will generally select a lower-priced option and the less healthy will select a plan with more comprehensive coverage.⁵⁷

Federal minimum benefits and elimination of annual and lifetime benefit caps under the ACA should, if uniformly enforced, greatly reduce the ability of carriers to use benefit design strategies for risk selection, increasing consumer protection and transparency. Carriers' ability to implement these types of benefit design strategies under current California law depends on whether the products are regulated by DMHC or CDI. Products sold under CDI jurisdiction have fewer benefit requirements and fewer restrictions affecting consumer cost-sharing levels than those subject to DMHC oversight. Even though there will be one set of essential benefits required under federal law, if ACA provisions are not uniformly defined, interpreted, applied, and enforced, as could readily happen with two regulators, the relative regulatory differences could allow carriers to continue to use pricing and product design to avoid high-risk, high-cost individuals.

Exchange Marketplace

Legislation establishing the California Health Benefit Exchange intends that all carriers operating in the Exchange will comply with common standards and meet uniform selection criteria. In addition, under California law, carriers in the Exchange will have to offer the same products outside of the Exchange. At the same time, most observers and stakeholders agree that the Exchange should not take on the role

of an additional regulator in the market. This means that there will likely be a role for state regulators to review, assess, and enforce compliance with key ACA and Exchange-specific requirements for participating California carriers.

In addition, the NAIC has warned that health insurance exchanges in general are at risk for adverse selection and has highlighted specific issues and concerns that could have that undesirable effect on exchanges.⁵⁸ NAIC points out that one of the resulting two markets (the exchange or the outside market) could become the equivalent of a state high-risk pool if one market is able to offer stripped-down plan designs while the other is required to offer more robust options. Given the goal of creating a competitive and sustainable marketplace in the California Exchange, consistent and reliable regulation of all products across all markets will be essential to sustain an appropriate risk balance.

Mandatory Uniformity

The ACA specifically requires states to apply the new PHS Act standards and requirements *uniformly* to all issuers in the state. In addition, the California Health Benefit Exchange will have the authority to certify, recertify, and decertify qualified health plans that will be offered through the Exchange. It will also set minimum criteria for selective contracting with plans that meet standards “in the best interests of qualified individuals and qualified small employers.”⁵⁹

The California Exchange legislation requires it to “consistently and uniformly apply... requirements, standards and criteria to all carriers.”

Compliance with state and federal uniformity requirements will be more difficult to accomplish with two state regulators and will necessitate clear and unambiguous state standards and active legislative oversight of the enforcement of those standards across all products and markets.

VII. Options for Reforming Health Insurance Regulation in California

THE NEW IMPERATIVES AND OPPORTUNITIES for health reform under the ACA necessitate a comprehensive review of how health insurance is regulated in California. Most observers agree that implementation of the ACA, including the creation of the California Exchange, will intensify the challenges presented by the existing dual regulatory approach. It is likely that these implementation challenges will motivate policymakers to revisit options for reshaping and reforming California's health insurance regulatory scheme.

This section identifies criteria that may be helpful in evaluating regulatory reform options. It also includes specific reform options that are offered as a starting point for discussion; these options could be considered separately or in some combination.

Criteria for Evaluating Reform Options

- **Improve the consumer experience.** The most compelling reason to implement regulatory reform is to improve the consumer experience, making it easier for consumers to understand their coverage choices, access health services when they need them, and get timely assistance when there are problems or issues with their coverage. Moreover, many of those who will be newly insured under the ACA have been without health coverage for long periods and may have little background, experience, or sophistication navigating the complexities involved in accessing care and securing coverage. A recent Kaiser Family Foundation study found that most enrollees in new exchanges will transition from being uninsured and having experienced significant access barriers.⁶⁰ New

Exchange enrollees are also likely to be older, less educated, lower income, and more racially diverse. Policymakers should evaluate regulatory reform options accordingly, with a focus on making sure regulatory reforms maximize the consumer benefit from ACA reforms. Regulatory improvements should also consider the needs and interests of newly insured consumers who may be less knowledgeable about their rights and responsibilities under their new coverage plans.

- **Ensure transparency and accountability.** As health reform is implemented, it will be essential to have adequate resources and commitment to monitor and track reform impacts. Policymakers will need accurate and timely information about market trends, the pace of coverage expansions, and the impact of various reforms being implemented at the state and community levels. To this end, transparent, timely, accurate, and understandable data collection and monitoring will be essential.
- **Ensure consistent interpretations of federal law.** At this early stage, it appears that the implementation of new federal market reforms will rely heavily on state regulators for enforcement of many provisions. If California's two state regulators interpret or enforce the provisions differently, carriers and other stakeholders may seek out or support the regulator with the interpretation most favorable to their business or policy interests. This result has the potential to encourage risk segmentation in the market, diminish the consumer experience, and interfere with the successful operation

of the Exchange. Consistent application and interpretation of state and federal ACA-related requirements will be a critical factor in the effectiveness of regulatory reform.

- **Evaluate potential system costs and savings.** To the greatest extent possible, regulatory reform should result in streamlining administrative requirements and reducing associated administrative costs. Regulatory reform is not likely to be successful if it includes a new laundry list of requirements and standards in addition to what has already been in place. Focus should be given to eliminating outdated or duplicative requirements and promoting meaningful, measureable standards and enforcement strategies that improve transparency and access to quality care for consumers. For example, increasing federal requirements and greater standardization may reduce or change the role of up-front state licensing and product approval, permitting streamlining of the process without compromising consumer protections. In addition, policymakers should assess state costs and other impacts that may result from regulatory reform, such as changes to the relative tax burden of different carrier types.
- **Build on the strengths of the existing regulators.** DMHC and CDI have different relative strengths. Given the breadth and extent of the ACA reforms, the state will be best served if it draws on the resident expertise and experience of both departments as California moves to implement federal health reform.

OPTION 1:

Consolidate Regulation in One State Agency

This review found virtually no defenders of the existing complex and duplicative regulatory environment in California. Stakeholders agreed that having two legal frameworks and two regulators as they are currently configured is confusing, costly, and cumbersome.

Consolidating oversight into one state department could increase accountability, improve efficiency, and reduce costs. Consolidation would require significant analysis and comparison of the statutory and regulatory purviews of each department, as well as the legal, operational, and organizational changes necessary to effectively combine regulatory jurisdiction. In addition, merging or consolidating two departments under the jurisdiction of two independent elected officials, the Governor and the elected Insurance Commissioner, would involve important political and logistical considerations. Finally, any significant reorganization would require attention to the regulatory history and cultures of each department and would need to incorporate effective change management strategies and leadership development. That type of detailed analysis and planning is beyond the scope of this report.

Based specifically on key elements of the ACA, some considerations and discussion on the relative advantages for the state from moving jurisdiction to either DMHC or CDI are presented below.

Moving Jurisdiction to DMHC

Consolidation within DMHC would disrupt coverage for a smaller number of consumers than consolidation at CDI simply because DMHC has responsibility for the vast majority of covered lives. As the stand-alone state agency with an exclusive focus on health plan licensure, DMHC is in a

strong position to dedicate its staff and resources to implementing federal reform. DMHC's statutory emphasis on managed care, and the expertise it has developed in regulating integrated delivery systems, are consistent with some provisions of the ACA, including new payment approaches and care delivery arrangements in ACOs. Key pieces of the ACA address health coverage issues that the DMHC already regulates, including minimum benefits, access to care, monitoring of quality and quality improvement, and oversight of integrated delivery models with complex risk-sharing and provider contracting arrangements.

Since its inception, DMHC has been mandated to focus on consumer protection, education, and transparency, and has developed an infrastructure for those functions through its Web site, the HMO Help Center, and the Office of the Patient Advocate. As the federally funded lead agency in the state's Consumer Assistance Program, DMHC is well-positioned to expand on its consumer assistance activities. Finally, the placement of DMHC within the state administration creates important opportunities for shared leadership and resources, and collaboration with other state agencies and programs that will be impacted by federal reform.

