California State Auditor

BUREAU OF STATE AUDITS

Department of Managed Health Care:

Assessments for Specialized and Full-Service HMOs Do Not Reflect Its Workload and Have Disparate Financial Impacts

May 2002
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CALIFORNIA STATE AUDITOR

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May 28, 2002 2001-126

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning assessments that the Department of Managed Health Care (department) charges to health maintenance organizations (HMOs) licensed in accordance with the State's Knox-Keene Health Care Service Plan Act of 1975. This report concludes that the assessments for specialized and full-service HMOs do not reflect the department's workload and have disparate financial impacts. The proportion of the overall assessments that are charged to specialized HMOs, at 48 percent, exceeds the 22 percent of work attributable to them based on data identifiable by class of HMO. The report recommends that the Legislature consider changing the assessment structure to reflect the proportion of documented workload devoted to specialized and full-service HMOs, and to reduce disparities in financial effects on HMOs. The report also finds that the department has increased the output for some of its core functions, has introduced several new services for HMO enrollees and is generally better at meeting statutory deadlines when compared to the same functions previously carried out by the Department of Corporations. Nevertheless, the department is having difficulty completing financial examinations and notifying HMOs of its decisions regarding requested health plan changes on time.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Enclosure

Department of Managed Health Care:

Assessments for Specialized and Full-Service HMOs Do Not Reflect Its Workload and Have Disparate Financial Impacts

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SUMMARY

Audit Highlights . . .

Our review of the assessment structure of the Department of Managed Health Care found that:

- ☑ *The portion of assessments charged to specialized HMOs, at 48 percent, exceeds the 22 percent of identifiable workload attributable to specialized HMOs.*
- ☑ *The current assessment structure results in disparate financial impacts with specialized HMOs charged about nine times more per dollar of premiums than full-service HMOs.*
- ☑ *Alternative methods could better align assessments with workload and reduce disparities in financial impact.*

In addition, our review of six core operating units found that:

- ☑ *Four units are meeting deadlines and/or have greatly expanded services.*
- ☑ *Two units, Financial Oversight and Licensing, are often late issuing financial examination reports and sending written notifications to HMOs regarding material changes in health care plans.*

RESULTS IN BRIEF

The annual assessments paid by two classes of health maintenance organizations (HMOs)—specialized and full-service—to support the operations of the Department of Managed Health Care (department) are not distributed equitably. The assessments do not reflect the different levels of effort that the department devotes to each class. This is not surprising, since the assessments are charged almost entirely on a per enrollee basis, with little recognition that full-service HMOs, which provide medical, vision, psychiatric, and other care, are likely to require the department's services more frequently than specialized HMOs, which provide only one type of care. As a result, these assessments are causing disparate financial impacts. On average they amount to a substantially larger percentage of the premiums of specialized HMOs than of full-service HMOs.

The proportion of the overall assessments that are charged to specialized HMOs, at 48 percent, far exceeds the 22 percent of work attributable to them based on data identifiable by class of HMO. In charging these assessments, the department is simply implementing the rate structure established by the Legislature in August 1997. We were unable to find any documented rationale for the rate structure, but we believe that it was designed to reflect the relative costs of protecting the enrollees of specialized HMOs and full-service HMOs. In reviewing the percentage of premiums paid in assessments, we found a wide disparity in the effect on HMOs. Specifically, full-service HMOs pay on average about 0.04 percent of their premiums to the department, while specialized HMOs pay 0.37 percent of theirs, or about nine times more per dollar of premiums. The impact is even more severe for specialized HMOs providing vision, psychological, and certain other coverage. These specialized HMOs pay more than 0.50 percent of their premiums to the department. For example, a specialized, chiropractic HMO with premiums of $79 million was assessed about $1.5 million for fiscal year 2001–02, while a full-service HMO with $82 million in premiums was assessed only $44,000.

Alternative assessment methods could reduce these inequities by taking the disparate workload into account or by basing assessment rates on premiums as a surrogate for both the number of

enrollees and the breadth of care provided. We offer two alternatives based on workload and HMO premiums that would bring the assessments for specialized HMOs more into line with the demonstrated workload and would reduce the differences in financial impact.

We shared our findings regarding the assessment structure and alternative assessment methods with the department and asked for its perspective on these matters. The department did not directly respond to questions regarding how the current assessment method factors in the extent of the department's services to specialized and full-service HMOs; why large disparities in assessments between specialized and full-service HMOs are not harmful; what overhead costs support if not core operations; and why the number of enrollees, rather than identifiable workload or HMO premiums, provides a better basis for allocating overhead. The department did assert, however, that the current assessment does not create a financial burden for any HMO and that the department's "infrastructure" is built on the premise of serving all enrollees equally regardless of the class of HMO. In addition, it responded that it has no preference as to the methodology used to assess plans. It said that its only concern is that the approach chosen provide a proper and timely mechanism to obtain the funding necessary for the department's budget, and secondarily that the method be straightforward and simple to administer.

Nevertheless, the department presented us with another alternative assessment method that would basically yield the same results as the current system. We do not consider this alternative to be equitable because the split between assessments for full-service and specialized plans would continue to poorly reflect the split in identifiable workload, and large disparities in financial impact would persist among HMOs. Absent a direct response to the questions we posed to the department, we have no basis to conclude that methods that do not factor in the extent of services provided to specialized versus full-service plans or that have a large disparate financial impact among HMOs are equitable.

