



Welcome to California

ICE 2009 ANNUAL CONFERENCE

The Regulator's View – Where Do We Go From Here?

**Rick Martin, Deputy Director
December 7, 2009**

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The California Department of Managed Health Care

- Created in 2000 to protect/promote interests of enrollees

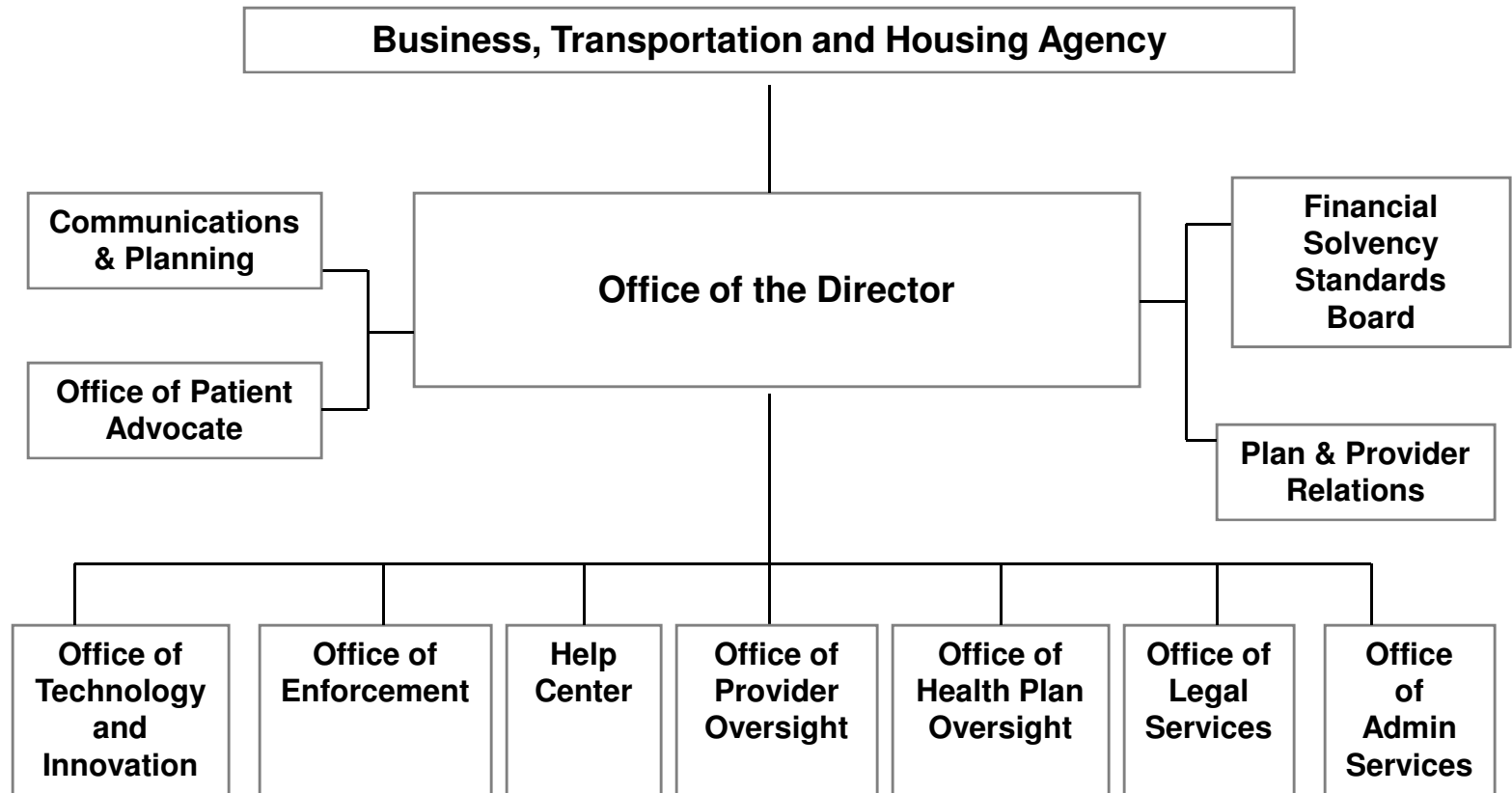
- DMHC regulates plans by:
 - Knox-Keene Act (KKA) and Regulations
 - Initial Licensure
 - After licensure, file changes to plan's operations
 - Financial audits and reporting requirements
 - Medical surveys
 - Consumer complaints
 - Provider complaints
 - Enforcement actions





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Organization



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DMHC: What We Do

- Regulate all HMO products
- PPO products (Blue Cross and Blue Shield)
- HMO Help Center
- Licensing New Products & Changes in Doctor & Hospital Networks
- Financial Oversight of 100+ Health Plans & 220 Capitated Medical Groups
- Provider Complaint Unit
- Routine & Non-Routine Financial & Consumer Practices Audits
- Enforcement Actions
- Health Policy

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DMHC Role: Ensure the Right Care at the Right Time

Focus on value, cost effectiveness, and market competition.