Moving Jurisdiction to CDI

As the state insurance agency, CDI has experience with rate review and rate regulation for other lines of insurance. It has actuarial and legal expertise that will be important in related aspects of ACA implementation, including premium rate review, MLR enforcement, and defining products in the reformed market by their actuarial value.

In addition, CDI is California's representative and sole voting member of the NAIC. The NAIC has been given a leadership role in many aspects of reform implementation under the ACA. Thus,

CDI has access to national expertise, resources, and relationships that strengthen its ability to analyze and administer key aspects of health reform, and to conduct oversight of national health insurance companies doing business in California. As an NAIC member, CDI will be positioned to translate and interpret insurance market reform terminology and concepts as they are developed by the NAIC and federal agencies.

CDI's licensure and regulation of insurance agents and brokers provides the Insurance Commissioner with a network of resources in communities that potentially can serve as an early warning system for troublesome market trends and access barriers.

Potential Pitfalls and Unintended Consequences

Because of the different legal requirements and approaches of CDI and DMHC, without specific statutory changes, reorganization could limit availability of some products or plans in the market. For example, products moving from CDI to DMHC would be newly subject to the increased benefit mandate of basic health care services under Knox-Keene, which could prematurely eliminate products now sold before federal minimums become effective in 2014. National insurance companies with CDI-regulated products, and for whom California represents a small percentage of their business, may not find it cost-effective to gear up to meet Knox-Keene consumer grievance, quality assurance, and quality improvement requirements to the extent state requirements exceed new federal standards in those areas.

Conversely, smaller carriers under DMHC, including carriers where the majority of the covered lives are enrolled in public programs such as Medi-Cal and Healthy Families, might be stretched to establish higher financial reserves if required to do

so under the CDI risk-based capital standard. Finally, less rigorous access standards at CDI currently enhance the ability of carriers to offer PPO and EPO products in rural communities. These carriers could have difficulty meeting Knox-Keene access standards without waivers because of severe provider shortages in those communities.

If California's agencies were consolidated during implementation of health reform, another possible effect would be overburdening state government as well as stakeholders. During the transition to regulatory consolidation, current efforts devoted to federal reforms could be delayed or compromised. Successful implementation of health reform will require not just coordinated implementation and enforcement of health insurance standards, but integration and cooperation related to many state-level programs and activities, including public programs, provider licensing, health information and data exchange, and the operations of the California Exchange. Changes in state leadership and responsibility during the transition could be confusing and problematic for consumers, providers, purchasers, carriers, and state and federal agency partners unless carefully implemented.

Potential Strategies to Minimize Negative Impacts

If the state moves to consolidate regulatory oversight at the same time it works to implement the ACA, policymakers should consider adopting one or more of the following to mitigate potential unintended consequences and to ensure effective consolidation of regulatory responsibility.

- **Phase-in.** To ensure effective and timely implementation of the ACA, the timeline for regulatory consolidation could be phased in consistent with federal reform timelines. This could include providing transitional licenses for

carriers moving products from one department to another, or assigning specific compliance deadlines for key standards (such as minimum essential benefits) in line with ACA timelines. Phasing in and realistically rolling out any regulatory reform at the state level would help avoid premature market disruption and limit confusion for consumers, providers, and carriers. Since the timeline for federal reform is relatively short, it would be advisable for state regulatory reform at this stage to be focused entirely on the tools and structure that would be needed for the state to consistently manage implementation of federal reform. Clear timelines for transition and consolidation, and certainty about the requirements that would apply to various products at key milestones along the way, would benefit all stakeholders.

- **Reorganize by product.** One organizing principle for consolidation might be to merge oversight of like products such as PPOs and EPOs in one department, or in a division within one department, and to do so based on whether the products would be subject to federal ACA reforms. For example, pure indemnity products under CDI, such as cancer-only or hospital-only policies, might not be compatible with regulation of more comprehensive products that would have to cover minimum essential benefits and meet other ACA benefit requirements. Traditional indemnity policies without any managed care components also might not be compatible with the vast majority of products sold in today's market, or with the objectives of federal reform. CDI does not track the exact numbers of traditional indemnity or PPO/EPO policies under its jurisdiction, but most observers agree that there is little, if any, pure indemnity health insurance remaining in California's market. In

any event, it would be important to identify the particular requirements and regulatory oversight that would apply to each product type.

- **Clear lines of authority.** Any consolidation effort would need not only to revise and set clear standards for the regulated entities, but also to include both transitional and long-term lines of authority for the remaining regulated entity or entities and affected state agencies and departments. During and after the transition, policymakers would need to ensure that communications among all state agencies implementing the ACA, including the Exchange, were maintained and strengthened. This could be accomplished through a state-level working group charged with overseeing and managing the transition to one regulating agency. California would also need to address the state's voting representation in the NAIC on health insurance issues and, through state legislation or gubernatorial delegation, assign California's voting member on health issues and provide notice to the NAIC, if it needs to be a different state official other than the elected Insurance Commissioner.

OPTION 2:

Institutionalize Coordination and Consistency

Consolidation of regulation in one agency is the course most likely to maximize efficiency, effectiveness, and uniformity in implementing the ACA market and coverage reforms. However, if California continues to have two separate state agencies regulating health coverage, policymakers should consider policies and strategies to promote and prioritize greater consistency and cooperation between CDI and DMHC. While there are examples

of formal and informal collaboration and cooperation between CDI and DMHC over the years, this report also highlights significant instances where identical state laws yielded very different regulatory standards and approaches—even for products that are otherwise similar in the market. The different approaches, requirements, and interpretations could weaken the goals and the impact of health reform, including California's implementation of a competitive Exchange marketplace.

In the early stages of reform implementation, CDI and DMHC have made efforts to communicate regularly at the staff and leadership levels, and to share information and expertise. ACA implementing legislation enacted last year required consultation between the two departments, and in some instances joint regulation. In many cases, the interpretation and guidance issued have been consistent and collaborative. However, there have already been instances of different requirements and processes for carrier compliance, such as varying formats for carriers to report their compliance with new market reforms in the Fall of 2010, and different MLR standards.

Below are some possible options and suggestions for improving coordination and consistency between CDI and DMHC.

Require Regulatory Consistency

One option to formalize collaboration and consultation would be to require by statute that CDI and DMHC work to ensure consistency in the implementation of the ACA. This requirement could be combined with joint reporting on coordination activities and legislative oversight of how and to what extent the requirements are met. As far back as 1984, legislation relating to the now defunct category of nonprofit hospital service plans under the Insurance Code included broad language requiring

the Insurance Commissioner and the Commissioner of Corporations (the predecessor department to DMHC) to consult prior to adopting any regulations affecting nonprofit hospital service plans, for the purpose of “ensuring, to the extent practical, that there is consistency of regulations...”⁶¹ The Insurance Code language was deleted when the nonprofit hospital service plan law was repealed, but the requirement still remains in Knox-Keene.⁶²

The implementation demands of the ACA may require a renewed statutory requirement for consultation and collaboration. To emphasize the importance of consistency in implementing guidance and regulations, policymakers could require DMHC and CDI to adopt identical ACA implementation regulations, absent a specific finding that there is a reasonable policy rationale for different standards.

Reinvigorate the Joint Senior Level Working Group

A joint senior level working group of DMHC and CDI still exists, although it is no longer subject to an annual reporting requirement. Health reform implementation tasks and new reporting requirements could be assigned to the working group. If rededicated to collaborative implementation of health care reform, the existing working group, made up of senior staff from both CDI and DMHC, could facilitate legislative and public oversight of ACA mandates, regularly reporting to policymakers and the public on its joint assessments and activities, and facilitate legislative and public oversight of ACA mandates.

