December 5, 2001

Hon. Keith Richman
Assembly Member, 38th District
Room 5128, State Capitol
Sacramento, California 95814

Dear Assembly Member Richman:

In September, you requested that we conduct a comprehensive review of the Department of Managed Health Care's (DMHC) $30 million budget as well as its daily operations. In response to your request, we are providing you with the following information:

- A review of the intended role and responsibilities of DMHC and other background information (see page 2).
- An analysis of the staffing and resources devoted to each of the department's main functions (see pages 2-3).
- A review of how DMHC responds to consumer complaints, including data on the number of calls the health maintenance organization (HMO) Help Center receives and applications received for Independent Medical Reviews (IMRs), and a discussion of the role of the Office of the Patient Advocate (see pages 3-8).
- Information on regulatory activities, including the licensure, financial examination and medical survey processes, and data on the number of reviews conducted (see pages 8-10).
- Information on enforcement actions taken by DMHC (see pages 10-11).

- An analysis of DMHC's involvement in the relationship between HMOs and medical groups (see pages 11-13).
- A discussion about the financial instability of medical groups in California (see pages 13-17).
- Examples of how other states regulate medical groups (see pages 17-18).
- Options you may wish to consider for improving regulation of the managed care industry (see pages 18-20).

Role and Responsibilities of DMHC

The department's stated mission is to work toward an accountable and viable managed care delivery system that promotes healthier Californians. This is accomplished by a variety of activities, including:

- Ensuring accountability through enforcement of the provisions of the Knox-Keene Health Care Service Plan Act of 1975, which authorizes state regulation of health care plans.
- Developing and launching public education and awareness efforts.
- Providing an annual HMO report card.
- Operating the HMO Help Center to help Californians resolve their problems with HMOs.
- Licensing and conducting medical surveys and financial examinations of health care service plans.
- Maintaining a toll-free physician phone line so that the Office of Plan-Provider Relations is informed early of systemic problems that may affect consumers.

Other state agencies play a role in regulating HMOs, including the Department of Insurance (DOI), Department of Health Services (DHS), the Managed Risk Medical Insurance Board (MRMIB), and the Department of Consumer Affairs.

Staffing and Resources Devoted to Main Functions

The DMHC's main functions are housed in five offices: the Office of Enforcement, the Office of Health Plan Oversight, the HMO Help Center, the Office of Legal Services, and the Office of the Patient Advocate. The three remaining offices, the Office of Administrative Services, the Office of the Director, and the Office of Technology and Innovation support DMHC's day-to-day operations. To carry out its duties, DMHC has 329 authorized positions, of which about 50 are currently vacant. As shown in Figure 1,

approximately one-third of the staff supports DMHC's day-to-day operations (the Office of Administrative Services, the Office of the Director, and the Office of Technology and Innovation), 27 percent is devoted to health plan oversight, and 21 percent of the staff works in the HMO Help Center. The remainder of the staff is split evenly between enforcement and legal activities. Funding for these activities is allocated in roughly the same proportion as staffing.

Figure 1

One-Fourth of DMHC Staff Devoted to Health Plan Oversight

2001-02
(Dollars in Thousands)

	Staff		Budget	
Office	**Total**	**Percent**	**Amount**	**Percent**
Administrative Services	58	18%	$3,773	12%
Director	27	8	2,847	9
Technology and Innovation	20	6	1,612	5
Enforcement	26	8	2,128	7
Health Plan Oversight	88	27	8,525	27
HMO Help Center	70	21	7,224	23
Legal Services	26	8	2,249	7
Patient Advocate	14	4	3,489	11
Totals	**329**	**100%**	**$31,847**	**100%**

Enclosure 1 shows DMHC's budget for each office in more detail and Enclosure 2 provides additional details on the HMO Help Center and the Office of Health Plan Oversight's budget.

How the Department Handles Consumer Complaints

The HMO Help Center

In response to your request we are providing information about the HMO Help Center which is a call center that DMHC operates 24 hours a day/7 days a week. The center received 162,349 calls in 2000-01 or an average of 450 calls per day. Based on the number of calls received in the first three months of the current fiscal year, the center is likely to handle approximately the same volume of calls in 2001-02. The number of calls actually received in August was 14,000, or an average of nearly 500 calls a day. However, the center received fewer calls in September—approximately 12,000, or an average of nearly 400 a day. The DMHC attributes the decline in September calls to the September 11 terrorist attacks.

Overall Type and Number of Consumer Calls. A caller to the HMO Help Center must first navigate through the interactive voice response system. Last year, nearly half of the calls to the hotline were handled by this system and the consumer did not need to further consult with a telephone operator. The remaining calls were handled by DMHC telephone operators and operators under contract with the department.

Of the calls handled by operators, about 50 percent of the consumers' calls were referred back to their health care service plans for completion of a 30-day HMO grievance process that must be undertaken before an enrollee is permitted to file a complaint with DMHC. Requests for general information comprise the next highest percentage of calls handled by operators. A small share of the calls that operators receive, approximately 5,000 annually or 6 percent, are consumer complaints that are still unresolved after having gone through the health plan's grievance process. These calls are described below in greater detail. Less than 1 percent of the calls received by operators, about 1,200 annually, are considered "urgent complaints," such as complaints concerning denial or delay of medication, premature release from a hospital, or inappropriate care.