The department has improved the timeliness and/or the breadth of services provided by four of the six operating units we reviewed when compared to operations previously managed by the Department of Corporations (Corporations). It has significantly increased the output for some of its core functions, has introduced several new services for HMO enrollees, and is

generally better at meeting statutory deadlines when compared to the same functions carried out by Corporations until June 2000. For example, in the first half of fiscal year 2001–02, the department's Division of Plan Surveys (Medical Surveys) completed 20 routine medical surveys (surveys) and ended calendar year 2001 with only 4 backlogged surveys. In contrast, Corporations had an output of 7 surveys in the first half of fiscal year 1998–99 and had 40 backlogged surveys at the end of calendar year 1998.

For two other units—the Division of Financial Oversight (Financial Oversight) and the Division of Licensing (Licensing)—the department needs to improve the timeliness of its work. Financial Oversight is having difficulty completing financial examinations on time. Its backlog of 13 examinations at the end of calendar year 2001 compares unfavorably to the backlog of 2 examinations that Corporations experienced at the end of calendar year 1998. When reports become backlogged, the public does not receive up-to-date departmental analysis of the financial health of HMOs. The backlog is primarily caused by a surge in financial examinations related to HMOs that were newly licensed in the mid-1990s, staff vacancies, and additional nonroutine work the department had to complete when several HMOs experienced financial difficulties. Financial Oversight is implementing recommendations made by a consultant that may help it reduce its backlog through better planning and the elimination of less effective review procedures, and it plans to fill staff vacancies and hire a contractor to keep up with its workload.

Similarly, Licensing has not promptly informed HMOs of its decisions to disapprove, postpone or deny significant proposed changes to their plans, referred to as material modifications. During 2001, Licensing was late in sending written notifications for 42 of the 122 material modifications it received. Slowness in notifying the HMOs can delay changes in operations that the HMOs believe are significant. In part, these delays may have resulted from a poor tracking system that contained incomplete data and that lacked triggers to alert managers to overdue items. Licensing has recently implemented a new information system that, among other improvements, may help it to better monitor the processing of HMO filings, but it is too early to tell whether the new system will help resolve the problem of late notifications regarding material modifications.

RECOMMENDATIONS

To ensure more equitable assessments of HMOs to support the department's activities, we recommend that the Legislature:

- Consider changing the department's assessment structure to reflect the proportion of the documented workload that the department devotes to specialized and full-service HMOs and to reduce disparities in the financial effect on HMOs, and

- Require the department to report triennially to the Legislature on the proportion of assessments charged to each class of HMO and the proportion of the documented workload related to each class of HMO.

To ensure that enrollees have up-to-date departmental analysis on the financial status of HMOs, the department should establish deadlines for the publication of financial examination reports and should closely monitor the success of its efforts to meet deadlines for these reports.

To ensure that HMOs are notified promptly of the status of their requests for material modifications to their plans, the department should closely monitor the time elapsed between the receipt of requests and the notifications it sends to HMOs and should make it a priority to send written notifications within the statutory deadline.

AGENCY COMMENTS

The department says that it has no position at this time on the formulas used to assess HMOs. Its only concern is that the chosen assessment formula provide a proper and timely funding mechanism for the department's needs, and that it be straightforward and simple to administer. The department is, however, concerned that a change in the existing formulas may impact some plans adversely. In addition, the department says that the Legislature should be advised of all different methodologies and their impacts, and suggests that the report should provide additional options for legislative consideration. We, however, believe no value is added by presenting numerous additional methods that do not meet our criteria, as we discuss in detail in our comments at pages 57 through 59.

With regard to the timeliness of financial examination reports, the department says that it has sometimes prioritized actions to protect consumers over issuing final reports. It also reiterates steps taken to improve its financial examination operations. With regard to the timeliness of written notifications related to material modifications, the department says it has sought to improve communications with HMOs by providing more informal forums for sharing information. Nevertheless, the department also reiterates efforts it has taken to ensure on-time performance. ■

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INTRODUCTION

BACKGROUND

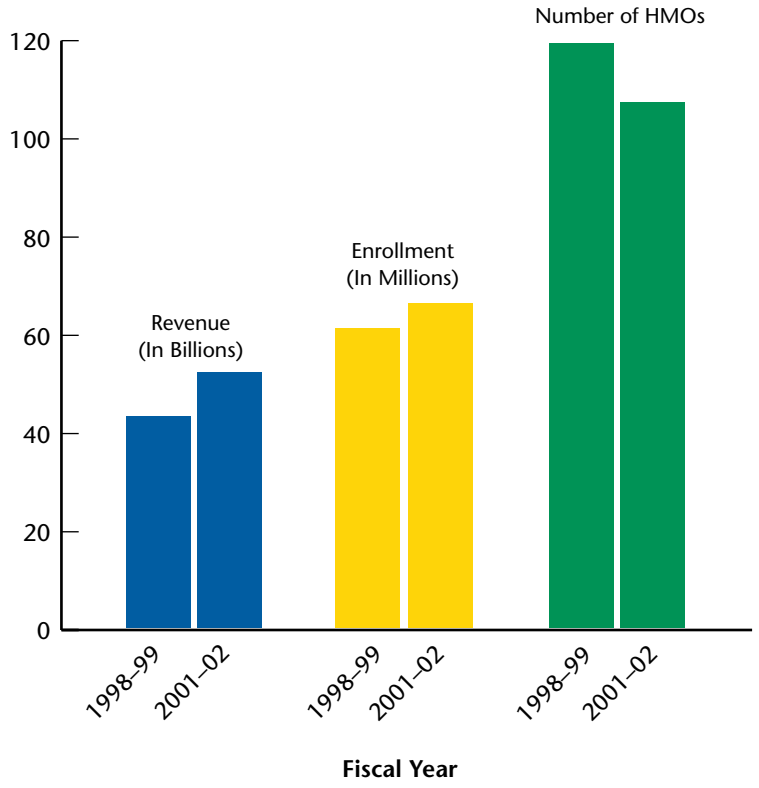
California's Department of Managed Health Care (department) began operations on July 1, 2000, assuming certain responsibilities from the Commissioner of Corporations and the Department of Corporations and adding new functions to expand the regulation of health care service plans known as health maintenance organizations (HMOs). The State's Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), as amended, provides authority for oversight of HMOs.