Require Timely Public Reporting

Both DMHC and CDI have been posting their guidance and regulations regarding the ACA on their respective Web sites, but have not always made the operational activities and documents for

implementing reform (such as, for example, carrier compliance filings) publicly available. The more transparent the regulatory and enforcement process is, the more likely that there will be an emphasis on consistency and serious oversight by policymakers and stakeholders when differences emerge. Transparency should also apply to the state’s activities in federal forums such as the NAIC that have been assigned new responsibility and authority under the ACA. State policymakers could seek to ensure that both DMHC and CDI have regular input and meaningful participation in the NAIC, consistent with their respective state roles, and that CDI seek input from and provide information to policymakers and stakeholders regarding NAIC activities, proposals, and standards.

Improve and Consolidate Data Collection

For decades, it has been difficult and sometimes impossible to get basic data regarding the companies, covered lives, products, and processes regulated by CDI and DMHC. To be fair, the departments individually provide varying degrees of access to information, and data needs have fluctuated as policymakers confront new and different problems to solve. As the state tackles health care reform, good data and consistent information about markets and products will be more important than ever. Clear, specific, and consistent data reporting requirements for DMHC and CDI, in conjunction with the Exchange, would help ensure that there is reliable information by which to monitor and adjust oversight and implementation of market reforms.

Require Joint Public Reporting on the ACA

One approach to promoting consistency and collaboration between CDI and DMHC could be to require by law that ACA-related postings by both departments be done in a consistent format

at a centralized shared Web site, dedicated for that purpose and linked to the state's health reform site. Policymakers could also require that both departments publicize on the common Web site any differences in guidance, regulation, or enforcement when they occur, including the rationale and the meaning for consumers of different requirements or standards. The goal of this option would be to maximize public and stakeholder awareness of the steps each department is taking to implement and enforce the ACA, and to shine a public spotlight on the day-to-day operational impact of having two separate regulators.

Realign Statutes and Regulations

One of the barriers to consistent regulation and enforcement between DMHC and CDI is the very different statutory frameworks under which each functions. Implementation of the new federal rules under the ACA will, at a minimum, require California to review and revise both the Insurance Code and Knox-Keene as appropriate to comply with and incorporate federal insurance reforms. This could also make possible a more thorough statutory overhaul, to both reconcile state law with the new federal requirements, and to reconcile differences between Knox-Keene and the Insurance Code.

A statutory review could also evaluate potential legislative options to encourage and promote voluntary consolidation of products within one agency consistent with the significant changes in the ACA. For example, the review could clarify that any PPO product could be licensed under DMHC, rather than just the PPO products of two companies allowed under DMHC through historical exceptions. This change could result in companies choosing over time to consolidate all of their HMO and PPO products under one regulator, DMHC, given that the ACA requirements already impose consistent benefit,

cost sharing, MLR, and rate review standards on all products.

Realigning statutory and regulatory standards could also impose consistent product definitions and permit greater emphasis on model-specific regulation and standards for HMOs, PPOs, and EPOs, as well as newly emerging delivery models such as ACOs (see box on page 39), rather than department-specific standards. For example, the DMHC Financial Solvency Standards Board, in collaboration with experts at CDI, could recommend specific and consistent solvency standards appropriate for all carriers and coverage model types.⁶³ In considering the appropriate standards for each coverage type, it would be critical to review the relative regulatory burden. For example, having more stringent requirements by type of product could result in similar disadvantages and advantages for carriers selling the products not unlike those that exist today between products regulated under Knox-Keene versus those under the Insurance Code.

Mandate Functional Consolidation

Both DMHC and CDI have different relative strengths as regulating agencies. As part of state implementation of the ACA, policymakers could consider voluntary or mandatory functional integration on an issue-specific basis using the relative strengths of each regulator. State implementation planning could require one department to take the lead on specific elements of the ACA; authorize or require memoranda of understanding between CDI and DMHC for that purpose; or mandate joint audits and field surveys related to ACA compliance.

For example, legislation could consolidate at the CDI review of premium rate filings and certification of the actuarial values of products to be sold after 2014. This would build on the CDI's staff and expertise in this area. Alternatively, joint purchasing

Accountable Care Organizations

The ACA requires the federal DHHS to establish by January 1, 2012 a Medicare “Shared Savings Program” intended to encourage providers to create new accountable care organizations (ACOs). The ACA calls for ACOs to be held accountable for improving individuals’ health and experience of care, improving the health of populations, and reducing the growth in health care expenditures.

On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) released a 429-page proposed rule for Medicare ACOs, which is subject to a 60-day comment period. The proposed rule broadly identifies entities eligible to be ACOs, including physicians and hospitals in group practice arrangements, networks, partnerships, or joint ventures; and hospitals employing physicians. Proposed ACOs must accept responsibility for 5,000 Medicare fee-for-service beneficiaries and may choose one of two program tracks. The first allows for shared savings for two years, transitioning to risk for shared losses in the third year. The second track allows ACOs to share in savings and assume risk for losses starting the first performance year, in return for a higher share of any savings generated.

In many respects, California is ahead of many other states in the development of payment and structural models that assign patients on an at-risk basis to organized and integrated delivery systems. California’s prevalent delegated model relies on HMO risk contracts with multispecialty medical groups receiving capitation payments—fixed monthly per-patient payments—to manage primary and specialty care for the HMO’s patients. The largest contracting medical groups must separately meet Knox-Keene financial and reporting standards as risk-bearing organizations (RBOs). The proposed federal ACO rules, however, would increase the standards, quality measures, and incentives for quality and financial management beyond what is typically in place in for existing RBOs and other medical groups in California.

According to CMS, the proposed ACO rules would make each ACO responsible for routine self-assessment, monitoring, and reporting of the care it delivers, and

would establish quality performance measures and methods for linking quality and financial performance. To achieve savings, ACOs would also be required to meet 65 quality standards encompassing five categories: (1) patients’ care experience; (2) extent of care coordination; (3) patient safety; (4) emphasis on preventive health; and (5) the health of frail elderly and at-risk populations.

CMS also proposes that ACOs be recognized and “authorized to conduct its business” under applicable state law and be capable of: (1) receiving and distributing shared savings; (2) repaying shared losses; (3) establishing, reporting, and ensuring ACO partners comply with program requirements and quality standards; and (4) performing the other ACO functions identified in the statute.

Under California law, DMHC is assigned sole responsibility for the evaluation and oversight of risk-bearing entities, including both health plans and RBOs contracting with health plans, such as physician medical groups. Policymakers expanded DMHC’s authority in this area following several high-profile financial failures of capitated medical groups in the early 1990s.

There is still much to be understood about how ACOs will operate, including the extent to which the model will be widely adopted outside of Medicare. The proposed federal rule raises potentially significant issues for California’s regulatory environment. For example, it is unclear whether the existing RBO framework and DMHC oversight would be sufficient to comply with the federal requirements for state recognition, or appropriate for newly created ACOs if they are more hospital-centric than medical group-centric.

Implementation of the ACO concept is one further example of how implementation of the ACA will necessitate serious review and possible revision of California law and regulation to ensure effective implementation and oversight. For more information about ACOs and California’s related history, see the December 2010 CHCF publication, *Accountable Care Organizations: Avoiding the Pitfalls of the Past*.

of independent actuarial expertise or a joint working staff group could be responsible for those activities. DMHC might assume responsibility for ensuring compliance with minimum benefit standards for all carriers subject to the federal essential benefits requirement.

In addition, the Exchange could require all carriers interested in participating as qualified health plans in the Exchange to have their networks and quality assurance systems reviewed by the DMHC for compliance with federal and state certification standards. Finally, a particular opportunity might arise to develop joint auditing tools and processes for carriers with affiliated companies under the jurisdiction of both departments.

In considering integration of key functions, policymakers would need to ensure that both regulators retained the tools and information to actively monitor and regulate carriers under their jurisdiction. For example, provider access challenges with a health plan often signal solvency issues, and rate filings can provide information to inform regulatory review of provider payment arrangements.