Operators had been referring only a small percentage of enrollee calls to other state agencies such as DHS or MRMIB to handle problems outside of DMHC's jurisdiction. However, the department has recently experienced an increase in the overlap of its complaint resolution efforts with other government agencies that regulate the health insurance industry, particularly DOI. Consumers are increasingly calling the wrong state agency with their complaints, leading to a duplication of efforts by state agencies and a delay in response to consumer complaints. This overlap can complicate and extend the resolution process. Because of such concerns, and in accordance with state law, the Director of DMHC and its Advisory Committee on Managed Care contracted for a study of the feasibility and merit of consolidating regulation of all health insurers within DMHC. This study includes within its scope the regulation of indemnity insurers, preferred provider organizations, exclusive provider organizations, and other managed care products currently regulated by DOI. A draft report discusses a number of options for making state regulation of managed care more consistent and effective. The final report is due to the department by the end of December.

Type and Number of Consumer Complaint Calls. The DMHC operators categorize consumer complaints into five types of issues: billing disputes, quality of care, benefits and coverage, access to care, and other.

Since DMHC's inception, about 30 percent of the complaints received concerned billing disputes between the health care plan and the beneficiary. For example, a beneficiary might contact the Help Center if he or she has not received proper reimbursement from their health care plan for services they received outside of their

usual health care clinic. Twenty-four percent of the complaints concern benefits and coverage issues.

Access to care complaints have steadily increased since DMHC began operation. In August 2000, these complaints accounted for 5 percent of all complaints received, but in October 2001 they accounted for 33 percent of the total. According to DMHC, the increase in access to care complaints may be a result of the increased number of medical group closures.

In contrast, enrollee complaints about the quality of the care that the health care service plans provide have decreased steadily from a high of 41 percent of the complaints in October 2000 to 7 percent of enrollee complaints in October 2001. The DMHC attributes the decrease to its enforcement efforts.

Handling of Consumer Complaint Calls. Staff works to resolve enrollee complaints by directly involving the beneficiary and the health care plan. The DMHC has taken this a step further by piloting a three-way calling system with two health care plans. When DMHC receives a complaint from a beneficiary in one of these plans, it works to resolve the complaint immediately by conducting a three-way call with the beneficiary, a DMHC operator, and a plan representative. According to DMHC, the pilot has been very successful in terms of getting issues resolved quickly and with satisfactory outcomes.

The information we have reviewed indicates that DMHC staff is generally handling consumer complaints in a timely and satisfactory manner. The center has focused on reviewing and closing cases within the 30-day mandate and resolves nearly all calls within this time frame. The department also surveys individuals who register complaints with the department to ensure quality customer services. During February 2001, the most recent survey completed, the department reported that 85 percent of the consumers surveyed said they were completely satisfied with DMHC's services; the remaining 15 percent reported that they were moderately satisfied. We did not attempt to independently validate this survey's results because DMHC plans to implement a more thorough survey mechanism and have the Office of the Patient Advocate conduct these surveys in the future.

Outcomes From HMO Help Center Activity

The DMHC maintains that the HMO Help Center has had two beneficial effects. The DMHC asserts and we concur that the center has helped the department identify systematic problems in the managed care industry and also resulted in positive outcomes for individual consumers. We discuss both of these effects below.

Identification of Systemic Problems in the Industry. The DMHC uses data collected from consumer complaints to detect problematic trends in the managed care industry.

The complaint analysts receiving consumers' calls meet weekly to discuss the nature of complaints that are received. According to call center staff, if a systemic problem is detected either within a plan or within several plans, staff will ordinarily work to resolve the immediate complaint, then refer the matter to a DMHC division that reviews health care plan operations in a systemic way. When these reviews identify systemic problems, DMHC may then initiate a nonroutine financial examination of the health plan involved that could lead to DMHC enforcement actions.

We are advised by DMHC that issues detected by the call center are also discussed officewide on a regular basis. Each month, the staff prepares a report calling such issues to the attention of DMHC senior directors. Call center staff meet regularly with staff in the enforcement, legal, and oversight offices to share information and discuss trends in complaints and systemic problems that they have detected.

The current process used to detect systemic issues is largely manual and relies heavily on the skills of complaint analysts. The DMHC inherited a Department of Corporations (DOC) complaint-tracking database that categorizes all complaints within four specific categories plus "other." This limited system does not allow DMHC staff to query the database or generate reports tailored to their needs. A new database system that is in the process of being implemented is designed to capture a greater number of call details, enable staff to generate reports intended to address particular problems, and allow all DMHC units to view complaint tracking data. The DMHC anticipates that this system will allow it to more easily detect systemic problems and increase its ability to respond proactively to indicators that plans and providers are facing financial or other difficulties.

Assistance to Individual Consumers. Information provided by DMHC indicates that the operation of the HMO Help Center is resulting in positive outcomes for some individual consumers, particularly as regards the payment of patient bills. For example, in fiscal year 2000-01, the department reported that the total of patient bills paid by health care plans as a result of staff efforts was more than $1.5 million.

In addition to resolving specific complaints, DMHC contends that the operation of the call center has positively impacted consumers more broadly. It cites as evidence the changes which have occurred in the types of complaints received. For example, as noted earlier, the number of complaints concerning quality of care issues has declined since the call center began operation. The DMHC attributes this decrease to a focus on enforcement, contending that health care plans are more likely than before to resolve complaints from beneficiaries using their internal complaint resolution process rather than allow complaints to be brought before DMHC. While the overall volume of calls has increased since the hotline began operation, DMHC attributes this to consumers' increased awareness of the call center and asserts that it is not necessarily an indication that consumers are having a greater number of problems with HMOs.

Independent Medical Review

In January 2001, DMHC implemented an Independent Medical Review (IMR) program that allows beneficiaries to request an independent review of certain kinds of disputes over health care services. The IMRs are limited to disputes about whether services were medically necessary, whether they were experimental or investigational and therefore not included in medical coverage, and denial of claims for services that have been provided for emergency or urgent care services outside of the clinics or hospitals that patients must ordinarily visit.