The department's stated mission is to work toward an accountable and reliable managed health care delivery system that promotes healthier Californians. Its focus is on assuring the accessibility and availability of medically-necessary health care that is delivered with appropriate oversight of quality through financially sound managed care systems. To meet its mandate, the department licenses HMOs to operate in California and enforces laws and regulations applicable to them. In helping to protect consumers, the department conducts medical surveys and financial examinations of HMOs and also receives and resolves consumer complaints, as directed by the Knox-Keene Act.

HMOs include full-service plans that provide most medical services and specialized plans that focus on limited medical services such as dental or vision care. As Figure 1 on the following page indicates, since fiscal year 1998–99 the number of HMOs in California has declined, but their revenues and number of enrollees have grown. As of September 2001, the department regulated 107 HMOs throughout California, consisting of 48 full-service HMOs and 59 specialized HMOs. For fiscal year 2001–02, the department has a budget of approximately $32.4 million and 334 authorized positions.

FIGURE 1

Comparative Statistics on HMOs
Fiscal Years 1998–99 and 2001–02



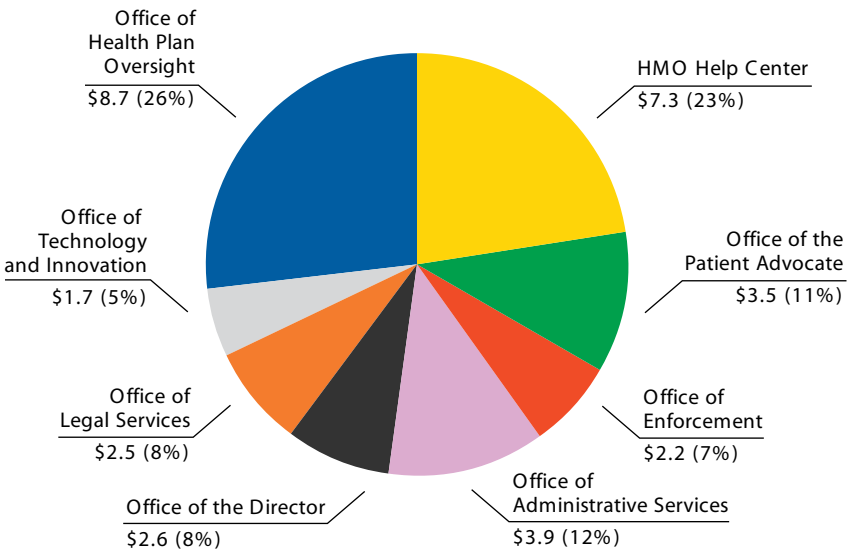
Source: Department summary reports for fiscal years 1998–99 and 2001–02.

THE DEPARTMENT INCLUDES FOUR CORE OPERATING DIVISIONS THAT FOCUS DIRECTLY ON REGULATING HMOs OR ASSISTING HMO ENROLLEES

Four core operating divisions of the department focus directly on regulating HMOs or assisting HMO enrollees and take responsibility for ensuring that HMO enrollees have adequate protection from violations of the Knox-Keene Act by HMOs. These divisions are the Office of Health Plan Oversight (Plan Oversight), HMO Help Center (Help Center), Office of Enforcement (Enforcement), and Office of the Patient Advocate. Figure 2 shows these divisions, as well as support divisions, and the relative size of each. For the department as a whole, support staff—those employees not directly providing services to HMOs or HMO enrollees—make up about 50 percent of the personnel budget. The ratio of support staff to line staff—those employees working directly with HMOs and their enrollees—varies from

FIGURE 2

Budgeted Expenditures
Fiscal Year 2001–02
(In Millions)



Source: Department expenditure reports as of December 31, 2001.

Types of Medical Surveys

Routine—These surveys evaluate compliance with state statutes and regulations concerning an HMO's quality assurance procedures, grievances and appeal systems, as well as its enrollees' access to health care services and its provision of continuity of care. The Knox-Keene Act requires surveys to be conducted at least once every three years.

Follow-up—These surveys evaluate an HMO's efforts to correct deficiencies identified in the public report for the routine medical survey. The Knox-Keene Act requires the department to conduct these surveys within 18 months of the department's release of the public report.

Nonroutine—The department typically conducts these surveys when it has information indicating that a health plan has committed a significant violation of the Knox-Keene Act.

division to division, however. See Appendix A for information about the breakdown between support staff and line staff in each division.

Plan Oversight has extensive responsibilities that include licensing HMOs, reviewing requested changes in HMO operations, and monitoring both the financial well-being of HMOs and the quality and accessibility of the care they provide. The Knox-Keene Act requires the department to conduct on-site evaluations, called medical surveys, of all HMOs once every three years. A medical survey ends with the department's release of a final, public report describing the survey's results. If the department identifies weaknesses during a routine medical survey, the report will disclose those deficiencies and any actions the HMO has taken or plans to take to correct the problems.

Types of Financial Examinations

Routine—These periodic examinations evaluate an HMO's fiscal and administrative affairs once every five years. These exams are also used to determine whether the plan is in compliance with those state regulations for which the department has oversight responsibilities. In addition, they assess whether the plan maintains proper internal controls to detect and prevent the misstatement of its fiscal operations and any non-compliance with regulatory requirements.