- Promote solvent, high quality, integrated care systems.
- Balance regulation to ensure that benefits to consumers outweigh burden on industry.
- Preserve the delegated model of managed care.
- Ensure that doctors and hospitals are paid fairly and on time.
- Provide leadership in fostering innovation in care systems through process redesign and HIT.

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California is the Nation's #1 HMO Market

- **More than 25% of America's HMO enrollees live in California.**
- **California health plans cover more than 24 million people.**
- **Two of every three Californians are enrolled in an HMO product.**
- **12 million are in the large group market (more than 50 employees) – 90% are enrolled in HMOs.**
- **4 million are in the small group market (2-50 employees) – 82% are enrolled in HMOs.**
- **2.1 million are in the individual market (not employer based) – 62% are enrolled in HMOs.**

CAHP 2009 Annual Report





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What a Difference 5 Years Makes

- **2004: First-Dollar Coverage** – Prevention and wellness are cornerstones, system should incent coming in early.
- **2005: “Consumer-Directed”** – a financially at-risk consumer will understand the value of benefits.
- **2007: “Financial Protection”** – Purpose of health coverage is to cover catastrophic loss with some narrow preventive services leaving low-cost and predictable forms of care to be financed out of pocket by the patient.
- **2008: “Normalizing” health insurance** – Should conform to traditional insurance (auto, home).
- **2009: “Something is Better than Nothing!”** Price is prime consideration - a plan with only a few benefits is better than going without.

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How is the HMO product doing?

- From 2003-2007, DMHC enrollment averaged losses of nearly 1% per year, while CDI enrollment grew 22% per year.
- In 2007, revenue grew faster in CDI-regulated plans than in DMHC-regulated counterparts.
 - Blue Shield 58% v 3%
 - ABC – 20% v 2%
- Decreases in individual enrollment range from 20% to 60% by plans.
- It's not just the HMO product – the entire concept of insurance has dramatically changed.

California Health Care Almanac
CHCF, January 2009

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Overall Enrollment Trends

- From 2006 through June 2009:
 - Commercial business declined 8%
 - Individual business declined 40%
 - Small group business declined 31%



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Average Annual Premiums for Single and Family Coverage, 1999-2009



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

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Factors in Momentum Away from HMO Products

- **Managed care public perception.**
- **Loss of union jobs with good benefits.**
- **National employers want to simplify to one design.**
- **Benefit plans have become too “rich” for employers.**
- **Employers are moving employees into high-deductible programs.**
- **ASO structure requires less upfront cash.**
- **Delegated RBOs can’t administer deductibles.**

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Licensing Trends: Continued Cost Shifting to Consumers

- Deductibles.
- Out of Pocket Maximums.
- Outpatient Prescription Drug Tiering
- Coinsurance vs. Copayments.

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Cost Shifting to Consumers Rebounds on Providers and Plans

Avoids Bad Economic Theory

- » Continuation of cost shifting is “irrational economic theory” superimposed on the marketplace.
- Cost shifting is only sustainable for so long as the market will bear it.
 - Once the market begins to resist, cost shifting cannot be sustained.
- Therefore, as a long term strategy to lower premium, cost shifting is destined to fail.



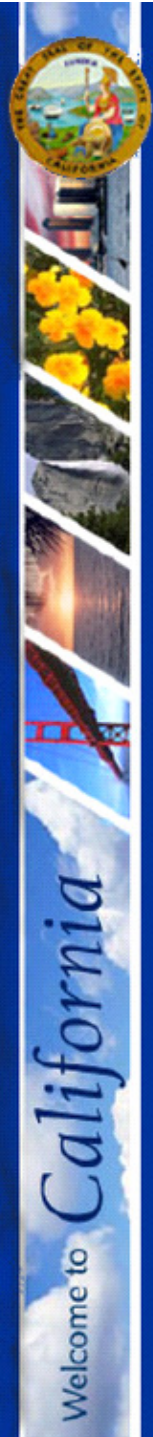
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Overall financial status of the DMHC-regulated health plans

- Overall, health plans have fared the economic downturn fairly well, compared to other industries.
- Commercial enrollment is greatly impacted by job losses, health insurance drop, or move to ASO.
- Keeping premiums high while experiencing lower utilization explains why their financial condition is relatively solid.
- Premium increases will average 10% this year, but will be significantly higher in Individual products.

