Health Insurance Oversight in California:

Observations on the Post-ACA Environment

by Deborah Reidy Kelch

In 2011, the California HealthCare Foundation (CHCF) published "Ready for Reform: Health Insurance Regulation in California under the ACA," authored by the Kelch Policy Group.[1] *Ready for Reform* examined health insurance regulation in California in light of the opportunities and challenges presented by the federal Affordable Care Act (ACA), including characteristics and limitations of California's "one-of-a-kind" health insurance regulatory approach. Two separate and independent state agencies, the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC), regulate health coverage in the state, with some products subject to CDI oversight and others subject to DMHC oversight.

In 2012, CHCF awarded the Kelch Policy Group a follow-up grant for support of the Health Insurance Alignment Project (Alignment Project). The Alignment Project provided expertise and background resources for policymakers and state staff working to implement the new ACA paradigm for private health coverage. Alignment Project activities included working in coordination with state staff to analyze and compare state and federal standards for health insurance coverage, including helping to identify differences in the state's two regulatory approaches and conforming state law changes needed in both.

This issue brief offers observations and lessons learned from the Alignment Project's unique opportunity to observe and contribute to ACA implementation in the state.

Enacting ACA Market Reforms in California

Immediately following passage of the ACA in 2010, California embraced and aggressively implemented the full breadth and spirit of the ACA, including establishing one of the first successful state-based ACA health insurance exchanges (also known as marketplaces) and dramatically expanding eligibility for Medi-Cal.

To implement ACA health insurance market reforms, California enacted legislation imposing many new standards on health insurance issuers including revising or expanding CDI and DMHC enforcement authority accordingly. In some cases, the Legislature introduced two companion bills, one in each house: one bill making conforming changes to the California Insurance Code (CIC) overseen by CDI and another bill addressing changes to the Health and Safety Code (HSC), the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), overseen by DMHC. For example, California enacted companion bills for market reforms in the individual and small group market and for essential health benefit requirements in those markets.

Most observers acknowledge that California's unique dual-regulator approach complicates oversight of health insurance in the state. Similarly, the two-agency regulatory structure presented distinctive challenges for the state's compliance with ACA reforms. Every federal standard and state implementation option requires legal and policy analysis within two different legal contexts. California's ACA implementation path dramatically underscores the significant resources, time and energy that state policymakers, staff and stakeholders continually dedicate to analyzing and working through the dual approaches.

California's health insurance oversight landscape is also more involved because the two state agencies implementing the ACA coverage expansions, Department of Health Care Services (DHCS) and California's ACA exchange, Covered California, contract with licensed health plans to provide health coverage to millions of Californians in Medi-Cal and the exchange, respectively. While DHCS and Covered California are not regulators, the health plan contracts each administers are subject to extensive state and federal standards affecting nearly all aspects of the coverage, from benefits to networks to quality measurement.

California's effort to implement the ACA through conforming state legislation and policies necessitated hours of analytical and tracking work. Legislative and state agency staff, with stakeholder input, worked many hours to revise California law without losing or compromising state requirements that might be more state-specific or consumer-protective. During the process of enacting state legislation, federal agencies were also releasing (and revising) ACA rules and guidance for states. The state compliance process is ongoing because federal agencies continue to update and revise federal rules and guidance. California ACA implementation is still very much in process as errors, omissions or conflicts emerge and require statutory and/or regulatory changes. Policymakers, regulators, stakeholders and other affected state agencies still confront daily challenges to reconcile and monitor the new state and federal requirements.

New Federal Standards Promote Greater Uniformity

Prior to passage of the ACA, states assumed the primary role in setting health insurance market rules and regulating most aspects of private health coverage. Under the ACA, states continue to have the lead in oversight but now also enforce ACA federal standards affecting virtually all aspects of health insurance—including eligibility for coverage, benefits, premium rates, market conduct, quality, and transparency—with some of the most sweeping changes affecting coverage in the individual and small group markets.