Nonroutine—These exams are typically performed as a follow up to determine whether certain deficiencies noted in a routine examination have been corrected, when there is a concern regarding the plan's ability to continue operations, or when significant complaints involving the plan have been received from the public or health care providers.

Types of Help Center Assistance

Written Complaints—HMO enrollees file formal complaints when they have an issue with their HMOs regarding billing, quality of care, benefits and coverage, or other issues. The Help Center reviews and resolves these complaints.

Independent Medical Reviews (IMRs)—Enrollees receive IMRs when they are dissatisfied with their HMO's decision concerning denial, delay, or modification of service or denial of reimbursement of claims.

Call Center—The Call Center maintains and operates a toll-free telephone number to receive consumer complaints regarding HMOs regulated by the department. Internal and contracted staff are available 24 hours a day, 7 days a week to help consumers resolve problems with their HMOs.

To ensure that enrollees are protected from HMOs that are financially unsound, the Knox-Keene Act also requires the department to review the financial status of every HMO at least once every five years. These reviews are called financial examinations and are conducted by Plan Oversight staff. The culmination of a financial examination is also a public report.

Yet another consumer protection function the department administers is responding to enrollee complaints about their HMOs. The Help Center directly assists consumers with health care issues, helping to ensure that patients receive the medical care and services to which they are entitled. The Help Center is responsible for answering enrollee telephone questions, resolving enrollees' complaints, and obtaining independent medical reviews at the request of enrollees.

The Help Center receives complaints from HMO enrollees. Based on its review of a complaint and the information obtained, the department decides whether an HMO has violated the law. If the department determines that a violation has occurred, it may refer the HMO to another division within the department for enforcement action. The Knox-Keene Act requires the department to send written notices indicating the final resolution of the complaint to affected parties within 30 days of receipt of the complaint. When the department's director believes that additional time is needed to fully and fairly evaluate a complaint, the director can authorize an extension of the 30-day deadline. The Help Center is also responsible for ensuring that enrollees receive an independent medical review when they question an HMO's decision to deny, delay, or not reimburse them for services.

The Office of the Patient Advocate is a new division within the department. Its mission is to act as an advocate for enrollee rights, and thus

promote healthier Californians by recommending enforcement actions, introducing new legislation, interacting with consumer advocacy groups, and bringing visibility to the department through educational outreach. It is responsible for producing an annual publication for the public with information on individual HMOs and the quality of their services. It is also responsible for educating the public regarding enrollee rights and the department's services.

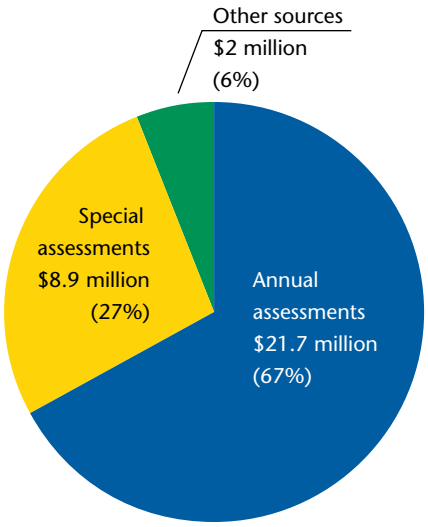
Although Plan Oversight, the Help Center, and the Office of the Patient Advocate are responsible for monitoring or regulating HMOs under the provisions of the Knox-Keene Act, these divisions do not impose fines or take legal action against HMOs. Instead, this responsibility rests with Enforcement, which handles the litigation needs of the department, representing the department in actions to enforce the managed health care laws and in actions that are brought against the department. Plan Oversight, the Help Center, the Office of Patient Advocate, and other divisions may refer cases to Enforcement.

HMOs PROVIDE THE BULK OF THE DEPARTMENT'S FUNDING THROUGH ASSESSMENTS

The department receives most of its funding from assessments paid by all HMOs licensed under the Knox-Keene Act. Fees for licenses, reimbursements from HMOs for the cost of certain services, fines, and interest provide the remaining revenues. Ninety-four percent of revenue is raised through the annual and special assessments described in the Knox-Keene Act. For the annual assessment, full-service HMOs are assessed a flat fee of $12,500 plus between $0.45 and $0.65 per enrollee, and specialized HMOs are assessed a flat fee of $7,500 plus between $0.24 and $0.48 per enrollee. The department establishes the special assessment rate to provide the department with sufficient revenues to support the operations of the department and a prudent reserve. The department also charges individual HMOs for the cost of any nonroutine examinations and for the contracted cost of independent medical reviews, and it exacts fines for violations of the Knox-Keene Act. The department does not receive any state funds. Figure 3 on the following page shows the various sources of revenue for the department.

FIGURE 3

Department of Managed Health Care
Projected Revenues for Fiscal Year 2001–02



Source: Department fund condition statement, estimated growth for fiscal year 2001–02.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the assessment mechanism used to generate funds for the Managed Care Fund, the fund that supports the department. Specifically, the audit committee asked us to determine the resources required by the department to administer and enforce the provisions of the Knox-Keene Act and to identify the resources required to regulate the different classes of HMOs. It also asked us to examine the fees and assessments paid by individual HMOs or classes of HMOs, to determine whether those fees and assessments reflect the level of regulatory activity associated with that HMO or class, and to determine whether those fees and assessments are needed to fund fixed costs that are unrelated to the workload. Finally, the audit committee asked us to propose alternative assessment structures, if necessary, that would more closely reflect the level of regulatory costs associated with the oversight of HMOs and ensure adequate funding for the department to meet its statutory responsibilities.

To examine the current assessment structure, we reviewed the Knox-Keene Act and other relevant laws and regulations. We also interviewed department administrative and budget unit staff and analyzed assessments for individual HMOs and classes of HMOs.