If DMHC determines that a case qualifies for review, it is forwarded to the Independent Medical Review Organization (IMRO), an external group that has been awarded a contract by DMHC through a competitive bidding process to conduct IMRs. After IMRO renders a decision, DMHC generally adopts and issues a written decision on the case. According to studies of external review programs, IMRs help ensure that health plans make decisions about access to care based on medical evidence rather than pressure to hold down medical expenditures.

The DMHC has received 1,263 requests for IMRs since January 2001. After reviewing these requests, DMHC determined that more than half were ineligible for review because they did not directly relate to disputed health care services, but rather concerned such issues as coverage or reimbursement. Of the remaining 573 requests, 447 were sent to IMRO for review. The HMO Help Center's IMR team handled the remaining cases that it determined could be resolved without an independent review.

Most of the IMRs reviewed by IMRO address disputes over the medical necessity of the services sought by patients. As shown in Figure 2, IMRO has upheld the health care plans' denials in 55 percent of the cases and overturned the health plans' denial decision 29 percent of the time. Seven percent of the cases were withdrawn from the review process by the health plans, and 9 percent of the cases remain pending. National statistics about decisions made by independent review organizations find that the decisions generally split evenly between the plan and the enrollee. The DMHC has predicted that the outcomes from its IMR process will eventually more closely parallel those national statistics.

Figure 2

IMRO Has Upheld Most Health Plans' Decisions

	Upheld	Overturned	Withdrawn	Pending	Total
Determinations of cases sent to IMRO	247 (55%)	128 (29%)	30 (7%)	42 (9%)	447 (100%)

While there are clear indications that the HMO Help Center has resulted in positive outcomes for consumers, the impact of the IMR process on consumer outcomes has not yet been clearly demonstrated. The department has noted a number of instances in which a request for an IMR has been withdrawn by a consumer after the health plan has received notification that a decision it had made was going to IMR. The DMHC contends that this trend demonstrates the value of the IMR process—that health plans are reconsidering their prior decisions to deny services to consumers and are instead resolving issues on their own rather than allowing disputes to go to IMR. Our review indicates, however, that relatively few IMRs are being withdrawn compared to the total number of cases. The small number of such cases raises questions about DMHC's claims about the extent of the impact of the IMR process.

Office of the Patient Advocate

The Office of the Patient Advocate works in conjunction with the HMO Help Center, but is not directly involved in resolving consumer complaints. Rather, the office is directed by state law to focus on the development and distribution of written materials that inform consumers of their rights and responsibilities in regard to effective ways to exercise their rights and secure health care services. The office also renders advice and assistance to enrollees regarding procedures, rights, and responsibilities related to the use of health plan grievance systems, and each year compiles report cards on the quality of care provided by HMOs.

How DMHC Regulates HMOs

You have requested information about DMHC's regulatory activities. As of November 2001, the department was responsible for the regulation of 108 different health care plans. The following three sections describe the regulatory roles and activity of DMHC from its inception.

Licensing

The Licensing Division of DMHC is responsible for assuring that licensed health plans provide preventive and other medically necessary health care services in an appropriately organized and financially stable setting. Three specialized plans have been licensed by DMHC since it began operation. (These are in addition to the plans previously licensed by its predecessor agency, the Department of Corporations.) In addition to licensing plans, the licensing division plays a role in resolving systemic problems with health plans. When DMHC staff in the HMO Help Center believes that it has detected a potentially systemic issue, the licensing division is usually contacted first. Before DMHC undertakes a financial examination or medical survey, the licensing division will contact the health plan and attempt to determine if the health plan has exhibited a serious lack of compliance or if the issue is easily resolved. For example, concerns about a health plan's failure to regularly provide beneficiaries with IMR applications might be easily resolved with a DMHC instruction to the plan to provide the applications.

Financial Examinations

The Division of Financial Oversight monitors and evaluates the financial viability of health plans to ensure continued access to benefits for enrollees and to protect consumers and providers from problems associated with potential insolvencies. The examinations include review of health plan financial statements, analysis of financial arrangements, and review of information the health plans are required to submit as part of the licensing process. The DMHC is required by law to conduct routine financial exams of health plans at least once every five years and to conduct additional nonroutine exams as needed. Nonroutine exams may also be instigated by complaints from the HMO Help Center or issues DMHC has identified by other means.

From July 2001 through the end of October 2001, 16 routine and 6 nonroutine exams were pending. Eleven of the exams are of full-service health plans and 11 are of specialized plans that provide only one type of service such as chiropractic care. The department starts an average of two to three new exams each month. During 2000-01, the department initiated 23 routine exams and 15 nonroutine exams, of which 25 were of full-service plans and 13 were of specialized plans.

The DMHC's financial examination duties also involve the Financial Solvency Standards Board, a panel established within DMHC under Chapter 529, Statutes of 2000 (SB 260, Speier), to develop solutions to health plan and provider solvency issues. The eight-member board includes DMHC's Director and individuals with training and experience in such subject areas as medicine, economics, accounting, actuarial studies, and the administration of health care delivery systems. The board advises the Director on matters of financial solvency and recommends requirements and standards for plan

operations and contractual relationships. The board also periodically monitors and reports on the implementation of financial solvency standards.

Medical Surveys

State law requires DMHC to periodically conduct an onsite survey of the health delivery system of each health plan subject to its regulation. The DMHC relies upon its own analysts, most of whom were registered nurses at one time, as well as outside consultants to conduct these medical surveys. The surveys include a review of procedures for obtaining services, procedures for regulating utilization, peer-review mechanisms, internal procedures for assuring quality of care, and overall plan performance in meeting enrollees' health care needs. The surveys are to occur at least once every three years. In addition, nonroutine surveys can result from complaints received through the HMO Help Center or reports from other DMHC staff.