Significantly, because the ACA set comprehensive standards for health insurance, California needed to eliminate or standardize many of the rules that historically differentiated products under CDI and DMHC. The new ACA standards generally apply to health insurance issuers regardless of the model of coverage (e.g., HMO or PPO) and, in California, regardless of the regulator overseeing the coverage. For example, all individual and small group coverage, regardless of state license or authority, must at a

minimum cover medically necessary essential health benefits. Issuers must offer products in standardized coverage tiers based on the percentage of health care costs covered by the policy (bronze, silver, gold, platinum and catastrophic). Prior to the ACA, only Knox-Keene plans had to cover a minimum set of basic services while insurers subject to the Insurance Code had no such requirement.

Federal Rules Require Reconciliation with California Law

Implementing the ACA in California meant evaluating the new federal rules in light of California law and consumer protections developed since the passage of Knox-Keene in 1975. Policymakers worked to ensure that both California regulators had sufficient and appropriate authority to monitor and oversee the new market rules despite having fundamentally different legal foundations.

In 1992, California enacted a guaranteed issue mandate for small employer coverage and in 1999 passed guaranteed renewal requirements in the individual market. Having an existing legal framework for the federal reforms both assisted with and complicated state legislation. The federal ACA introduced different terminology and methods to accomplish similar but not identical goals, requiring reconciliation with both the Insurance Code and Knox-Keene. California retained some standards where compatible, and either enhanced or clarified state law to meet the federal rules. For example, California retained stronger enforcement provisions related to when issuers can deny or fail to renew existing individual and small employer coverage. On other issues, California deferred to federal rules in their entirety, such as the federal risk adjustment program and federal calculations for ensuring issuers spend sufficient revenues on health care, known as medical loss ratio requirements.

Early federal court challenges to the ACA also influenced California's approach to conformity. In recognition of pending court challenges and other elements of uncertainty affecting ACA implementation at the federal level, California law includes complex contingencies that would repeal specific ACA requirements if federal action reduces or eliminates key elements such as the individual coverage requirement.

Despite the process of multiple bills and the effects of two independent regulators, California achieved substantively similar legal requirements applicable to all issuers. However, consumers may still experience different standards because the two regulators separately interpret and enforce the laws.

The State Exchange Changes the Oversight Landscape

The establishment of California's state-based exchange created a new public forum for considering and evaluating the standards and operation of individual and small-group health insurers. Although Covered California is not a regulator, there are new federal requirements for issuers participating in exchanges, increased public scrutiny and elevated public expectations for the exchanges to impact and monitor health insurance markets and coverage.

Covered California's core purpose is to select and offer health coverage options for individuals and small groups through the exchange. Covered California administers eligibility for federal premium assistance for low-income individuals and families and collaborates with the state DHCS, and county human services agencies, on eligibility for the subsidies and Medi-Cal. Federal and state rules also assign the exchange responsibility to educate and inform consumers about health coverage and to improve quality and the consumer experience. Under California law, Covered California must select and contract with issuers to "offer the optimal combination of choice, value, quality and service."[2]

Covered California's responsibility to be an active purchaser and comply with extensive federal and state exchange rules turned out to be more complicated with two state regulators. Covered California must analyze two sets of laws and work with each regulator independently. Policymakers, stakeholders, the media and the public may not always readily appreciate the complexity of legal authority and the respective roles and responsibilities of Covered California, CDI and DMHC.

The new role of Covered California amplifies the challenges of having two regulators in the state. Covered California's primary authority over qualified health plans is through the selection, certification and contracting process; but it must rely on the two regulators to enforce most of the state and federal rules that apply to health insurance inside and outside the exchange. Thus, Covered California often must often defer to CDI and DMHC even though the standards each enforces are different.

For example, federal and state law require exchanges to contract only with issuers who are "licensed in good standing" with state regulators. In California, this requirement means different things for CDI- and DMHC-regulated issuers. Covered California's contract therefore outlines the respective standards issuers must meet to demonstrate good standing depending on the regulator.[3] For example, in licensing health plans, DMHC evaluates quality assurance and quality management policies and practices, as well as plan administrative and organizational capacity, while CDI does not. CDI enforces the National Association of Insurance Commissioner's financial solvency standard for insurers, known as risk-based capital, while DMHC enforces a state-specific solvency standard, tangible net equity.