To determine whether the current fee assessment structure reflects the relative costs of regulating each class of HMO, we obtained recent available workload data from cost accounting records, caseload and time tracking systems, and staff surveys; developed percentages of effort related to specialized and full-service HMOs; and applied these percentages to divisional costs. Specifically, we used:

- Help Center reports showing the number of independent medical review cases for 2001 for each HMO.
- Help Center reports showing written complaints received in 2000 and 2001 for each HMO.
- Help Center reports showing total Call Center telephone call volume between July 1, 2000, and December 31, 2001, and the call volume for nine large specialized and full-service HMOs.
- A survey of workers in the Help Center's Division of Preventive Health Intervention and Division of Legal Case Review indicating the portion of time they devoted to the Call Center, independent medical reviews, written complaints, or other functions between July 2001 and March 2002.
- Enforcement reports showing the number of hours spent on legal cases in 2001, identified by individual HMO.
- Departmental accounting records showing the number of personnel dollars assigned to specialized and full-service HMO functions, based on timesheet data, for the first half of fiscal year 2001–02.

We estimated the split in workload for the department as a whole by adding together the divisional costs and comparing the totals for the two classes of HMO.

We determined that the current assessment structure does not closely mirror the workload for each class of HMO and results in disparate financial impacts on HMOs. To develop alternative

assessment methodologies, we interviewed department staff; interviewed staff and reviewed laws for three other regulatory agencies in California: the Department of Corporations, the Department of Insurance, and the Department of Health Services; and interviewed staff and reviewed laws for the state agencies regulating HMOs in Florida, Illinois, New Jersey, and Texas. To determine the effect of alternative assessment methodologies, we obtained department databases that show the number of enrollees and the premium, Medicare, and Medicaid receipts (premiums) for individual HMOs. We used this data to calculate the average assessment per enrollee and the average assessment per premium dollar for each HMO class, and the division of assessments between the two classes of HMO. We presented our alternatives and our rationale for evaluating them to the department for its response.

To determine whether there is adequate funding to ensure that the department meets its responsibilities, we reviewed the performance of six functions in the department's two largest operating divisions—Plan Oversight and the Help Center. Where appropriate, we reviewed the volume of outputs and the timeliness of those outputs, generally for the first half of fiscal year 2001–02, relative to deadlines set by statute or by the department. We compared the results to performance indicators for the first half of fiscal year 1998–99 that we compiled for our 1999 audit of HMO regulation under the Department of Corporations. For the same periods, we also compared the number of labor hours or dollars, depending on the availability of data, that core staff devoted to performing these functions. ■

CHAPTER 1

The Current Assessment Model Does Not Reflect the Workload Attributable to Specialized and Full-Service HMOs

CHAPTER SUMMARY

The percentage of the total assessment that is charged to specialized and full-service health maintenance organizations (HMOs) by the Department of Managed Health Care (department) does not match the level of effort the department devotes to these two classes of HMO. Although assessments for specialized HMOs amount to 48 percent of total assessments, only 22 percent of the department's work that is identifiable by HMO class is attributable to them. In charging these assessments, the department is simply implementing the rate structure established by the Legislature in August 1997. We have found no documented rationale for this rate structure, but it appears to have been designed to reflect the relative costs of protecting the enrollees of specialized and full-service HMOs.

Our review of the financial impact of the assessment on HMOs, as represented by the percentage of their premiums that the HMOs are charged for assessments, found a wide disparity between the different classes of HMO. Specifically, the assessments the department billed to full-service HMOs amounted to about 0.04 percent of their premiums on average, while those for specialized HMOs amounted to about 0.37 percent on average, or about nine times more per premium dollar. Differences in the financial impact on specialized and full-service plans can be quite large. For example, a chiropractic HMO with premiums of $79 million was assessed about $1.5 million for fiscal year 2001–02, while a full-service HMO with $82 million in premiums was assessed only $44,000.

Given the gap between actual workload and assessment levels, along with the difference in financial impact, it appears that another assessment structure would be more equitable. We present two alternatives, one based on departmental workload and a second alternative based on

a combination of workload and HMO premiums, that we believe would better match HMO assessments to workload and more evenly spread the cost of regulation.

In assessing the fairness of the current and various alternative assessment methods, we considered three factors: how closely the assessment reflects the identifiable workload split, how disparate the financial impacts on full-service and specialized HMOs are in terms of percent of premiums, and how easy it would be to administer the assessment. After discussing the current and proposed assessments with department administrators, we sought to confirm or clarify the department's perspective on whether the current method equitably allocates costs to HMOs. In particular, we asked department administrators how the current assessment method factors in the extent of services the department provides to specialized and full-service HMOs or why that consideration is unneeded; whether the department considers the disparate financial impacts we identified to be harmful to specialized HMOs; what overhead costs support if not core operations; and why the number of enrollees, rather than identifiable workload or HMO premiums, is the appropriate basis for allocating departmental overhead.

The department did not respond to our specific questions. It did, however, assert that the current assessment does not create a financial burden for any HMO. The department also said that the department's "infrastructure" is built on the premise of serving all enrollees equally regardless of class of HMO. This response, however, begs the question of how the effort the department actually devotes to specialized and full-service plans corresponds to the amounts it asks them to pay.

The department also said it has no position on the formula to be used to calculate assessments and its only concern is that the approach chosen provide a proper and timely mechanism to obtain funding necessary for the department's budget, and secondarily that the method be straightforward and simple to administer. Nevertheless, the department presented us with another alternative method that would yield approximately the same result as the current assessment method. We do not consider this alternative to be equitable because the split between assessments for full-service and specialized plans would continue to poorly reflect the split in identifiable workload, and large disparities in financial impact would persist among HMOs. Absent a direct response to the questions we posed to the

department, we have no basis to conclude that methods that do not factor in the extent of services provided to specialized versus full service plans or that have a large disparate financial impact among HMOs are equitable.