VIII. Conclusion

THE PURPOSE OF THIS REPORT IS TO jumpstart a conversation among policymakers, insurers, regulators, and the public about health insurance regulation in California and the future policies and structures that will be needed under health reform. Fulfilling new obligations and seizing new opportunities under the ACA will require enhanced accountability and consistency in California's regulation of health insurance. Retaining California's bifurcated system could seriously limit the impact of the federal reforms in the state.

Reforming and improving California's health insurance regulatory structure will take serious discussion, analysis, and planning among all stakeholders. Most of the ideas included here would require state legislation to implement and effective legislative oversight to ensure success.

The time leading up to full implementation of the ACA is short. The conversation about regulatory reform needs to begin in earnest now, leading to consideration of potential legislation by early 2012, in order to ensure that California has a highly effective and efficient regulatory system in place to support full implementation of the ACA beginning in 2014.

IX. Methodology

IN PREPARING THIS REPORT, KELCH Associates held three in-person stakeholder advisory meetings with consumer advocates, carriers, and key legislative staff. In addition, Kelch Associates conducted numerous formal and informal interviews with key stakeholders and experts. The research also included consultation with other states to develop the overview of state regulatory models included here. Staff and leadership at both the DMHC and the CDI were helpful and cooperative in meeting, providing information, and responding to inquiries.

This report also builds on and incorporates many of the impressions and findings from previous reports and analyses of the issues stemming from California's dual regulation of health insurance. Kelch Associates reviewed numerous state and national reports, articles, Web sites and documents as background for this report.

Endnotes

1. Roth, D.L. and D. Kelch. *Making Sense of Managed Care Regulation in California*. California HealthCare Foundation, 2001 (www.chcf.org).
2. Ibid.
3. The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 are collectively referred to as the Affordable Care Act (ACA).
4. Examples of where the federal government had oversight of health insurance prior to the ACA include: The U.S. Department of Labor oversees many aspects of employer-provided health insurance benefits under the Employee Retirement Income Security Act of 1974, known as ERISA; federal law and standards govern continuation coverage pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA); and the federal Centers for Medicare and Medicaid monitor and set standards for managed care programs serving individuals in the two public coverage programs.
5. Wilson, K.B. *Health Insurance in California: A Recent History*. California HealthCare Foundation, 2011 (www.chcf.org).
6. Knox-Mills Health Plan Act (Chapter 880, Statutes of 1965).
7. AB 78, Chapter 525, Statutes of 1999.
8. Wilson.
9. California Physicians' Service v. Garrison, 28 Cal.2d 790 (1946).
10. Department of Managed Health Care and California Department of Insurance. Joint Senior Level Working Group. SB 1913 *Annual Report, Appendix X: Comparison of Claims Settlement*, December 12, 2003.
11. California Insurance Code §10133 (c).
12. AB 3480, Chapter 329, Statutes of 1982.
13. For more information about how the two companies were authorized or required to sell PPO business under Knox-Keene, see Roth and Kelch, *Making Sense of Managed Care Regulation in California*.
14. SB 1221, Chapter 987, Statutes of 1993.
15. Managed Health Care Improvement Task Force. *Improving Managed Health Care in California (Volumes 1–3)*. January 1998.
16. Following the Managed Health Care Improvement Task Force recommendations, California's State Auditor, under the direction of the Joint Legislative Audit Committee, conducted a series of analyses and program reviews related to the regulation of health plans in California. In 1998, the Auditor recommended that health plan regulation be moved from the Department of Corporations to a new or existing department under what was then the Health and Welfare Agency. In 1999, two reports found continuing issues and challenges with health care payments and consumer protections under the oversight of the Department of Corporations. All three reports are available online at the State Auditor's Web site at www.bsa.ca.gov.
17. AB 78, Chapter 525, Statutes of 1999.
18. AB 78, Chapter 525, Statutes of 1999.
19. Kelso, J.C. *Regulatory Jurisdiction Over Health Insurance Products: The Department of Managed Health Care and The Department of Insurance*. November 26, 2001. Obtained online at www.hmoHELP.ca.gov.
20. Long, P. and J. Gruber. "Projecting the Impact of the Affordable Care Act On California." *Health Affairs* 30, No. 1 (2011): 63–70.
21. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most pension and health plans voluntarily established by employers, and provides protection for individuals in these plans. ERISA requires plans to provide participants with plan information including features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

22. Federal Register. Volume 75, No. 230. December 1, 2010. [45 CFR Part 158]
23. Federal Register. Volume 75, No. 230. December 1, 2010. [45 CFR Part 158.240; 158.601-158.615]
24. Federal Register. Volume 75, No. 230. December 1, 2010. [45 CFR Part 158, §158.211]
25. Federal Register. Volume 75, No. 230. December 1, 2010.
26. On May 23, 2011, DHHS issued the final rate review regulation subject to a 60-day comment period.
27. U.S. Public Health Service Act §2794.
28. Federal Register. Volume 76, No. 99. May 23, 2011. [45 CFR Part 154]
29. Kaiser Family Foundation and Georgetown University Health Policy Institute. *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable*. December 2010.
30. AB 1672, Chapter 1122, Statutes of 1992.
31. National Association of Insurance Commissioners. February 28, 2011. Letter to Secretary Sebelius commenting on the December 23, 2010 proposed rate review regulation.
32. 45 CFR Subpart C §154.301.
33. Title I of the ACA generally includes changes to the Public Health Service Act applicable to private health coverage and provisions applicable to the Health Benefit Exchanges.
34. National Association of Insurance Commissioners. *Preemption and State Flexibility in PPACA*. 2010. Obtained online at www.naic.org.
35. SB 900, Chapter 659, and AB 1602, Chapter 655, Statutes of 2010.
36. AB 2244, Chapter 656, Statutes of 2010.
37. SB 1088, Chapter 660, Statutes of 2010.
38. AB 2470, Chapter 658, Statutes of 2010.
39. AB 2345, Chapter 656, Statutes of 2010.
40. SB 1163, Chapter 661, Statutes of 2010.
41. SB 890 of 2010.
42. CA Insurance Code §10293.
43. CCR Title 10, Chapter 5, §2222.10-2222.19. Filed December 29, 2006; operative March 29, 2007. Register 2006, No. 52.
44. California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Article 1, §2695.1-§2695.17.
45. National Association of Insurance Commissioners. *Survey of State Authority to Enforce PPACA Immediate Implementation Provisions*. August 5, 2010. Obtained online at www.naic.org.
46. Among the total of 70 reported full-service plans licensed by DMHC, 15 are double-counted due to a second filing as a “Quality Improvement Fund” (QIF) plan for Medi-Cal purposes.
47. It is difficult to identify an analytically sound method of estimating CDI personnel or workload focused on the regulation of carriers under CDI. This is because CDI enforces different statutory requirements for each line of business and organizes staff by regulatory function across all lines of business. In addition, the Rate Regulation Branch of CDI is primarily dedicated to rate regulation for property and casualty insurance, such as auto insurance, under the provisions of Proposition 103 and is not currently involved in review of health insurance rates. According to CDI, the Health Actuarial Office, which includes four actuaries, conducts the reviews of health insurance rates. The staffing structure at CDI means that an estimate of health insurance workload based on, for example, applying the percent of total companies under CDI jurisdiction which sell health insurance (7 percent) across the board to the total personnel years at CDI would not take into account an entire branch primarily focused on one line of non-health insurance. Both CDI and DMHC are implementing 2010 rate review legislation in compliance with the ACA, and both departments requested dedicated positions and consultant resources for that purpose as part of the 2011–12 state budget. The new rate review standards presumably will have the effect of focusing additional resources within the Health Actuarial Office of CDI on health insurance rates. As of this writing, however, the authors of this report