Covered California requires contracted health plans to comply with either CDI or DMHC provider network standards depending on the product, but the CDI and DMHC standards, while similar, are not identical. As another example, CDI recently updated and strengthened its network adequacy regulations to reflect many of the concepts and goals of the ACA, such as the inclusion of mental health and substance use treatment as essential health benefits in evaluating network access and also incorporated numerous related provisions from the Knox-Keene Act. However, DMHC has not yet updated its rules in response to the ACA, but is currently reviewing the network adequacy and timely access rules and standardizing health plan reporting of networks to improve oversight and monitoring of networks and access.

Sometimes Covered California imposes the highest standard on all participating issuers regardless of product licensure. For example, Covered California requires all its contracted issuers to maintain a

consumer grievance and complaint process consistent with detailed timelines and rules in Knox-Keene even though products under the Insurance Code are not subject to the same specific requirements.

Significantly, Covered California implemented standardized benefit designs with the goal of simplifying the consumer health insurance shopping experience. Covered California issuers must offer at least one of the standardized plans in all five coverage categories. In addition, California law requires issuers in the exchange to offer the same products if they sell coverage outside the exchange and issuers not in the exchange to offer at least one qualified health plan "mirror" product in each tier outside the exchange. The combination of the Covered California standard designs and state requirements that extend the benefit designs into the outside market is profoundly affecting the coverage options available in the individual and small group markets and reducing differences among products in the market, including narrowing the differences between products overseen by CDI and DMHC.

ACA Tests State Institutional Capacity

The challenge to evaluate existing state law and comply with ACA market reforms necessarily called for a deep examination of the historic rationale and context for long-standing state requirements. Legislators, state staff and stakeholders worked to do that analysis and to enhance and refine state law. At the same time, the process highlighted state capacity challenges and the loss of institutional knowledge that accompanies legislative term limits and turnover among legislative and state agency staff. Policymakers had few objective resources available to provide the historical context and legislative intent underlying California's extensive body of health insurance law.

In addition, there is no agency of state government assigned the institutional responsibility to track, analyze and reconcile the legal and policy differences in California's two regulatory regimes. There is no single state agency with the responsibility *and the necessary legal authority* to ensure consumers in all health insurance markets have access to comparable, accurate information as they choose among the available health coverage options. Legislation cannot entirely guarantee regulatory consistency since, as described above, each regulator interprets and enforces the law independently.

The goal of a health insurance regulatory program should be to establish a system of straightforward regulations that the regulator enforces to hold industry accountable in a fair and consumer-focused manner. However, California's current structure means that when consumers, purchasers, providers or the media identify problems, policymakers must pinpoint the type of license or certificate governing the coverage, which rules apply and the respective regulator's authority and inclination to enforce the rules. Oversight by policymakers, the press and the public is constrained by the complexity and, on occasion, by the competing views and approaches of CDI and DMHC. The multiple layers and disparate standards make it more difficult for policymakers to remedy identified deficiencies in a manner that yields consistent statewide solutions.

While having two health insurance regulators increases the quantity of laws and regulations applicable to issuers in the state, and in some cases raises the bar of consumer protection as each agency identifies the most effective strategies and rules, dual regulation fundamentally weakens accountability by complicating legislative oversight. To change state policy, policymakers and stakeholders must evaluate and reconcile the very different standards, approaches and opinions of two agencies. Unfortunately, the public debate in California often focuses on the complexities and policy differences of the state's two health insurance regulators rather than focusing on objectively measuring the effectiveness and accountability of either program.

ACA Reframes the Policy Choices

For nearly five years, California has been working to implement federal health insurance market reforms in state law, policy and practice. It has been a momentous effort with significant work continuing to revise, update and improve the oversight and regulation of health insurance in the new ACA context. The state's efforts remain complicated and more challenging because it continues to regulate health insurance with two separate and legally independent agencies.

The challenges of two regulators are not new and have been studied and examined for decades.[4] Typically, the focus of past analyses centered on which individual regulator or legal framework had the tougher or more desirable standards and approach. However, comparing regulators issue-by-issue, or based on the approach adopted by any individual Insurance Commissioner or DMHC Director, has only led to inaction and paralysis in resolving the regulatory overlap. Most analyses find strengths and weaknesses in both departments and legal configurations. At any point in time, the political context for state regulation may favor one regulator over the other.