According to DMHC, a medical survey could result in enforcement actions being taken against a health plan, but to date this has not occurred. The department indicates that it instead focuses the medical surveys on working out health plan problems and ensuring the implementation of corrective action plans resulting from medical surveys.

Since DMHC began operation, a total of 49 medical surveys have been completed. These included reviews of 18 full-service plans, 18 dental plans, 5 vision plans, 7 behavioral health plans, and 1 chiropractic plan. All of these were routine reviews. The DMHC has not yet conducted any nonroutine medical surveys.

Enforcement Activities

Every formal enforcement action DMHC takes is the result of a financial examination, a complaint from the HMO Help Center, or a referral from the licensing division. The DMHC has taken formal action against 24 health care service plans and five dental plans since July 1, 2000 in response to determinations of violations of managed care laws, as shown in Figure 3. The number of plans DMHC has taken action against is less than the total number of actions shown in Figure 3 because in some instances multiple actions have been taken against a single plan.

One example of a formal action taken by the department was to require a plan with financial difficulties to accept a conservator who would ensure the uninterrupted provision of services to beneficiaries, payment of claims, and closure of the health plan's operations. The DMHC has also issued cease-and-desist orders to unlicensed plans, prepared letters of agreement between DMHC and a plan for miscellaneous violations such as failure to pay claims for prescription drugs, and revoked the licenses of plans with significant financial issues.

Figure 3

Enforcement Actions Since DMHC Began Operation

2000-01 and 2001-02 (year to date)

	Accusation of Wrongdoing	Conservator Appointed	Cease and Desist Order Issued	Letter of Agreement Regarding Violation	License Surrendered/ Revoked
2000-01	6	3	6	8	5
2001-02 (year-to-date)	3	1	2	4	0
Total	**9**	**4**	**8**	**12**	**5**

As noted earlier, DMHC has in some cases taken several actions against a single plan over a period of time. For example, DMHC fined one health plan $30,000 for failure to provide the 30-day advance notice required by law for changes in premium rates or changes in coverage, $15,000 for violation of confidentiality of medical records, and $60,000 for submitting false statements about the plan's finances. In some instances, it appears that initial violations found by DMHC were a precursor to greater troubles. For example, in July 2000, action was taken against one health plan for the plan's failure to file financial reports. Nine months later, the plan surrendered its license because of financial issues. Enclosure 3 provides additional detail on other enforcement actions taken by DMHC.

According to DMHC, the total amount of fines collected from health care service plans in fiscal year 2000-01 was $430,000. For fiscal year 2001-02 (year-to-date) the total amount of fines collected is $92,000. The largest single fine collected since DMHC began operation was a $250,000 penalty for one plan's failure to pay provider claims. The DMHC has levied numerous fines of $2,500 against plans for administrative violations specified in the Knox-Keene Act.

The DMHC's Involvement in the HMO-Medical Group Relationship

The Knox-Keene Act requires that all contracts between health plans and medical groups be "fair, reasonable, and consistent" with the objectives of the act and makes DMHC responsible for enforcing these provisions of this act. While some have interpreted the provision to grant DMHC broad authority, DMHC has interpreted this more narrowly. Specifically, DMHC does not interpret "fair" and "reasonable" to mean that it shall be involved in issues relating to the sufficiency of payment rates or plan-medical group contracts. Instead, it enforces this provision of the law in several other ways. This may be an area the Legislature would wish to review in the future.

The Department's Interpretation of Its Responsibilities. We are advised by DMHC that its licensing staff regularly reviews contract provisions to ensure that they are not vague and are clear and understandable. The DMHC further indicates that it reviews so-called risk-sharing agreements between health plans and medical groups during routine and nonroutine financial examinations. (Medical groups that receive a capitated rate per beneficiary are essentially sharing financial risk with the health plans. The shared risk is primarily whether payments for health coverage will be collectively sufficient to pay the costs of all medical services needed by insured individuals.) The DMHC reviews the risk-sharing agreements to determine whether they are adequate to ensure access to health care for consumers and to ensure that plans have procedures to monitor the financial viability of providers whose payments are capitated. Also, DMHC indicates that it reviews contracts to ensure that they contain provisions for the fast, fair, and cost-effective resolution of disputes with both contracting and noncontracting providers. The DMHC contends that its enforcement of patients' rights laws and the use of tools such as IMRs will influence the managed care marketplace in a way that results in fair capitation rates for providers. The department was unable to provide evidence to prove this contention.

In keeping with its narrow interpretation of the law, DMHC has not devoted significant resources to overseeing the relationship between HMOs and providers. The Office of Plan and Provider Relations, which is responsible for this function, has only two staff members—a deputy director and an office technician. According to DMHC, the broad purpose of the office is to identify and resolve problems between health plans, hospitals, physicians, and other providers to ensure early resolution of consumer issues. However, the actual practice of the office is to limit its involvement to resolving complaints by providers against health plans about unfair payment practices. The DMHC has interpreted existing regulations to limit its participation in the plan-provider relationship to payment practices, rather than payment level or payment sufficiency.

Providers report problems to the office through a toll-free provider hotline and an e-mail address. The office receives approximately 300 such calls and 32 such e-mails per month. From the period of February 2001 through September 2001, about 87 percent of the calls involved payment problems and related legal questions. About 4 percent of the calls were from mental health providers concerning the mental health parity law, Chapter 534, Statutes of 2000 (AB 88, Thomson). About 3 percent were from brokers, consumers, attorneys, and others who had general legal questions about the regulation of HMOs. The remaining callers sought help on a wide variety of issues. In May and June of 2001, a significant number of calls (about 15 percent of the total in those months) involved questions regarding Chapter 529, the 2000 legislation authored by Senator Speier which also included a number of provisions relating to the health plan-medical group relationship.