- could not identify a sound method for estimating overall CDI staff resources dedicated to the regulation of health insurance.
48. SB 1913, Chapter 793, Statutes of 2002.
 49. DMHC and CDI. *Annual Report of the Senior Level Work Group*. January 2006.
 50. California's "Patient Bill of Rights" is a 21-bill package of 1999 legislation sponsored by consumer advocacy groups establishing standards and requirements in managed care delivery systems, including mandatory coverage of medical second opinions, timelines for prior authorization, access to patient medical records, patient confidentiality protections, and independent medical review of health care service denials.
 51. AB 2907, Chapter 925, Statutes of 2002.
 52. AB 2179, Chapter 797, Statutes of 2002.
 53. Brandeis University / The Heller School for Social Policy and Management. *Policy Brief: Consumer Education and Patient Engagement to Ensure the Benefits of Health Reform are Achieved*. July 16, 2010. Obtained online at www.sillermancenter.brandeis.edu.
 54. Kelso.
 55. Blumberg, L. J. *Addressing Adverse Selection in Private Health Insurance Markets*. The Urban Institute: Testimony before the U.S. Congress Joint Economic Committee. September 22, 2004.
 56. Ibid.
 57. National Association of Insurance Commissioners. *Draft White Paper on Adverse Selection in Health Insurance Exchanges*. March 16, 2011.
 58. Ibid.
 59. AB 1602, Chapter 655, Statutes of 2010.
 60. Healthcare Marketplace Report for the Kaiser Family Foundation. *A Profile of Health Insurance Exchange Enrollees*. March 2011.
 61. Chapter 1006, Statutes of 1984.
 62. HSC §1342.5.
 63. For purposes of full disclosure, Deborah Kelch, author of this report, is currently an appointed member of the DMHC Financial Solvency Standards Board.

Appendix A: Selected Early Implementation Insurance Reforms in the Affordable Care Act (ACA) (2010–12), Compared to California Law

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
Uniformity of insurance reforms	Requires states to apply ACA-related state standards or requirements adopted uniformly to all issuers in each insurance market. [ACA §1252]	<p>Requires the Director to consult with the Insurance Commissioner prior to adopting any regulations applicable to health plans and to other entities governed by the Insurance Code to ensure, to the extent practical, consistency of regulations. [HSC §1342.5]</p> <p>Requires DMHC and CDI to maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and maintain consistency in the regulations of the two departments. [HSC §1342.4]</p> <p>Required annual reports to the Legislature for five years through 2007. [HSC §1342.4]</p>	<p>No similar consultation requirement in the Insurance Code. Identical language to HSC 1342.5 was added to the Insurance Code in 1984 (Ch. 1006 of 1984) but was subsequently deleted when the Insurance Code provisions relating to nonprofit hospital service plans (no longer in existence) were deleted.</p> <p>Same as HSC requirements for joint senior level working group. [INS §12923.5]</p> <p>Same reporting as HSC. [INS §12923.5]</p>
I. Market and Underwriting Rules			
Guaranteed issue of coverage for children under age 19	On and after 9/23/10, issuers (except grandfathered individual plans) may not deny coverage to children under 19 because of a pre-existing condition and may not impose a pre-existing condition exclusion on benefits for children. Rules apply to grandfathered group plans, but not to grandfathered individual coverage in existence as of 3/23/10. [ACA §1201, Public Health Service Act (PHSA) §2704, 45 Code of Federal Regulations (CFR) 147.108]	<p>2010 Legislation (AB 2244, C. 656): Prohibits plan contracts for group coverage and non-grandfathered plan contracts for individual coverage from imposing pre-existing condition exclusions on any child under age 19 or denying coverage for any child based on health status. [HSC §1357.06(a)(2), §1357.51(c), §1399.826]</p> <p>Requires health plans to affirmatively market and sell products that cover children during specified time periods. [HSC §1399.828(a)]</p> <p>Consistent with federal law, allows health plans to adjust contract rates based on a child’s health status. Specifically, allows plans to charge up to two times the standard risk rate during an open enrollment period or for late enrollees, and to apply a 20 percent surcharge to a child who applies for coverage outside of those timeframes. [HSC §1399.829]</p> <p>Bans health plans from offering new contracts in the individual market for five years if they fail to write new contracts for children in the individual market after 1/1/11. [HSC §1399.834]</p>	<p>2010 Legislation (AB 2244, C. 656): Prohibition on insurers from imposing pre-existing condition exclusions on any child under age 19 or denying coverage for any child based on health status is the same as HSC. [INS §10198.7(c), §10951]</p> <p>Requirement that insurers affirmatively market and sell products that cover children during specified time periods is the same as HSC. [INS §10953(a)]</p> <p>Limits on rate differentials for children same as HSC. [INS §10954]</p> <p>Ban on market participation if carrier drops child-only coverage same as HSC. [INS §10959]</p>

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
I. Market and Underwriting Rules, <i>continued</i>			
Dependent coverage up to age 26	<p>Effective 9/23/10, requires non-grandfathered issuers offering group or individual coverage with dependent coverage to continue to make such coverage available for an unmarried adult child until age 26. Prior to 2014, applicable to a grandfathered group health plan only if the adult child is not eligible for employer-sponsored coverage.</p> <p>[ACA §1001, PHSA §2714, 45 CFR Part 147]</p>	<p>2010 Legislation (SB 1088, C. 660): Prohibits non-grandfathered plan contracts after plan year 9/23/10 from imposing a limiting age for dependent children less than 26 years.</p> <p>Dependents under 26 whose coverage had previously ended must be given a 30-day opportunity to enroll, as specified.</p> <p>Grandfathered plans that are group plans may only exclude a dependent under 26 who is eligible to enroll in an employer-sponsored plan.</p> <p>[HSC §1373(d)(5)]</p>	<p>2010 Legislation (SB 1088, C. 660): Same provisions as HSC.</p> <p>[INS §10277(f)]</p>
Discrimination based on salary	<p>Effective 9/23/10, extends to non-grandfathered fully-insured group health plans the existing prohibition against self-funded plans discriminating in favor of highly compensated individuals based on wages or salaries.</p> <p>[ACA §1001, PHSA §2716]</p>	<p>No comparable statute relating to discrimination based on salary. Existing state law prohibits plans from failing to sell or setting rates based on, among other things, race, color, religion, sex [gender], national origin, ancestry, or sexual orientation.</p> <p>[HSC §1365.5]</p>	<p>No comparable statute relating to discrimination based on salary. Insurance code prohibits different types of discrimination, for same types of reasons as listed in HSC.</p> <p>[INS §10140 and §10140.2]</p>
Grandfathered plans	<p>Allows individuals to retain “grandfathered coverage”: group or individual coverage in which a person was enrolled on 9/23/10. Coverage may be renewed, family members enrolled, and new employees and their families added.</p> <p>Grandfathered plans are subject to the ban on lifetime limits, the restrictions on rescission, the prohibition on excessive waiting periods, and the requirement to cover adult children to age 26. Grandfathered employer coverage cannot impose pre-existing condition exclusions on children and is subject to restrictions on annual limits. To remain grandfathered, plans cannot make significant coverage changes that reduce benefits or increase costs. Issuers are required to provide consumer notices about grandfathered status of plans in all plan materials.</p> <p>[ACA §1251, PHSA §2715 45 CFR Part 147]</p>	<p>2010 Legislation: HSC does not include one conforming definition of “grandfathered plans”; however, several bills enacted in 2010 reference such plans, including:</p> <ul style="list-style-type: none"> • AB 2244 (C. 656), which defines “individual grandfathered plan coverage” for the purposes of excluding such plans from new state and federal rules that prohibit the use of pre-existing condition exclusions for children. [HSC §1399.825(b)] • SB 1163 (C. 661), which addresses certain small group marketing rules for grandfathered plans. [HSC §1357.03] • SB 1088 (C. 660), which permits grandfathered group plans not to offer coverage to dependents up to age 26. [HSC §1373] 	<p>2010 Legislation (AB 2244, C. 656): Insurance Code conforms to HSC provisions for AB 2244 (C. 656), SB 1163 (C. 661), and SB 1088 (C.660). [INS §10950, §10705, and §10277]</p>