Implementation of the ACA, however, raises a fresh set of issues, challenges and policy choices regarding health insurance regulation in California. The new standards for health insurance issuers and the impact of Covered California are eroding differences among health insurance products in the market and narrowing the differences between products overseen by CDI and DMHC. At the same time, consumers, providers, purchasers, stakeholders and the public increasingly expect transparent, consumer-oriented standards and meaningful legislative oversight of those standards.

Policymakers established DMHC 15 years ago with the goal of creating a visible state agency singularly focused on managed care and consumer protection.[5] At the time, substantial differences persisted in the products regulated by CDI and the Department of Corporations (the predecessor of the DMHC) such that the Legislature did not consolidate all managed care products under the new DMHC. In post-ACA 2015, however, there are fewer permissible differences in products and less justification for different rules and enforcement. Consequently, California's health insurance market is shifting toward DMHC products. Enrollment data recently released by CDI and DMHC reveal that as of the end of 2014, DMHC regulates the largest portion of enrollment in all three commercial markets, with 82% of the individual

market, 77% of the small-group market, and 91% of the large-group market. In prior years, CDI was the predominant regulator of individual health coverage in the state.[6]

The market and product changes under the ACA, along with the market shift to more Californians enrolled in health plans under the DMHC, may provide policymakers with different options for improved coordination of health insurance oversight than have been practical in the past. For example, policymakers could consider moving all individual and small group coverage to the DMHC in recognition of the similar state and federal rules that apply in those markets under the ACA. Issuers of small group and individual coverage must guarantee availability of coverage, provide essential health benefits incorporating Knox-Keene basic services, comply with detailed rating rules and offer coverage inside and outside the exchange in designated coverage tiers.

Alternatively, policymakers could require Covered California to contract solely with DMHC-regulated health plans. This approach would be similar to Medi-Cal's reliance on DMHC-licensed health plans in Medi-Cal managed care. The Medi-Cal model makes it possible for DHCS to work in partnership with one regulator, DMHC, in the oversight of Medi-Cal managed care plans. For example, DHCS and DMHC coordinate onsite medical surveys of health plans participating in Medi-Cal. As enrollment in Medi-Cal managed care grows, DMHC continues to work with DHCS to improve oversight of Medi-Cal managed care plans. Similarly, if Covered California contracted exclusively with DMHC-regulated health plans, policymakers, Covered California and DMHC could harmonize policies and oversight for Exchange-qualified health plans subject to consistent enforcement by DMHC.

Conclusion

The sweeping regulatory and market changes underway as part of ACA implementation call for a renewed focus on how best to empower state regulators with the proper legal authority, resources and responsibility to hold the health insurance industry accountable in a meaningful and practical way. To accomplish this, California could continue trying to combine, synchronize and reconcile features of both current regulatory programs into more uniform state standards. However, an unmistakable final finding of the Alignment Project is that the ACA presents policymakers with an unprecedented opportunity, and potentially some less disruptive options than in past years, to empower and hold accountable a single regulator with the clear mandate to put consumer protection at the center of health insurance regulation in California.

Additional Resources

Additional Alignment Project documents and research available at:
http://www.kelchpolicy.com/health-insurance-alignment