The DMHC indicates that the Office of Plan and Provider Relations works closely with staff in the department's other divisions—including licensing, financial exams, medical survey, and enforcement—to resolve these complaints. Problems with provider payments from health care plans are recorded in a database that enables enforcement and financial division staff to detect trends in unfair business practices and possibly trigger nonroutine financial examinations of health plans engaged in such practices. During the past year, at least three health plans have been identified for nonroutine exams as a result of these complaints. The office also works with the HMO Help Center to identify and resolve systemic problems within health care plans and provider groups. Legal questions concerning provider contracts and HMO requirements are referred to house counsel.

Recent Legislation Further Defines the Department's Role. The Legislature has taken some actions to broaden DMHC's responsibility for managing the HMO-medical group relationship. Chapter 825, Statutes of 2000 (SB 1177, Perata) and Chapter 827, Statutes of 2000 (AB 1455, Scott), both of which took effect January 1, 2001, increased DMHC's role in ensuring prompt payment of providers. The legislation directs DMHC to develop regulations that would require health plans to establish procedures to resolve provider billing claims and disputes. Health plans would also be required by regulation to make providers aware of the dispute-resolution procedures and to report to DMHC the number and nature of provider disputes. The legislation increases the rate of interest that must be paid on late claims, and prohibits plans from engaging in unfair payment practices. Because these regulations were implemented only recently, it may take some time to see what impact they have on the relationship between providers and health plans.

Financial Instability of Medical Groups in California

In the following sections, we examine the financial challenges facing medical groups in California and discuss some of the possible causes of their financial instability. As we discuss further below, medical groups' problems appear to be the result of a combination of factors and probably should not be attributed to a single cause. Ineffective management, inadequate computer systems that cannot properly manage patient data and billings for medical services, unanticipated surges in pharmaceutical costs, and changes in medical practices and patient utilization of services may be contributing to the situation. In addition, other possible causes of financial instability include the way medical groups are regulated in California, medical groups bearing too much risk, and low capitation rates. We discuss these issues below.

Medical Groups Face Financial Challenges

A number of recent closures and bankruptcies have demonstrated that California's medical groups face significant financial challenges. These problems have significant

ramifications for the health care industry and consumers. Health plans must seek to maintain a sufficient number of providers to meet beneficiary needs. The failure of medical groups forces beneficiaries to find new providers, requires the sometimes problematic transfer of their personal medical records to new providers, and can interrupt the continuity of their care.

Complete statewide data on the number of medical groups that have closed or face financial difficulties are not available. However, there is evidence that financial problems are likely to continue, particularly for medical groups that share financial risk with health plans for providing health care. The DMHC released for the first time in October 2001 a set of grades of the financial solvency of risk-bearing medical groups. Based upon the grades, it appears that about one-third of the groups are facing significant financial troubles. Specifically, 75 of the 243 groups, or 31 percent of those complying with the financial disclosure requirements, reported that they did not maintain either a positive working capital (the extent to which current assets exceed current liabilities) or a positive tangible net equity (the extent to which tangible assets exceed liabilities), two standard measures of financial stability.

Medical Groups Are Not Directly Regulated

There is some evidence that an important factor affecting the financial status of medical groups is in the different ways they and health plans are regulated. In California and other states, health insurance companies and their health plans are subject to significant regulation. A number of regulatory safeguards have been established to protect health insurance consumers. Health insurance companies, for example, are commonly required to maintain adequate financial reserves because of the significant amount of risk that they bear. This risk is primarily the possibility that the premiums received for their coverage will be insufficient to pay for the medical needs of the persons they insure.

Health care plans transfer some of this risk to independent medical groups through contracts for the provision of medical services to their beneficiaries. In effect, some medical groups function as HMOs when they agree to provide medical services at a predetermined (capitated) rate for patients. Nonetheless, these medical groups do not qualify as health care service plans under the Knox-Keene Act and thus are not regulated by DMHC, DOI, or any other state entity.

Health Plans Indirectly Regulate Medical Groups. Chapter 529 (the 2000 bill discussed earlier) directed DMHC to indirectly regulate medical groups by requiring that their contracts with health care plans meet certain standards to ensure the medical group's administrative and financial capacity during the contract period. The measure also required DMHC to grade risk-bearing medical groups based on four standards, including their maintenance of positive working capital and their tangible net equity. In

essence, this legislation established an early warning system to detect medical groups that might face insolvency. Other regulatory agencies such as DOI use a similar approach to help protect consumers from the outcomes of financial insolvencies of insurers.

In March 2001, DMHC issued emergency regulations specifying the obligations of physician groups and health plans for compliance with Chapter 529. As part of these regulations, medical groups must submit annual audited financial statements and quarterly status reports to DMHC. In addition, HMOs must submit monthly reports to each medical group listing the patients enrolled and amount of capitation paid for each beneficiary. The regulations also required HMOs to disclose during contract negotiations how the responsibility for costs is divided between the medical group and the health plan, and to further disclose the expected utilization rates, costs, and risk adjustment factors for the patients to be provided services under the proposed contract.

Finally, HMOs must provide quarterly reports to medical groups disclosing the income and expenses for shared risk pools. A risk pool is an amount of funds that is set aside by an HMO and a medical group to pay for the provision of certain services that are not the full responsibility of the medical group, such as hospitalization. Under such arrangements, the medical group is not held responsible for paying for these specific services. At a predetermined time, the health plan must divide the money (called risk pool receivables) remaining in the risk pool with the medical group. The Chapter 529 regulations require HMOs to disperse to medical groups their share of money remaining in the pool within 180 days of the determination of the amount of unspent funds in the pool, a calculation that occurs on a regular basis (usually once each year).

