California Association of Health Plans

FACT SHEET

California's Health Plan & Insurance Regulators

March 2011

In California, there are three regulators for health coverage: state regulation of health plans by the Department of Managed Health Care, state regulation of insurers by the California Department of Insurance, and regulation of self-insured employee health benefit plans by the federal Department of Labor (for self-insured employers). The DMHC primarily regulates California's health maintenance organizations while the CDI oversees traditional health insurance, typically preferred provider organizations. This fact sheet highlights differences between California's health plan and health insurance regulators.

	Department of Managed Health Care	California Department of Insurance
Focus	**Health Plans** which promise to provide or deliver care.	**Insurers** which promise to pay for care.
Leadership	A Director, appointed by the Governor and confirmed by the Senate, with sole focus on regulating health care service plans	Elected Insurance Commissioner, overseeing all insurance products, including Auto, Life, Disability, Workers' Compensation, Property, Casualty, PPO products, Homeowners', Renters', and other types of insurance.
Enrollment	21.6 million (approximately 59 percent of CA population)	2.4 million (approximately 7 percent of CA population)
Regulated Health Insurance Products	Health care service plans (also called HMOs) and two grandfathered Preferred Provider Organizations (PPOs)	Non-HMO insurance, including indemnity plans and most PPOs. Also, all non-health insurance products.
Plans operate in order to	Arrange for and organize the delivery of health care and services through contracted or employed providers and owned facilities.	Protect against the expenses or charges associated with illness or injury and may provide other services, such as preventive care.
Governing Laws/ Regulations	The Knox-Keene Health Care Service Plan Act of 1975	The California Insurance Code
Area of Responsibility	Health plans guarantee comprehensive health care services to enrollees, or to pay for the cost of those services, in return for a periodic charge paid by the enrollee or on their behalf (from their employer, for example).	Insurers pay medical expenses or a portion of medical expenses according to the specific coverage under the contract.
Shared Risk	HMOs pay providers a lump sum for each enrollee (capitation) regardless of how much service is provided, thereby sharing risk with providers. The regulator is responsible for HMO and provider solvency.	None
Benefits	Members are guaranteed a set of basic health services and a number of other legally mandated services, like mental health, contraception, cancer screenings, and more.	Members are provided the services outlined in their contracts and any legally mandated services.
Public Programs	Medi-Cal, Healthy Families, Medicare Advantage and Access for Infants and Mothers	Medicare Advantage
Quality	Medical surveys, provider reviews, and mandatory quality assurance systems must be available at every health plan.	Insurers choose to participate in quality programs nationally and in the state.
Financial Solvency	Minimum financial reserve standards through "tangible net equity" requirements must be met. Plans submit monthly and quarterly financial reports to the Department.	"Risk-based capital" standards must be met to ensure that insurers have adequate financial reserves to cover claims liabilities. Extensive financial examinations of insurers are conducted.
Fee and Tax Structure	An annual "per enrollee assessment" is placed on plans. Plans are subject to applicable corporate taxes but not a gross premiums tax.	Insurers must pay licensing fees and other filing fees. Insurers also must pay a gross premiums tax.
Consumer Protections	The HMO Help Center and the Office of the Patient Advocate serve health plan enrollees and health plans maintain systems to respond to consumers. Knox-Keene health benefits are valuable consumer protections.	Insurers typically have an internal grievance or complaint system. A consumer help line is also available to assist members.
Claims Payments	Claims payments must be timely, accurate and allow for dispute resolution. Plans must pay claims within 30 to 45 days or pay a penalty and interest to providers.	Claims must be paid within 30 days or pay a penalty and interest to providers.

The California Association of Health Plans (CAHP) is a statewide trade association representing 41 full-service health care plans. Through legislative advocacy, education, and collaboration with other member organizations, CAHP works to sustain a strong environment in which our member plans can provide access to products that offer choice and flexibility to the more than 21 million Californians they serve.

Historically, health policy leadership and health plan regulation have been coupled in the Executive Branch. For the past 35 years, the Governor's leadership in developing health care policy has aligned with his responsibility to regulate health plans. Health plan and health insurance regulation has been split for over 70 years—virtually, since regulation of the industry first began.

Timeline of California's Regulatory Milestones

1946 California's Supreme Court found that **prepaid health plans were not in the business of insurance** and are not subject to regulation by the Insurance Code or the Department of Insurance.

1965 The Knox-Mills Act passed and required **registration of prepaid health plans with the Attorney General**. Knox-Mills was not a licensing framework and established minimal regulatory authority.

1973 The **federal HMO Act was passed** and established comprehensive benefits, community rating requirements, administrative oversight procedures, requirements for financial reserves, annual open enrollments, prohibitions on pre-existing condition limitations and other requirements.

1975 The Knox-Keene Health Care Service Plan Act of 1975 (KKA) established the current statutory framework under which health plans and some PPOs operate in California. The KKA transferred regulatory authority **from the Attorney General to the Department of Corporations** (DOC). The Act set rules for mandatory basic health care services, financial stability, availability and accessibility of providers, review of provider contracts, administrative organization and consumer disclosure and grievance requirements.

1982 The Insurance Code authorized insurers to enter into alternative payment contracts that created new insurance products: **Preferred Provider Organizations** (PPOs). PPO products offer members favorable rates for selecting in-network providers while maintaining the option of seeking health services out-of-network for a higher rate, however, they were still operating as indemnity insurance and **still regulated by the Department of Insurance**.

2000 AB 78 (passed in 1999) transferred regulatory responsibility for HMOs **from the Department of Corporations to the newly established Department of Managed Health Care.**

The history of why these departments emerged as the regulators of each respective area is extensive. You may refer to the CAHP Fact Sheet Managed Care Blooms in California for more background.

SOURCES

Regulatory Oversight of Health Insurance in California. California HealthCare Foundation. June 2003.
California Health Plans and Insurers. California HealthCare Foundation. October 2010.

Please contact Maral Farsi at mfarsi@calhealthplans.org or 916.558.1545 with any questions about this fact sheet.