Attachment

California Legislation Implementing the ACA, 2010–2014

Affordable Care Act Health Insurance Reform in California Implementing Legislation 2010–2014	
Summary	**Bill Number**
2010	
California Health Benefit Exchange Establishes the California Health Benefit Exchange (Exchange), an independent public entity, as the state-administered Exchange pursuant to the federal Patient Protection and Affordable Care Act (ACA). Requires the Exchange to, among other things: (1) offer health insurance coverage for individuals and small businesses as specified in state and federal law and (2) administer eligibility for federal premium tax credits for individuals between 100% and 400% of the federal poverty level. Establishes the powers and duties of the board governing the exchange.	Assembly Bill (AB) 1602, Chapter (Ch.) 655, Statutes of 2010; Senate Bill (SB) 900 (Ch. 659/2010)
Coverage for children Requires health plans and health insurers to guarantee issue (accept for coverage) all children regardless of their health status, claims history or other health-related conditions beginning January 1, 2011.	AB 2244 (Ch. 656/2010)
Preventive services Enacts the ACA requirement that health care service plan contracts and health insurance policies issued amended, renewed or delivered on or after Sept 23, 2010 cover specified preventive services without consumer copayments or other cost sharing.	AB 2345 (Ch. 657/2010)
Cancellation and rescission of coverage Prohibits health plans and health insurers from rescinding or canceling coverage, except for fraud, nonpayment of premium and other specified circumstances.	AB 2470 (Ch. 658/2010)
Dependent coverage Effective September 23, 2010, allows dependents up to age 26 to be covered as such on a parent or legal guardian's health plan or insurance policy.	SB 1088 (Ch. 660/2010)
Premium rate review Requires health insurers and health plans to file with California Department of Insurance (CDI) or Department of Managed Health Care (DMHC), respectively, at least 60 days prior to implementing a rate change in individual and small employer coverage so that the regulator may review whether the rate changes are justified, as specified. Requires a similar filing of unreasonable rate increases (10% or more) for large group coverage.	SB 1163 (Ch. 661/2010)

Affordable Care Act Health Insurance Reform in California Implementing Legislation 2010–2014	
Summary	**Bill Number**
2011	
Maternity services In anticipation of ACA requirements for 2014, extends to individual and group health insurance under CDI the requirement to cover maternity benefits. Health plans under DMHC must already cover maternity as a medically necessary, basic health care benefit.	AB 210 (Ch. 508/2011) (group policies) SB 922 (Ch. 509/2011) (individual policies)
Health Care Eligibility, Enrollment, and Retention Act Enacts the Health Care Eligibility Reform, Enrollment, and Retention Planning Act and requires the California Health and Human Services Agency to consult with specified state agencies and stakeholders in an ACA planning and development process related to eligibility, enrollment, and retention in state health subsidy programs.	AB 1296 (Ch. 641/2011)
Medical loss ratios; annual and lifetime benefit limits Establishes enforcement authority for ACA medical loss ratio requirements by CDI and DMHC. Prohibits lifetime benefit limits and gradually phases out annual benefit limits leading to January 1, 2014.	SB 51 (Ch. 644/2011)
2012	
Small group market reforms Conforms California's existing small employer guaranteed availability rules to ACA requirements. Among other provisions, prohibits exclusions for preexisting conditions and limits premium rating factors to age, family size, and geographic regions, except for grandfathered plans.	AB 1083 (Ch. 1083/2012)
Essential health benefits Establishes California's ACA essential health benefits benchmark plan for all individual and small group coverage as the Kaiser Small Group HMO 30 plan.	AB 1453 (Ch. 854/2012); SB 951 (Ch. 866/2012)
California Health Benefit Exchange Gives CDI and DMHC authority to enforce unfair competition laws against anyone holding themselves out as representing, constituting, or otherwise providing services on behalf of the Exchange without a valid agreement with the Exchange.	AB 1761 (Ch. 876/2012)
Consumer Operated and Oriented Plans Establishes a licensing framework at CDI or DMHC for Consumer Operated and Oriented Plans as authorized under the ACA.	AB 1846 (Ch. 859/2012)