It Is Too Early to Assess the Impact of Indirect Regulation. Since the Chapter 529 regulations were released only recently, it will take some time before their impact can be properly assessed. However, Dr. Lawrence Casalino, a University of Chicago expert on managed care issues, concluded in a recent article in *Health Affairs* (July/August 2001) that the regulations will probably help to stabilize California's managed care marketplace by eliminating weaker medical groups. He also concluded that these changes will further DMHC's stated mission of protecting consumers by moving patients to stronger medical groups and reducing the disruption caused by medical group bankruptcies.

Bearing Too Much Risk Results in Financial Troubles

Some researchers have suggested that, because medical groups are largely unregulated, they have taken on too much risk for the costs of patient care. A study by California Healthcare Foundation (October 2001) concluded, for example, that the root of the medical groups' problem is that financial risk has shifted to them from insurance companies.

The foundation study specifically found that medical groups often face insolvency because of their reliance on payments from risk pools. As discussed earlier, medical groups conduct their operations on the assumption that they will receive payments of surplus funds from the HMO-medical group risk pool. The surplus in the pool is ordinarily paid out once a year. However, the amounts due to the medical groups are often held up in disputes with health plans. Since a medical group's liabilities typically consist of obligations that must be paid on a short-term basis, such as claims payments and salary expenses, their reliance on once-a-year risk pool payments for cash to pay such bills could lead to financial problems.

The California Healthcare Foundation study found that the more that risk pool receivables comprised the current assets of a medical group, the less liquidity it generally has. The study thus recommended that the Chapter 529 standards be modified to include a cash ratio standard (the ratio of a medical group's cash plus marketable securities divided by current liabilities) as a better measure of near-term liquidity than its tangible net equity. The study found that a group might appear to be financially sound according to its tangible net equity, but that an evaluation according to its cash ratio could demonstrate serious liquidity pressures. As a result, the researchers concluded that a review of insurers according to their cash-ratio standards would better enable DMHC to identify medical groups with near-term liquidity problems.

The importance for risk-bearing entities to maintain reserves is stressed by Casalino in his recent *Health Affairs* article. Casalino maintains that medical groups in California embraced sharing risk with health plans, yet the medical groups failed to develop some of the qualities that are essential components of viable risk-bearing entities. For example, he contends medical groups have been unwilling to accumulate cash reserves and maintain levels of assets in excess of liabilities sufficient to meet financial obligations.

Capitation Rates Are Low, But Other Factors Play a Role

Associations of medical professionals and health plans have participated in an ongoing debate about the adequacy of capitation payments paid by health plans to medical groups. Complicating that debate is the lack of accurate or complete information about capitation rates or the number of medical groups that have actually filed for bankruptcy.

According to a recent article in *Health Affairs* (July/August 2001) by Dr. James Robinson, another expert on the managed health care industry, low payment rates are a significant cause of medical groups' problems. But, the author states that the relationship between low payment and organizational turmoil is complex and inconsistent. He finds, for example, that even though payment rates in some parts of the

United States are much higher than in others, this has not always ensured financial stability of the medical groups in those regions.

Robinson also found that while physician reimbursement rates have varied significantly within California, so has the incidence of financial difficulties experienced by medical groups in different regions of the state. For example, medical groups in Los Angeles are having greater troubles than those in San Francisco even though the Medicare HMO reimbursement rates are greater in Los Angeles. Furthermore, in every region within California some medical groups are earning modest profits while others are facing financial difficulties, making it difficult to determine the exact relationship between physician rates and the financial instability of medical groups.

A California Healthcare Foundation study (October 2001) likewise found that higher capitation payments to a medical group were not associated with better liquidity. The study found that medical groups with higher capitation rates actually tended to have *lower liquidity*. According to the study, this could be because medical groups with higher capitation rates tend to care for sicker patients or because medical groups with higher payments tend to pay their physicians higher rates and retain less cash.

Regulation of Medical Groups in Other States

You have requested that we provide you with information about how other states regulate medical groups. We found wide variation in the extent and method of regulating medical groups that appears to be related to the extent to which states have implemented managed care. As of January 2000, HMOs had not penetrated the health care system in other states to the extent that they had in California. California's 54 percent enrollment in managed care plans is the highest of any state in the country. Only eleven other states had a penetration rate that exceeded 34 percent. As a result, most states have not developed comprehensive regulations to address weaknesses in the managed care system that may compromise patient care.

Our review found that one state has chosen to regulate medical groups, as well as HMOs, in an effort to stabilize the managed care industry. The Organized Delivery System Act, enacted in 2000 in New Jersey, requires the licensing by the state Commission of Banking and Insurance of any organization that contracts with health insurers to provide health care services and which assumes financial risk for patient care. As part of licensure, these medical groups must file annually audited financial statements and maintain an adequate level of reserves. Medical groups that do not assume risk are required to obtain certification from the state Department of Health and Senior Services attesting that they do not bear any risk for the medical services they provide. As a result, all New Jersey medical groups are subject to either licensure or certification.

In an attempt to stabilize its health care industry, North Carolina law requires that HMO premiums be adequate to cover "anticipated costs." The state Department of Insurance enforces this requirement by conducting actuarial reviews of payment rates to medical groups. North Carolina does not regulate the financial solvency of provider groups.