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
II. Benefits			
Annual and lifetime benefit limits	<p>Lifetime: Prohibits lifetime limits on the dollar value of essential health benefits in group and individual coverage.</p> <p>Annual: Phases in to 2014, for non-grandfathered products, annual dollar restrictions on coverage of essential health benefits as follows:</p> <ol style="list-style-type: none"> 1. For a plan year 9/23/10 to 9/23/11: no more than \$750,000; 2. For a plan year 9/23/11 to 9/23/12: no more than \$1,250,000; and 3. For a plan year 9/23/12 to 9/23/14: no more than \$2,000,000. <p>[ACA §1201, PHSA §2711, 45 CFR 147.126]</p> <p>States may apply to DHHS for one-year waivers of the annual limit restrictions on behalf of mini-med plans, pursuant to DHHS sub-regulatory guidance issued.*</p>	<p>No state law, regulations or guidance implementing these specific ACA provisions.</p> <p>Existing law: Licensed full-service health care service plans must provide basic health care services, as defined, subject only to limitations approved by the director (copayments, deductibles, or other limits). [HSC §1367 (i)]</p>	<p>No state law, regulations or guidance implementing these specific ACA provisions.</p> <p>No minimum basic benefit requirement.</p> <p>Existing law: Commissioner may withdraw approval of an individual or mass-marketed policy of disability insurance if CDI finds that the benefits provided under the policy are unreasonable in relation to the premium charged. [INS §10293]</p>
Coverage for prevention services	<p>Issuers (except grandfathered plans) must cover, without enrollee cost sharing, approved preventive services: immunizations, child preventive care and screenings, and breast cancer preventive care and screenings.</p> <p>[ACA §1001, PHSA §2713, 45 CFR 147.130]</p>	<p>Health and Safety Code has historically contained a more comprehensive requirement for coverage of preventive services. For example, HSC requires licensed plans to offer basic health care services, which must include preventive health services. [HSC §1345 and §1367]</p> <p>2010 Legislation (AB 2345, C. 657): Group and individual health care service plan contracts issued or amended after 9/23/10 required to comply with federal law on preventive services and any rules or regulations issued under it. [HSC §1367.002]</p>	<p>Insurance Code has historically contained less comprehensive requirements for coverage of preventive services. For example, INS Codes §10123.5 and 10123.55 require only group coverage to offer comprehensive preventive care to children up to age 18, and then only on terms to be negotiated between the insurer and the group policyholder.</p> <p>2010 Legislation (AB 2345, C. 657): Same requirements as HSC. [INS §10112.2]</p>
Low-benefit plans	<p>Issuers offering mini-med plans must notify consumers that their plan offers extremely limited benefits. DHHS guidance also restricts the sale of new mini-med plans with low annual limits, and phases out annual limits by 2014. [ACA §1001, PHSA §2711]</p>	<p>No state law, regulations or guidance implementing the ACA provisions.</p> <p>Mini-med policies would not likely meet HSC basic benefit standards and could not be offered or sold under the HSC.</p>	<p>No state law, regulations or guidance implementing the ACA provisions.</p> <p>Insurance Commissioner has general authority where benefits provided under the policy are unreasonable in relation to the premium charged. [INS §10293]</p>

*"Mini-med" policies offer coverage with limited benefit configurations compared with standard comprehensive major medical insurance. Mini-med policies are generally intended to be an individual's primary source of health insurance, rather than a supplement to other coverage, and generally provide coverage (within limits) for most types of medical services. Some mini-med policies have fairly low deductibles but cap benefits under the policy through annual benefit-specific limits or overall caps on annual benefits (e.g., \$1,000, \$5,000, \$10,000, or higher). According to America's Health Insurance Plans, approximately 2.5 million consumers nationwide are covered under mini-med policies in the individual and group (including both fully-insured and self-funded) markets.

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
III. Premiums and Rates			
Medical loss ratios (MLR)	<p>Issuers (including grandfathered plans) must annually submit to DHHS ratios of incurred losses to earned premiums (MLRs).</p> <p>Beginning in 2012, issuers offering group or individual health coverage (including grandfathered plans) must provide an annual rebate to enrollees if an MLR is less than 85 percent for its large group business, or 80 percent for its small or individual group business.</p> <p>[ACA §1001, PHSA §2718(b), 45 CFR, Part 158.220–158.232]</p>	<p>No state law, regulations or guidance implementing the ACA provisions.</p> <p>No state MLR statute applicable to health care service plans.</p> <p>Health plans must limit administrative costs, as defined. An established health plan with more than 15 percent administrative costs, or a health plan in development with more than 25 percent administrative costs, must justify the costs to the director or institute procedures to reduce the costs.</p> <p>[HSC §1378, California Code of Regulations (CCR) Title 28 §1300.78]</p>	<p>No state law implementing the ACA provisions.</p> <p>Insurance Commissioner may withdraw an individual policy of disability insurance if he finds that the benefits provided are unreasonable in relation to the premiums charged. [INS §10293]</p> <p>Based on §10293, the Department promulgated regulations in 2006 to require individual insurance products to meet a 70 percent lifetime loss ratio. In early 2011, this regulation was amended to further require that an insurer’s individual book of business must also meet a combined 80 percent loss ratio under the definitions established by the ACA.</p> <p>[CCR Title 10, §2222.12]</p>
Review of premium increases	<p>Requires issuers to submit to states and to DHHS justification for rate increases of 10 percent or more. State standards apply when states conduct the review.</p> <p>In proposed rules, states conduct the review if DHHS determines that the state process meets specified standards. If DHHS conducts the review in place of a state, the proposed federal standards for excessive, unjustified, and unfairly discriminatory rate increases would apply.</p> <p>[ACA §1003, PHSA §2794, 45 CFR, Part 154]</p>	<p>2010 California Legislation (SB 1163, C. 661): Requires health care service plans to file rate information with DMHC for individual and small group policies 60 days prior to implementing a rate change. Filing must include changes in benefits, earned premiums, incurred claims, average rate of increase and annual medical trend factor assumptions, and the certification of an independent actuary. DMHC to make specified information publicly available, including information on unreasonable rate increases. DMHC may not establish rates charged by health plans. [HSC §1385.01 – §1385.13]</p> <p>DMHC issued guidance to plans on 5/24/11 that substantially mirrors guidance issued by CDI. [DMHC Plan Letter No. 8-K]</p> <p>Existing law governing small employer coverage requires rates for small employers to meet specified rating rules but does not authorize rate setting or rate approval.</p> <p>[HSC §1357.12 and §1357.13]</p>	<p>2010 California Legislation (SB 1163, C. 661): Same statutory requirements for rate filings as HSC. [INS §10181 – §10181.13]</p> <p>CDI issued guidance 2/3/11 regarding requirements for rate filings. Rate review criteria include whether: insurer’s assumptions are reasonable and supported by substantial evidence; changes are substantially justified by credible experience data; the increase exceeds the rate of medical inflation; and individual policies meet the 80 percent MLR standard. Also will consider insurer’s rate of return and employee and executive compensation.</p> <p>[CDI Guidance 1163:2]</p> <p>Similar requirements for small employer coverage as HSC.</p> <p>[INS §100700 et. Seq.]</p>
Measuring plan value	<p>By 9/23/11, DHHS, in consultation with issuers, consumers, employers, providers, and other appropriate entities, must develop a methodology to measure health plan value, including overall cost to enrollees, quality of care, efficiency in providing care, relative risk of enrollees compared to other plans, actuarial value or other comparative measure of the covered benefits, and other relevant factors.</p> <p>[ACA §10329]</p>	<p>Historically, the Office of Patient Advocate is required to compile an annual quality of care report card on health care service plans. [HSC §1368.02]</p> <p>In 2010, the Legislature passed AB 1602 (C. 655), which among other things, requires California’s Health Benefit Exchange, rather than the DMHC or CDI, to rate health plans pursuant to the criteria established in federal law.</p> <p>[Government Code (GOV) §100500 et. Seq.]</p>	<p>No requirement similar to HSC.</p>