Affordable Care Act Health Insurance Reform in California Implementing Legislation 2010–2014	
Summary	**Bill Number**
Multiple-employer welfare arrangements Prohibits multiple-employer welfare arrangements from offering, marketing, representing, or selling any product, contract, or discount arrangement as minimum essential coverage or as compliant with ACA essential health benefits unless the coverage meets ACA standards.	SB 615 (Ch. 266/2012)
2013	
Medi-Cal Eligibility Expansion Enacts the ACA coverage expansion, including provisions affecting eligibility, simplified enrollment processes, benefits, and retention provisions for Medi-Cal and the California Children's Health Insurance Program.	AB 1 X1 (Ch. 3/2013–14 First Extraordinary Session; SB 1 X1 (Ch. 4/2013–14 First Extraordinary Session)
Individual market insurance reforms Enacts ACA reforms for individual health insurance coverage, including guaranteed availability and a prohibition on preexisting condition exclusions. Updates small employer requirements in response to federal regulations.	AB 2 X1 (Ch. 1/2013–14 First Extraordinary Session); SB 2 X1 (Ch. 2/2013–14 First Extraordinary Session)
Bridge plan Requires the Exchange, contingent on federal approval, to make available a bridge plan product for individuals transitioning between Medi-Cal and Exchange coverage.	SB 3 X1 (Ch. 5/2013–14 First Extraordinary Session)
Conversion and continuation coverage Makes inoperative state laws guaranteeing continuation coverage under the federal Health Insurance Portability and Accountability Act of 1996 and the state-specific program allowing individuals losing job-based coverage to secure individual coverage without medical underwriting. Requires health plans and insurers to notify individuals of new public and private coverage options under the ACA, as specified.	AB 1180 (Ch. 41/2013)
California Health Benefit Exchange Requires the Exchange to conduct outreach for individuals enrolled in the state Major Risk Medical Insurance Program based on contact information provided by the Managed Risk Medical Insurance Board. Requires and authorizes Department of Health Care Services to follow specific rulemaking and reporting requirements in implementing the Medi-Cal expansion.	SB 28 (Ch. 442/2013)

Affordable Care Act Health Insurance Reform in California Implementing Legislation 2010–2014	
Summary	**Bill Number**
Stop-loss insurance coverage Limits the use of stop-loss insurance by small employers as of January 1, 2016 so that stop-loss coverage cannot be triggered by low claims cost thresholds, known as attachment points (e.g., less than $40,000 for the group), as specified.	SB 161 (Ch. 443/2013)
Consumer out-of-pocket costs Enacts ACA limits on enrollee annual maximum out-of-pocket costs and imposes additional related state-specific standards. Allows carriers in the small group market to update no more than quarterly the rates charged for new small employers and to small employers at annual renewal.	SB 639 (Ch. 316/2013)
2014	
Open enrollment periods Revises the open enrollment period for the individual market to November 15–February 15, starting in 2015, in response to federal guidance.	SB 20 (Ch. 24/2014)
Market reform clean-up Makes several corrections and clarifications to ACA-related individual and small group rules, including clarifying that health plans and insurers must combine CDI and DMHC individual and small group products as one single risk pool, in each market segment, for rating purposes.	SB 959 (Ch. 572/2014)
Small group waiting periods Eliminates outdated state law relating to waiting periods for pre-existing conditions in conformity with federal ACA requirements.	SB 1034 (Ch. 194/2014)

Notes

[1] Kelch Policy Group is an independent health policy research and consulting firm based in Sacramento, California. Deborah Kelch, firm principal, co-authored the 2011 CHCF report in collaboration with Brent Barnhart, JD. Later in 2011 the Governor appointed Mr. Barnhart as the Director of the Department of Managed Health Care.

[2] California Government Code §11050(c).

[3] Covered California final Qualified Health Plan model contract for 2014. Attachment 3: Licensed in Good Standing. Available online at: http://hbex.coveredca.com/solicitations/QHP/

[4] Roth, DL and Kelch, DR. *Making Sense of Managed Care Regulation in California.* Prepared for the California HealthCare Foundation. November 2001. Available online at: http://www.chcf.org/publications/2001/12/making-sense-of-managed-care-regulation-in-california
See also: Kelso, JC. *Regulatory Jurisdiction Over Health Insurance Products: The Department of Managed Health Care and*

the Department of Insurance. November 2001. Available online at: http://www.mcgeorge.edu/Documents/Publications/ccglp_pubs_regulatory_jurisdiction_over_certain_health_insurance_products.pdf

[5] AB 78, Chapter 525, Statutes of 1999, established DMHC with the legislative intent that "*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*." In addition, for the first time since its passage in 1975, SB 78 amended the original legislative intent of Knox-Keene to add the following goal of the Act: "*Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department*." (Health and Safety Code Section 1342 (h).

[6] Wilson, Katherine. *Enrollment in Individual Health Plans Up 47% in 2014*. Prepared for the California HealthCare Foundation. May 2015. Available online at: http://www.chcf.org/articles/2015/05/enrollment-individual-up