Some Weaknesses in the State's Regulatory Approach

Our review of the department's operations suggests there are some weaknesses in the state's approach to regulation of the managed health care industry. These concerns include:

- The state's lack of sufficient information to fully assess why a number of medical groups in California are experiencing financial instability.
- Inconsistencies in the way the state regulates HMOs and risk-bearing medical groups which, like the HMOs, take on significant financial risks in their operations.
- The limited role that DMHC has determined it can play in the HMO-medical group relationship despite the significant impact these contracts can have on the quality and stability of patient care.
- Potential problems resulting from the division of state regulation of the managed care industry among several different state agencies.
- The possibility that the assessments DMHC imposes on HMOs are insufficient to meet the department's statutory responsibilities.

Options to Improve Regulation of the Managed Care Industry

Below, we offer several approaches you may wish to consider that would change the way the managed health care industry is regulated in California. Some of these options may work together, while others represent alternative courses of action. All would require substantial further study and analysis.

- ***Licensing and Certification of Medical Groups.*** You may wish to consider legislation similar to the measure enacted in New Jersey requiring that all medical groups be licensed or certified, with licensure required for groups which assume risk. This approach would enable DMHC to develop reporting requirements that would allow the state to collect complete and accurate data about medical groups that could identify more clearly what key factors are causing instability among California's medical groups.
- ***Regulation of Medical Groups.*** You may wish to consider legislation establishing regulatory requirements for risk-bearing medical groups

comparable to those already in place for health insurance companies. The state could require each medical group to maintain a reasonable level of financial reserves, a minimal level of working capital, and adherence to established cash-ratio standards.

- ***Expand DMHC's Role in the Health Plan-Medical Group Relationship.*** As your may be aware, a 2000 California legislative proposal which was not enacted, SB 2007 (Speier), would have significantly expanded DMHC's involvement in the health plan and medical group relationship by requiring DMHC to review every medical group contract with a health care service plan to determine if that contract compromised patient care. Based upon a review of criteria such as reimbursement methods and scope of services, DMHC could either approve the contract as proposed, or deem the terms unenforceable and recommend modifications. You may wish to consider that same approach in future legislation.

  Potential legislation could specify certain factors that health care plans would have to take into account when negotiating capitation rates with medical groups, such as specifying the level and types of risk that providers could bear. Another approach would be to consider legislation similar to that enacted in North Carolina requiring that HMO premiums be adequate to cover anticipated costs. Implementation of any of these proposals would probably require a significant increase in DMHC's staffing and budget, although these resources could be obtained by imposing assessments on medical groups and health care plans.

- ***Consolidating Regulation of the Health Insurance Industry.*** State regulation of the health insurance industry is split primarily between the DMHC and DOI. You may wish to consider legislation aimed at resolving some of the problems created by having two regulatory agencies oversee one industry, such as confusion and duplication of efforts in the resolution of consumer complaints about health care coverage. As we discussed earlier, the Director of DMHC and its Advisory Committee on Managed Care have contracted for a study of the feasibility and merit of consolidating regulation of all health insurers within DMHC that is due to be completed by the end of December. The study could provide the basis for legislation for further regulatory reform of the health care industry.

- ***Ensuring That DMHC Assessments Are Adequate.*** Finally, you may wish to consider legislation to ensure that DMHC has the financial resources needed to carry out its present mission to regulate HMOs. The Bureau of State Audits was recently assigned an audit examining the assessments that DMHC imposes on health plans to generate revenues for the Managed Care Fund,

the special fund which supports the department's main activities. The basis of this audit is legislative concerns that the current statutory formula used to assess fees does not properly reflect the relative cost of regulating the different types of companies regulated by DMHC. The audit may also shed light on whether there is adequate funding for the department to meet its assigned responsibilities. The audit is scheduled to begin early next year and will take about four months to complete.

Please contact Dan Carson or Farra Bracht at 319-8350 if you have any questions about the information provided in this letter or require any other assistance in regard to these issues. The information that you requested on November 9, 2001 will be provided in a subsequent memorandum.

Sincerely,

Elizabeth G. Hill
Legislative Analyst

Enclosures

Enclosure 1

Department of Managed Health Care

Draft Budget by Office (in thousands)

As of October 1, 2001

	Personal Services	OE&E	Total
Director's Office	1,944	903	2,847
Admin Services	2,877	896	3,773
Enforcement	1,552	576	2,128
Health Plan Oversight	5,874	2,651	8,525
HMO Help Center	3,479	3,745	7,224
Legal Services	1,672	577	2,249
Technology & Innovations	1,135	477	1,612
OPA	684	2,805	3,489 [1]
Total	19,217	12,630	31,847

[1] For purposes of display, the OPA budget reflects $2,000,000 for Consumer Education that is budgeted in the Health Plan Program

Source: Department of Managed Health Care

Enclosure 2

Department of Managed Health Care

2001-02 Current Year - OE&E (in thousands)

OE&E	Hlth Plan Oversight	HMO Help Ctr
General Expense	325	138
Printing	35	37
Communications	33	222
Postage	14	15
Travel In-State	260	39
Travel Out-State	40	1
Training	29	23
Facilities Operation	589	608
Utilities	1	1
Cons & Prof-Interdept'l	153	46
Cons & Prof-Ext	538	2,091
Consolidated Data Center	0	0
Data Processing	95	100
ProRata	525	413
Equipment	14	11
Total OE&E	2,651	3,745