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
IV. Consumer Protections			
Coverage rescissions	<p>Prohibits rescission of an enrollee’s coverage by a plan (including a grandfathered plan) unless the enrollee performs an act or practice of fraud or makes an intentional misrepresentation of a material fact.</p> <p>[ACA §1001, PHSA §2712, 45 CFR §147.128]</p>	<p>2010 Legislation (AB 2470, C. 658): Prohibits a health care service plan from rescinding a contract once an enrollee is covered, unless the plan can demonstrate that the enrollee has performed an act or practice of fraud or made an intentional misrepresentation of material fact. Coverage is required to continue pending an enrollee’s appeal to DMHC. Prohibits plans from canceling a policy due to misrepresentation after 24 months following issuance of the contract.</p> <p>[HSC §1365(b), §1368(a)(6), §1389.21(a)(c)]</p>	<p>2010 Legislation (AB 2470, C. 658): Same as HSC.</p> <p>[INS §10273.4, §10273.6, §10273.7, §10384.17, §10713]</p>
Appeals and grievances	<p>Internal appeals: Issuers must implement an appeals process for coverage and claims determinations, including culturally and linguistically appropriate notice to enrollees of appeals processes, and state offices that assist with appeals. Issuers must allow enrollees to review their files to present evidence, and allow enrollees continued coverage pending outcome of the appeal.</p> <p>[ACA §1001, PHSA §2719]</p> <p>External review: Issuers must either: a) comply with applicable state external review process meeting at least the NAIC Uniform Model Act, and which is binding on the issuer; or b) implement an effective process meeting minimum DHHS standards if the state has no external review, or if the plan is self-insured and not subject to state regulation. DHHS may deem an issuer’s existing external review process to be in compliance.</p> <p>[ACA §1001, PHSA §2719(b)]</p>	<p>No state law, regulations or guidance specifically implementing these ACA provisions.</p> <p>Internal appeals: HSC requires every health plan to establish and maintain an internal grievance system for enrollees to submit grievances to the plan. Requires internal appeals process of a contested claim by competent reviewers.</p> <p>[HSC §1368, CCR Title 28, §1300.68, §1370.2]</p> <p>External appeals: California law requires that enrollees have access to an independent external review if a health plan denies, changes, or delays a service or treatment because the plan determines it is not medically necessary; will not cover an experimental or investigational treatment for a serious medical condition; or will not pay for emergency or urgent medical services already received.</p> <p>[HSC §1370.4, §1374.30, CCR §1300.70.4, §1300.74.30]</p>	<p>No state law, regulations or guidance specifically implementing these ACA provisions.</p> <p>Internal appeals: The Fair Claims Settlement Practices Act requires disability insurers to respond to a claimant regarding a claim within 15 calendar days, acknowledging receipt, providing necessary forms and instructions, and beginning an investigation, and has no more than 30 calendar days to contest a claim. Preauthorization of non-emergency medical services must be given immediately but in no event more than 5 calendar days from the request for preauthorization.</p> <p>[INS §790.03(h), 10 CFR §2695]</p> <p>External appeals: Same as HSC.</p> <p>[INS §10169 – §10169.5]</p>

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IV. Consumer Protections, <i>continued</i>			
Patient access protections	<p>Choice of primary care provider (PCP): Requires group plans and issuers that require or provide for enrollees to designate a PCP to allow enrollees to choose any available participating PCP. [ACA §1001, PHSA §2719A(a), 45 CFR Part 144]</p> <p>Pediatrician as PCP: Requires group plans and issuers that require or provide for enrollees to designate a PCP to allow child enrollees to choose a pediatrician as a PCP. [ACA §1001, PHSA §2719A(c), 45 CFR Part 144]</p> <p>OB/GYN access: Prohibits group health plans and issuers from requiring female enrollees to obtain authorization or referral for obstetrical or gynecological (OB/GYN) care provided by a participating professional as long as the provider agrees to the issuer's policies and procedures, and provides services pursuant to a treatment plan. Requires issuers to treat the provision of OB/GYNs as PCPs. [ACA §1001, PHSA §2719A(d), 45 CFR Part 144]</p> <p>Emergency care: Prohibits non-grandfathered plans from imposing prior authorization for emergency department (ED) services, requiring an ED to have a contractual relationship with the plan, or from imposing more restrictive requirements or limitations on an out-of-network ED. [ACA §1001, PHSA §2719A(b), 45 CFR Part 144]</p> <p>Cancer clinical trial: Non-grandfathered health plans and issuers may not deny, limit, or impose additional conditions on coverage of routine patient costs for items and services furnished in connection with participation in a clinical trial, or discriminate against an individual due to participation. Plans may require that a patient participate through a participating provider who participates in the clinical trial. Patients may participate in a trial conducted outside their state. [ACA §1201, PHSA §2709]</p>	<p>No state law, regulations or guidance specifically implements these ACA provisions.</p> <p>Primary care provider: An enrollee may select as his/her PCP any available primary care physician who contracts with the plan in the service area where the enrollee lives or works. [HSC §1373.3]</p> <p>Pediatrician as PCP: Pediatricians deemed to be primary care physicians. [HSC §1351(e), 28 CCR §1300.45(m)]</p> <p>Direct access to OB/GYN: Requires health plans to include OB/GYNs as PCPs provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status. [HSC §1367.69(a)]</p> <p>Plan contracts must allow an enrollee the option to seek OB/GYN physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services. [HSC §1367.695]</p> <p>Emergency care: Requires health plans to reimburse providers, including non-contracting providers, for emergency services and care provided to enrollees to stabilize the enrollee's medical condition. Requires plans to make a physician available on a 24-hour basis for consultation and for resolving disputed requests for authorizations for post-stabilization care. [HSC §1371.4]</p> <p>Cancer clinical trial: Requires plans to provide coverage for all routine patient care costs for enrollees diagnosed with cancer and accepted into a clinical trial for cancer, provided the enrollee's contracting, treating physician recommends participation in the clinical trial after determining that the trial has a meaningful potential to benefit the enrollee: [HSC §1370.6]</p>	<p>No state law, regulations or guidance specifically implements these ACA provisions.</p> <p>Primary care provider: No comparable reference to primary care provider in the Insurance Code.</p> <p>Pediatrician as PCP: No comparable reference to pediatrician in the Insurance Code.</p> <p>Direct access to OB/GYN: Requires disability policies that cover hospital, medical, or surgical expenses (health insurance) to include OB/GYNs as PCPs, provided the PCP meets the plan's eligibility criteria for all specialists seeking primary care physician status. [INS §10123.83]</p> <p>Requires health insurance policies to allow a policyholder the option to seek OB/GYN services directly from a participating OB/GYN provider. [INS §10123.84]</p> <p>Emergency care: No comparable provision to HSC applicable to insurers or health insurance policies.</p> <p>Cancer clinical trial: Same as HSC. [INS §10145.4]</p>