THE NUMBER OF ENROLLEES DRIVES AN HMO's ASSESSMENT UNDER THE CURRENT ASSESSMENT STRUCTURE

Assessments paid by HMOs licensed in the State are the primary support for the department's operations. The department calculates each HMO's annual assessment based on statutory provisions established in August 1997 that call for each HMO to pay a nominal flat fee plus an additional amount per enrollee. The flat fee and rate per enrollee are slightly lower for specialized HMOs than they are for full-service HMOs. Although we have not found a documented rationale for this statutory rate structure, it appears that it was intended to reflect the relative costs of protecting enrollees.

We considered three factors crucial to equitable assessments:

- ✓ *Fees charged to each class of HMO should reflect the proportion of workload devoted to each.*
- ✓ *Fees should be distributed so that the financial burden does not fall disproportionately among the HMOs.*
- ✓ *The assessment plan should be cost-effective.*

In determining the fairness of the current fees and of alternative fee structures, we identified three factors that we consider crucial to equitable assessments. First, we believe that the fees charged to each class of HMO—the specialized HMOs and the full-service HMOs—should approximate the proportion of the department's workload devoted to each; in other words, the assessments should generally reflect the relative costs of protecting the enrollees for each class. In addition, we believe that the fees should be distributed so that the financial burden does not fall disproportionately among the HMOs. Finally, we believe that the assessment plan used should be cost-effective, not requiring an excessive amount of administrative effort to calculate and bill for assessments.

SPECIALIZED HMOs PAY A MUCH LARGER PROPORTION OF ASSESSMENTS THAN WORKLOAD FIGURES APPEAR TO WARRANT

The current assessment structure does not reflect the relative level of effort that the department devotes to the two classes of HMO. Consequently, specialized HMOs pay a larger share of department costs than appears warranted by our analysis of the department's workload. Although workload information is not available for all units, for certain units we were able to

use department records to identify the workload split. It is not surprising that the level of assessments and the amount of work performed are so divergent, since assessments are charged almost entirely on a per enrollee basis, with little recognition that full-service HMOs, which provide medical, vision, psychiatric, and other care, are likely to require the department's services more frequently than specialized HMOs, which provide only one type of care.

We asked the department to provide its perspective on how the current assessment method factors in the extent of services the department provides to specialized and full-service HMOs. The department did not directly answer our question, only stating that the operations of the department, supported by the department's "infrastructure," are built on the premise of serving all enrollees equally regardless of the class of HMO. This response begs the question of how the effort the department actually devotes to specialized and full-service plans corresponds to the amount it asks them to pay.

Using workload figures for those divisions in the department for which data is available by HMO class, we calculated how much of the workload is attributable to full-service HMOs and how much to specialized HMOs. The divisions we used in our calculations accounted for about 64 percent of the department's budgeted expenditures in fiscal year 2001–02 and include three of the department's four primary operating divisions. The remaining divisions do work of a general nature and did not keep records that would allow us to assess the split in workload. After weighting the identifiable workload data for the relative size of the divisions, we found that these divisions devote approximately 22 percent of their efforts overall to regulating specialized HMOs and 78 percent to regulating full-service HMOs.

Although only 22 percent of its identifiable workload relates to specialized HMOs, the department charges them 48 percent of total assessments.

These proportions are far different from the relative assessments billed to the HMOs: 48 percent of the department's assessments were billed to specialized HMOs and 52 percent were billed to full-service HMOs. Table 1 details the workload splits and the related divisional costs attributable to specialized and full-service HMOs, as well as the weighted proportion of the total costs. Some units also work on other functions that are not differentiated by class of HMO. For example, the Office of Enforcement (Enforcement) spends a substantial amount of its time defending the department against lawsuits brought by HMOs. Table 1 does not show workload splits or divisional costs attributable to these other functions.

Because we believe it is reasonable to assume that divisional costs relate closely to the specific functions the division performs, we applied the workload percentages for specialized and full-service HMOs to each division's total costs for the first half of fiscal year 2001–02 to arrive at the estimated amount that each class of HMO cost that division. In all of the units shown in Table 1, specialized HMOs account for far less of the workload than full-service HMOs, and in no case does their share approach 48 percent of the workload.

On an annualized basis, which doubles the amounts for the six months presented in Table 1, the divisional costs attributable to specialized HMOs amount to about $3.4 million, and those for full-service HMOs total about $12 million. Together, these divisional costs of $15.4 million make up approximately 50 percent of the department's assessment for fiscal year 2001–02.

TABLE 1

Split of Workload Costs Identified by HMO Type
Specialized and Full-Service HMOs
July Through December 2001

Departmental Unit	Workload Split * (Percentage) Specialized	Full-Service	Divisional Cost* (In Thousands) Specialized	Full Service
Help Center:				
Independent Medical Review	1%	99%	$ 7	$ 706
Standard Complaints and Initial Review	11	89	202	1,632
Call Center	10	46	85	391
Enforcement	6	56	53	499
Legal Services	17	60	172	608
Plan Oversight	33	62	1,157	2,173
Total divisional cost			**$1,676**	**$6,009**
Proportion of cost identifiable by type of HMO			22%	78%

Sources: Department accounting and payroll records, and timekeeping and call volume databases. State Controller's Office payroll information. Bureau of State Audits survey of Help Center's Division of Preventive Health Intervention and Division of Legal Case Review staff.