Challenging & Changing Provider Networks

- What is an adequate network?
- Financial viability of provider groups
- Hospital change of ownership/bankruptcies
- Shift in bargaining power between health plans and providers
- Hospital systems' bargaining tactics.
- Lack of specialty providers in certain network areas
- Increase in actual contract terminations
- Capacity issues
- Providers with exclusive admitting privileges at terminating hospital
- New products – impact on providers
- What is adequate reimbursement?





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Block Transfer Statistics: Results from Contract Termination

– 2008 Calendar Year

Provider Groups	99 filings
<u>Hospitals</u>	<u>291 filings</u>
Total	390 filings

– 2009 Calendar Year*

Provider Groups	103 filings
<u>Hospitals</u>	<u>220 filings</u>
Total	323 filings

**As of 10/13/09, this data reflects contract termination dates that occur between 1/1/09 to 12/31/09.*



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Provider Perceptions about Payers

- Deliberately delay payments
- Apply non-standard bundling logic
- Have proprietary fee schedules and change them at will
- Downcode claims without merit
- Have cryptic denial reasons on EOBs
- Make appeals difficult
- Deny payments for authorized services



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Provider Complaint Unit

- **Since its establishment in 2004, the Provider Complaint Unit has:**
- **Received more than 20,000 complaints.**
- **Recovered almost \$17.5 million in additional payments to providers.**
- **Identified and effected change to unfair payer payment practices.**

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Current Trends in Claims Disputes

- Poor dispute resolution responses.
- Failure to consider good cause on late claims.
- Bouncing provider back and forth between the plan and group.
- Inappropriate reimbursement requests and offsets.
- Plan not paying according to contract.
- Failure to recognize provider's complaint as a provider dispute.
- Failure to properly adjudicate claim until provider complains to DMHC.



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Best Practices – Claims

- Getting claims to the right place in the first place
- Forwarding with EOB message – no “black holes”
- System-coded DOFRs to reduce human error
- Published, consistent payment policies
- Coherent denial or pend messages
- Customer service by claims experts
- Minimize retroactive eligibility changes
- Incentivize staff accuracy and speed
- Collaborate with contracting on rate interpretation
- Research and correlate interim hospital bills
- Hospital Stop Loss – designated experts



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Claims Initiatives

- DMHC estimates 80% of all claims denied in California are misdirected, and that 95% are adjudicated within 45 days.
- Yearly claims audits on the Big 7 plans, rather than the once every five years that is required by statute.
- DMHC posts the financial filings on its website to promote transparency to the public, although not required to do so.
- Reasonable & customary payment data collection and analysis.
- Greater emphasis on RBO solvency auditing with an emphasis on identifying RBO's with existing or emerging claims payment violations, to ensure/enforce prompt payment of claims.

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DMHC Goal #1: Ensure Fair Provider Payment

Continue a strict and aggressive enforcement policy to ensure that the state's physicians and hospitals are fairly and promptly reimbursed for Care

- Create accountable audit system
- Ensure reasonable and customary payment for non-contracted services
- Address systemic issues
- Resolve provider complaints
- Expedite enforcement actions

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DMHC Goal #2: Administrative Simplification of Transactions

- Multi-payer portal to conduct eligibility verification, benefit design, and financial responsibility.
- System to accurately track deductibles and out-of-pocket maximums.
- Transparency for costs associated with health care services.
- Electronic claims/billing systems (providers delay sending claim/billing information to plan which results in delayed billing to consumer).
- Real-time claims tracking, adjudications.
- Electronic EOBs.