ISSUE	ACA PROVISIONS AND RELATED FEDERAL REGULATIONS/GUIDANCE	HEALTH AND SAFETY CODE (HSC) CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC)	INSURANCE CODE (INS) CALIFORNIA DEPARTMENT OF INSURANCE (CDI)
IV. Consumer Protections, <i>continued</i>			
Federal Internet portal on health insurance options	Requires DHHS, in consultation with the states, to establish an Internet portal to identify affordable coverage options. Requires issuers to submit specified data to DHHS. [ACA §1103]	Requires DMHC, in collaboration with CDI, to review the Internet portal established by DHHS, and if found to inadequately facilitate fair and affirmative marketing of individual and small group products, to jointly establish an electronic clearinghouse. [HSC §1346.2]	Same as HSC. [INS §10112.4]
Uniform coverage and benefits disclosure	<p>Requires DHHS to develop standards for individual and group benefits and coverage, and to provide enrollees a summary of benefits and coverage. [ACA §1001, PHSA §2715]</p> <p>Requires DHHS to adopt standardized definitions for terms used in health coverage, including insurance-related terms, to aid consumers in understanding and comparing coverage, and medical terms for comparing medical benefits. State standards providing less information preempted. [ACA §1001, PHSA §2715]</p> <p>Requires issuers and self-insured plan administrators to provide applicants and enrollees with a summary of benefits and coverage meeting DHHS standards. [ACA §1001, PHSA §2715(d)]</p>	<p>Requires health plans to provide specified disclosure re: benefits, services, and terms of the plan contract to afford consumers with full and fair disclosure of the provisions of the plan in readily understood language.</p> <p>Authorizes DMHC to require that the materials be presented in a reasonably uniform manner to facilitate comparisons between plan contracts, and specifies details about the information to be provided. [HSC §1363]</p> <p>Requires plans to provide a uniform DMHC comparative benefit matrix to facilitate comparisons between plan contracts for coverage provided pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), and requires DMHC and CDI to make the matrix available online. Requires specified plan disclosure of the matrix. [HSC §1363.06, §1363.07]</p> <p>In 2010, the Legislature passed AB 1602 (Chapter 655), which among other things requires California’s Health Benefit Exchange, rather than the DMHC or CDI, to make information available in a standardized format pursuant to federal law. [GOV §100502]</p>	Similar requirements to HSC for disclosure and benefit matrices. [INS §10127.14, §10113.8]
Administrative simplification	Amends federal rules re: health information transactions and electronic fund transfers, and requires DHHS to adopt eligibility and financial responsibility rules for services prior to or at the point of care. Must provide for transparent claims and denials (including adjudication and appeals). Health issuers must file compliance statements. [ACA §1104, §10109]	<p>No state law, regulations, or guidance implementing these specific ACA provisions.</p> <p>Requires plans to have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies requests by providers to provide services based on medical necessity. Medical necessity decisions re: proposed services must be consistent with criteria or guidelines that are supported by clinical principles and processes. [HSC §1367.01]</p>	No state law, regulations or guidance implementing these specific ACA provisions. Same as HSC. [INS §10123.135]

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IV. Consumer Protections, <i>continued</i>			
Disclosure, advertising and marketing requirements	<p>Requires DHHS to develop standardized formats for coverage options, including percentage of total premium revenues expended on nonclinical costs, eligibility, availability, premium rates, and cost sharing, which must be consistent with the uniform explanation of coverage. [ACA §1103]</p> <p>Requires Department of Labor (DOL) to update and harmonize its rules with DHHS standards concerning disclosures by qualified health plans, plan terms and conditions, and periodic financial disclosure. [ACA §1311(e)]</p>	<p>Prohibits plan advertisements from being published or distributed until they have been submitted to DMHC at least 30 days prior to use, and determined by DMHC not to be untrue, misleading, or deceptive. [HSC §1360, §1361]</p> <p>Requires plan disclosure forms regarding benefits, services, and terms of the plan contract to afford consumers with a full and fair disclosure of the provisions of the plan in readily understood language and in a reasonably uniform manner so as to facilitate comparisons between plan contracts. [HSC §1363]</p>	<p>Requires insurers to provide summary information on a supplemental disclosure form about each [health] insurance policy offered by the insurer to provide full and fair disclosure of the policy provisions, including: principal benefits, exceptions, reductions, and limitations; a summary of the process used to authorize or deny payments; and the full premium cost of the policy, copayments, coinsurance or deductibles, and renewal terms. [INS §10603 – §10604]</p>

GLOSSARY OF TERMS AND ACRONYMS

Health plans: Full-service health care service plans licensed pursuant to the Knox-Keene Act.

Health insurers: Disability insurers certified to sell health insurance under the Insurance Code, including policies that cover hospital, medical, or surgical services.

Issuer: Federal ACA terminology for companies that issue health coverage. In California, “health plans” and “health insurers” are collectively termed “carriers.”

CCR: California Code of Regulations

CDI: California Department of Insurance

CFR: Code of Federal Regulations

DHHS: U.S. Department of Health and Human Services

DMHC: (California) Department of Managed Health Care

HSC: (California) Health and Safety Code

INS: (California) Insurance Code

PHSA: (Federal) Public Health Services Act

Appendix B: Regulation of Health Coverage in Dual-Agency States, by Regulatory Area

STATE	RATES	SOLVENCY	BENEFITS	NETWORK ADEQUACY/ QUALITY	COMPLAINTS/ EXTERNAL REVIEW
Alabama	Insurance	Insurance	Department of Public Health (HMOs only)	Department of Public Health (HMOs only)	Department of Public Health (HMOs only)
Arkansas	Insurance Department	Insurance Department	Insurance Department	Department of Health Services (HMOs only)	Insurance Department
Colorado	Division of Insurance	Division of Insurance	Division of Insurance	Department of Public Health and Environment (HMOs only)	Division of Consumer Services
Florida	Office of Insurance Regulation, Department of Financial Services	Office of Insurance Regulation, Department of Financial Services	Office of Insurance Regulation, Department of Financial Services	Agency for Health Care Administration (Commercial HMOs, Medicaid Health Plans)	Office of Insurance Regulation, Department of Financial Services
Maine	Bureau of Insurance	Bureau of Insurance	Bureau of Insurance	Bureau of Insurance & Department of Health & Human Services	Bureau of Insurance
Maryland	Insurance Administration	Insurance Administration	Insurance Administration	Insurance Administration & Department of Health and Mental Hygiene (HMOs only)*	Insurance Administration
*In Maryland, the Department of Health reviews an HMO's application for licensure to determine whether it has an adequate quality assurance program in place prior to issuing an initial license. Enforcement of state quality assurance standards is performed by the Insurance Administration through market conduct examinations.					
Massachusetts	Department of Managed Care, Department of Insurance	Office of Patient Protection, Department of Public Health			
Minnesota	Office of Insurance Commissioner	Office of Insurance Commissioner	Department of Health (HMOs only)	Department of Health (HMOs only)	Department of Health (HMOs only)
Mississippi	Insurance Department	Insurance Department	Insurance Department	State Health Officer	Insurance Department (effective in 2012)
New York	Insurance	Insurance	Insurance	Managed Care Division, Department of Health (Managed Care only)	Managed Care Division, Department of Health (Managed Care only)
Pennsylvania	Insurance Department	Insurance Department	Insurance Department	Department of Health	Insurance Department & Department of Health

STATE	RATES	SOLVENCY	BENEFITS	NETWORK ADEQUACY/ QUALITY	COMPLAINTS/ EXTERNAL REVIEW
Rhode Island	Office of the Health Insurance Commissioner	Office of the Health Insurance Commissioner	Office of the Health Insurance Commissioner	Department of Health	Department of Health
Virginia	Bureau of Insurance	Bureau of Insurance	Bureau of Insurance	Department of Health	Bureau of Insurance
Wyoming	Insurance Department	Insurance Department	Insurance Department	Department of Health (HMOs only)*	Department of Health (HMOs only)

*In Wyoming, the Department of Health reviews an HMO's application for licensure to determine whether it has an adequate quality assurance program and an adequate member complaint system in place prior to issuing an initial license. Enforcement of state quality assurance standards is performed by the Insurance Department through market conduct examinations. Investigation and resolution of consumer complaints about HMOs are handled by the Insurance Department.

Sources: NAIC, America's Health Insurance Plans, individual states, and state Web sites.



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