Source: Department of Managed Health Care

Enclosure 3

Department of Managed Health Care
Office of Enforcement

July 1, 2000 - present

ACCUSATIONS

Matter ID	PLAN	VIOLATION	ACTION/DATE	RESOLUTION
00-136	Baycare	Failed to file financial reports.	$17,500.00 7/5/2000	Charges uncontested
01-043	Community Dental	Failure to file financial statements	$2,500.00 7/27/2001	$2,500.00 fine collected on 8/30/2001
01-001	Health Net	Failure to provide 30 day notice.	$30,000.00 2/2/2001	$30,000.00 fine collected on 2/15/2001
99-282	Ideal Dental	Fiscal and quality of care issues.	$10,000.00 9/25/2000	Charges uncontested; Received 2 of 10, $1,000.00 payments, on 8/3/2001 and 8/30/2001
98-126 00-190	Kaiser	Failed to provide medically necessary treatment and access to care	$1,100,000.00 amended 12/1/2000	Hearing pending
01-067	ProMed Health Care	Failure to file financial statements	$5,000.00 8/16/2001	$5,000.00 fine collected on 8/30/2001
00-003	Safeguard	Failed to reimburse providers within 30 days, upstreaming of funds, and inadequate provision against the risk of insolvency.	$2,500.00 7/11/2000	$2,500.00 fine collected on 8/2/2000
98-013	United Health Care	Failed to provide continuity of care and readily available and accessible services. Administrative interference in medical decisions.	$100,000.00 10/5/1999	$25,000.00 fine collected on 11/9/2000, The plan provided exculpatory evidence which resulted in the significant reduction of the penalty.

CONSERVATORSHIPS

	PLAN	VIOLATION	DATE	RESOLUTION
99-196	HealthDent	Financial issues	7/19/2000	Court appointed Conservator
01-073	Maxicare	Financial issues	5/25/2001	Court appointed Conservator
01-031	Preferred Health	Financial issues	2/8/2001	Director appointed Conservator
01-053	WATTS Health Plan	Financial issues	8/8/2001	Director appointed Conservator

CEASE AND DESIST ORDERS

	PLAN	VIOLATION	DATE	RESOLUTION
00-189	Alianza Economica	Unlicensed plan	4/13/2001	Plan complied
00-136	Baycare	Failed to file financial reports.	7/5/2000	
00-183	Blue Cross	Failure to provide proper notification and continuity of care	9/5/2000	
01-079	Blue Shield	Transfer of enrollee's	6/7/2001	
01-006	Grupo Intermedic	Unlicensed plan	8/17/2001	
01-006	IMS	Unlicensed plan	8/17/2001	
99-069	Latino Health	Unlicensed plan	9/2/2000	
01-002	PacifiCare	Failure to pay claims	2/1/2001	$250,000.00 fine collected on 3/16/2001 C&D Order lifted on 3/8/2001
00-216	Primecare Dental	Failure to file a material modification for sale of office	10/24/2000	

MISCELLANEOUS

	PLAN	VIOLATION	DATE	RESOLUTION
01-093	Aetna	KPC medical records/continuity of care	8/20/2001	Plan complied; awaiting signed letter of agreement
01-093	Blue Cross	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	Blue Shield	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	Cigna	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	Health Net	KPC medical records/continuity of care	8/20/2001	Plan complied; awaiting signed letter of agreement
01-093	Intervalley	KPC medical records/continuity of care	8/20/2001	Plan complied; awaiting signed letter of agreement
01-054	Laurel Dental	Failure to file final audit	9/21/2001	Collected fine $2,500.00
01-093	MaxiCare	KPC medical records/continuity of care	8/20/2001	Plan complied; awaiting signed letter of agreement
01-093	PacifiCare	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	SCAN	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	Tower Health	KPC medical records/continuity of care	8/20/2001	Plan complied; **received** signed letter of agreement
01-093	UHP HealthCare	KPC medical records/continuity of care	8/20/2001	Plan complied; awaiting signed letter of agreement
01-093	Universal	KPC medical records/continuity of care	8/20/2001	Plan complied; **received**
01-053	WATTS Health Plan	Financial issues	8/8/2001	

LETTERS OF AGREEMENT

	PLAN	VIOLATION	DATE	RESOLUTION
99-283	Aetna	Failure to pay for prescription drugs	3/6/2001	Collected fine $2,500.00
01-030	Blue Cross	Failure to pay claims within 30 days	2/5/2001	Collected fine $2,500.00
98-053	Cigna	Failure to pay for medically necessary care	1/23/2001	Collected fine $10,000.00
00-273	Health Net	Violated confidential medical records	3/16/2001	Collected fine $15,000.00
01-007	Health Net	Financial Violation (False Statements)	4/17/2001	Collected fine $60,000.00
01-025	Heritage P. N	Failure to pay interest on late claims	10/1/2001	Collected fine $50,000.00
00-182	Kaiser	Releasing medical records without consent. Failing to file appropriate amendments to operate online service.	1/2/2001	Collected fine $25,000.00
99-236	PacifiCare	Failure to give a timely referral to out-of-plan specialist.	8/30/2001	Collected fine $25,000.00
01-045	PacifiCare	Denial of coverage for needed vitamin supplements	9/13/2001	Collected fine $2,500.00
00-194	Safeguard	Failed to pay claims in timely manner.	11/7/2000	Collected fine $10,000.00
99-332	Simple Care	Unlicensed plan	7/25/2000	Stopped business
00-157	Various Plans	Warning calls were made for Non-compliance with submitting enrollment reports	7/19/2000	Plans complied
98-010	Ventura Cou	Denial of coverage for durable medical equipment	7/16/2001	Collected fine $2,500.00

LICENSE SURRENDERED/REVOKED

	PLAN	VIOLATION	DATE	RESOLUTION
00-136	Baycare	Financial issues	3/1/2001	Surrendered license
98-002	FPA	Financial issues	5/25/2001	Revoked license
99-282	Ideal Dental	Financial issues	10/31/2000	Pending

98-027	Laurel Denta	Various	7/25/2000	Revoked license
00-243	Priority Plus	Various	1/16/2001	Surrendered license

Note: Per Herb Schultz. The chart is up-to-date, however, because of on-going enforcement issues that could get resolved at any time, it can change.