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DMHC Goal #3: Foster E-Health System Technology

- Expand access to broadband thru CA Telehealth Network.
- Promote telemedicine and telehealth solutions.
- Support the adoption of information technology systems by physicians, hospitals, community health centers for “meaningful use” under federal incentive payments.
- Facilitate incentive payments
- Expand E-Health infrastructure
- Resolve provider shortages



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DMHC Goal #4: Improve Quality of Health Care

- Measure quality of care
- Promote quality by providers
- Encourage healthy behaviors
- Regulate centers of excellence
- Add formulary protection
- Prevent Medicare marketing abuses
- Improve peer review/quality outcomes
- Prosecute improper delays/denials of care

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DMHC Goal #5: Prevent Unlawful Rescissions

- Disclose underwriting practices
- Ensure fair application process
- Require fair investigations
- Maintain accountability
- Monitor plan compliance
- Coordinate enforcement efforts
- Enhance current protections

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DMHC Goal #6: Enhance Mental Health Services

- Ensure mental health parity compliance
- Adopt consumer protections
- Provide timely and predictable services
- Resolve enrollee complaints
- Educate consumers



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DMHC Goal #7: Right Care Initiative

- Launched in 2007 by the DMHC to improve clinical quality improvement in three areas:
 - Cardiovascular disease (with particular emphasis on hypertension).
 - Diabetes.
 - Hospital acquired infections.
- By 2011, the health plans and medical groups performance targets are specifically:
 - To reach the national 90th percentile of performance in cardiovascular disease and diabetes HEDIS measures.
 - To reduce specific hospital acquired infections to a median of zero.

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DMHC Goal #8: Provide Language Assistance

- Resolve consumer complaints
- Educate consumers and others
- Identify and resolve problems

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Help Center Requests for Interpreters

- **Jan - Aug 2009 – received 1,051 language line calls. (Avg of 131 per month)**
 - For comparison, in 2008 received a total of 874 Language Line calls (average of 73 per month)
 - Increase of nearly 80% in 2009.
- **Also received 4,227 Spanish calls which were answered by bilingual agents.**
 - Averaged 528 per month compared to 5,004 for all of 2008 – about a 27% increase.



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DMHC Goal #9: Regulate Discount Health Plans

- Adopt regulations
- Enact Licensing process
- Monitor financial viability
- Ensure compliance with regulations
- Address consumer complaints
- Prevent unlawful activities
- Educate consumers

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DMHC Goal #10: Implement Timely Access

- Protect enrollee access to care
- Annual compliance report
- Perform annual plan surveys
- Review plan compliance filings
- Educate providers on complaint process



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Timely Access Countdown

- The final regulation text was submitted to OAL on November 3.
- OAL will issue its decision by December 18.
- If approved by OAL, the regulation will be forwarded to the Secretary of State, and become effective 30 days later.
- Within 9 months of the effective date, plans must file their proposals for compliance for DMHC review and approval.
- Within 12 months of the effective date, plans must be in full compliance as approved by DMHC.



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Impact of Timely Access Regs

California will soon be the first state set standards to shorten the time a patient has to wait to see a doctor:

- **Triage or screening by telephone 24-7.**
- **Waiting time for triage no longer than 30 minutes.**
- **During normal business hours, waiting time to speak to a plan's customer service rep no longer than 10 minutes.**
- **Most urgent care appointments available within 2 days.**
- **Appointments for non-urgent primary care visits available within 10 business days.**
- **Non-urgent appointments with a specialist available within 15 business days.**

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Signed Bills Amending the Knox-Keene Act

1. AB 23 (Jones) extends Cal-COBRA coverage and makes related changes.
2. AB 108 (Hayashi) prohibits specified acts impacting individual coverage.
3. AB 119 (Jones) prohibits the use of gender to determine contract charges.
4. AB 171 (Jones) regulates financial arrangements related to dental care.

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Signed Bills Amending the Knox-Keene Act

5. AB 235 (Hayashi) clarifies transfer obligations involving emergency psychiatric conditions.
6. AB 830 (Cook) revises various drug reference guides for certain purposes.
7. AB 1164 (Tran) provides clean-up revisions to the Knox-Keene Act.
8. AB 1540 (Health Committee) allows more expedient changes to notices.

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Signed Bills Amending the Knox-Keene Act

9. AB 1541 (Health Committee) extends time period to transition from publicly-funded coverage.
10. AB 1543 (Jones) updates provisions governing Medi-Care supplement coverage.
11. SB 296 (Lowenthal) requires information to help access mental health services.

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Signed Bills Amending the Knox-Keene Act

12. SB 630 (Steinberg) requires coverage of dental and orthodontic services for cleft palate procedures, as specified.



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HEALTH REFORM

Make California the answer!

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- www.dmhc.ca.gov
- Help Line 1-888-466-2219

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