* Workload splits do not total 100 percent where part of a unit's efforts was devoted to other functions that are not differentiated by class of HMO. Divisional cost figures reflect only the portion of costs attributable to specialized and full-service HMOs; costs attributable to other functions are not presented.

The workload splits for the HMO Help Center (Help Center) units, particularly the Standard Complaints and Initial Review unit and the Independent Medical Review unit, diverge the most from the split of assessments between specialized and full-service HMOs. To carry out its responsibilities, the Help Center responds to written complaints, telephone inquiries, and requests for independent medical reviews (IMRs) from enrollees. The Call Center's data on call volume identified roughly 10 percent of telephone calls as being related to specialized HMOs and 46 percent as being related to full-service HMOs. Much of the remaining call volume was not identifiable by HMO class because the center's tracking system specifically identified calls related to only nine large HMOs. It did not track the remaining 44 percent of calls by individual HMO or by HMO class.

Workload is heavily weighted toward full-service HMOs in each of the divisions where work is identifiable by class of HMO.

Enforcement's workload for specialized HMOs, at 6 percent, was also small, especially when compared to the 56 percent related to full-service HMOs. As we mentioned earlier, this division spent much of its time, 38 percent, on "other" work that was not specific to any HMO class. About 95 percent of these other efforts related to defending the department against lawsuits filed by HMOs.

The workload figures for the Office of Legal Services (Legal Services) also show that the bulk of the workload, 60 percent, was related to full-service HMOs and that specialized HMOs generated only 17 percent of the workload. Like Enforcement, Legal Services spent a significant, though smaller, portion of its time on general departmental work. This general work, accounting for 23 percent of the office's time, included analyzing legislation and supporting the department's Advisory Committee on Managed Care.

Finally, although the Office of Health Plan Oversight (Plan Oversight) presented the most even workload split between full-service and specialized HMOs that we were able to review, the split still diverged significantly from the split for assessments. The workload ratio appears to be closer because the division must regularly carry out financial examinations and medical surveys of all HMOs in order to assure their financial viability and adequacy of care. Nevertheless, even though this office oversees more specialized HMOs than full-service HMOs, the workload related to full-service HMOs was almost twice that for specialized HMOs.

The workload split in Table 1 on page 19 presents our calculation of the costs directly attributable to specialized and full-service HMOs for the first six months of fiscal year 2001–02. When we presented this information to the department as a potential basis for revising the assessment structure, the department raised concerns that its operations are evolving and that it is impossible to say how factors such as future legal requirements and enrollee expectations will impact the workload split. We recognize that changes in programs may result in a change in the workload split between HMO classes, and we therefore think it is important for the department to reassess its workload periodically to determine whether the split has changed significantly. However, only a radical change in the department's basic operations would be likely to alter the current split in workload significantly. For example, a 100 percent increase in the proportion of written complaints for specialized HMOs, from 11 percent to 22 percent, would increase the overall workload percentage for specialized HMOs by only 2 percent, from 22 percent to 24 percent.

THE EXISTING ASSESSMENT STRUCTURE HAS A DISPROPORTIONATE FINANCIAL EFFECT ON SPECIALIZED HMOs

Besides poorly mirroring the workload split, the current assessment structure has a disproportionate financial effect on specialized HMOs. The department asserts that the current structure does not create a financial burden on any particular HMO. However, we found that the average assessments for specialized HMOs represent a much larger portion of their premium, Medicare, and Medicaid receipts (premiums), than they do for full-service HMOs. We analyzed the effect on premiums rather than on total revenues because premiums represent the amounts HMOs receive in exchange for providing their services. Total revenues also include other funds, such as interest income, that are independent of services provided.

The percent of premiums for specialized HMOs is about nine times higher per premium dollar than it is for full-service HMOs.

On average, the current structure requires specialized HMOs to pay 0.37 percent of their premiums to the department, as opposed to 0.04 percent of premiums paid by full-service HMOs. This amounts to about nine times more per premium dollar for specialized HMOs. As Table 2 on the following page illustrates, the effect is magnified for HMOs that provide vision, psychological, and certain other services. These HMOs pay more than 0.50 percent of their premiums to the department on average.

TABLE 2

HMO Assessments as a Percentage of HMO Premiums

HMO Type	Premiums (In Millions)	Assessment (In Millions)	Assessment as Average Percentage of Premiums
Full-service	$40,922	$16.1	0.04%
Specialized:			
Dental	3,167	5.9	0.19
Vision	549	3.7	0.67
Psychological	242	3.6	1.49
Other	$ 104	$ 1.7	1.63%

Sources: Assessment amounts are from department records for the fiscal year 2001–02 assessment period. Premium amounts are from HMO annual statements for their fiscal periods ending during calendar year 2000.

When brought down to the individual HMO level, the difference can be quite striking. For example, a chiropractic HMO with premiums of $79 million was assessed about $1.5 million for fiscal year 2001–02, while a full-service HMO with $82 million in premiums was assessed only $44,000. The specialized HMO has about 4.2 million enrollees with average annual premiums per enrollee of about $19; the full-service HMO has about 35,000 enrollees with average annual premiums per enrollee of about $2,345. We shared this example with the department and asked for its viewpoint on why such a disparate impact would not be harmful to specialized HMOs. The department did not address our example, but asserted that only one HMO has indicated it considers the current assessment formula unfair or in need of change. Also the department said that the current assessment, which averages approximately $.50 per enrollee per year, does not cause a financial burden for any HMO. An average of the cost per enrollee for all HMOs, however, hides important differences in financial impact among them. Such disparities make us seriously question the department's assertion that the current structure does not harm individual HMOs.

OTHER METHODS WOULD BETTER REFLECT THE WORKLOAD AND REDUCE FINANCIAL DISPARITIES

Assessment models that more directly reflect the split in workload between specialized and full-service HMOs and that include rates based on HMO premiums, which act as a surrogate for the number of enrollees and the breadth of care provided, appear

to offer a more equitable way to pay for the department's costs than the current method. Although we also considered other methods that do not explicitly take workload into account, we found that they did not provide a good enough match to the workload split by HMO class, had disproportionate financial effects, or both. Table 3 presents the financial impacts of the four funding alternatives we considered. Calculations in the table reflect the department's fiscal year 2001–02 funding need from assessments of approximately $31 million and result in varying financial impacts and assessments for each HMO class.

TABLE 3

Comparison of Current and Alternative Assessment Methods

	Current Method	Alternative Assessment Methods			
		A Flat Fee Per Enrollee	B Total Cost Allocated by Divisional Workload*	C Cost Allocated by Divisional Workload and Premium*	D Flat Fee Per Premium Dollar
Total assessment by HMO class (in millions)					
Full-service	$16.1	$11.5	$24.2	$26.4	$28.2
Specialized	14.9	19.5	6.8	4.6	2.8
Percentage of total assessments by HMO class					
Full-service	52 %	37 %	78 %	85 %	91 %
Specialized	48	63	22	15	9
Average assessment per enrollee (in dollars)					
Full-service	$ 0.71	$ 0.50	$ 1.07	$ 1.16	$ 1.24
Specialized	0.38	0.50	0.18	0.12	0.07
Average percentage of assessment per premium dollar					
Full-service	0.04%	0.03%	0.06%	0.06%	0.07%
Specialized	0.37	0.48	0.17	0.12	0.07

Sources: The current assessment amounts are based on the department's fiscal year 2001–02 assessment records. Amounts for alternative methods are based on department records of HMO enrollees and premiums, and workload figures developed by the Bureau of State Audits.

* Assessment methods preferred by the Bureau of State Audits.

Alternatives A and D offer simplified methods for calculating assessments but do not meet our criterion of approximating the split in workload between specialized and full-service HMOs. Alternative A would assess a per capita charge per enrollee irrespective of HMO type. The focus on the number of enrollees would make this alternative similar to the current model. Unlike the current model, however, which charges specialized and full-service HMOs different rates per enrollee, it would

lack any recognition that different classes of HMOs generate different levels of work for the department. As the table shows, this scheme would move the proportion of assessments paid by specialized HMOs to 63 percent, even further away from their estimated workload of 22 percent. Additionally, this alternative would create even more divergence in the financial impact on HMO classes, requiring specialized HMOs to pay, on average, 16 times more than full-service HMOs per premium dollar.

In contrast, Alternative D, which charges all HMOs the same rate per dollar of premiums, would eliminate any difference in financial impact between classes. However, the proportion of assessments for specialized HMOs, at about 9 percent, would move too far in the other direction, poorly mirroring the 22 percent level of workload associated with the class.

Alternative B would closely match the portion of assessments for each HMO class to the split in identifiable workload and would reduce disparities in financial impact.

Alternative B would closely align the proportion of assessments to the workload by apportioning the $31 million in assessments between specialized and full-service HMOs according to workload estimates and then dividing this amount within the class by the amount of premiums each HMO collects, to arrive at an assessment amount for each HMO. In this example, $6.8 million, or 22 percent of the $31 million the department needs, would be allocated to assessments of specialized HMOs, and individual specialized HMOs would pay an assessment at the rate of 0.17 percent of premiums.

The result of Alternative B is an assessment that closely matches the identified workload and reduces disparities in financial impact. Specialized HMOs would pay approximately three times the rate per premium dollar that full-service HMOs pay, rather than the nine times they pay currently. Additionally, no specialized HMOs would pay more than 0.17 percent, eliminating the large disparities that HMOs providing vision, psychological, and certain other services experience. This method allocates the departmental overhead costs according to the identifiable split in workload and is similar to the department's own method for allocating overhead costs in its accounting system. The department's system distributes costs for the Director's Office, Office of Administration, and Office of Information Technology to its other divisions based on their proportion of budgeted personnel positions. See Appendix B for the steps we used to calculate assessments under Alternative B.

Alternative C would reduce differences in financial impacts by charging the same rate per premium dollar to all HMOs for departmental overhead.

Finally, Alternative C offers a different method for taking workload into account, one that reduces even further the differences in financial impact. This method apportions between the HMO classes the divisional workload costs of $15.4 million that can be identified by class and then divides the remaining overhead costs of $15.6 million across all HMOs according to their premiums. This method of allocating the $15.6 million of overhead would have a common financial impact by assessing each premium dollar at the rate of 0.03 percent, and we therefore believe that this method, like Alternative B, offers a sound structure for assessments. See Appendix B for the steps we used to calculate assessments under Alternative C.

We shared the alternatives above with the department, indicating those we prefer. In responding to us, the department stated that it has no position on the formula issue or preference as to the methodology used to assess HMOs. It said that its only concern is that the approach chosen provide a proper and timely mechanism to obtain the funding necessary for the department's budget, and secondarily that the method be straightforward and simple to administer.

Nevertheless, the department presented us with another alternative method that would yield approximately the same results as the current assessment method. Similar to Alternative C, it would divide divisional costs according to workload, with 24 percent of these costs assessed to specialized HMOs. It would, however, allocate the remaining overhead costs at the same rate per enrollee regardless of the class of HMO, assessing specialized HMOs 63 percent of these costs. We asked the department to provide its perspective on what its overhead supports, if not its core operations, and why the number of enrollees, rather than identifiable workload or HMO premiums, provides a better alternative for allocating overhead. The department did not directly answer our question, stating only that the operations of the department, supported by the department's "infrastructure," are built on the premise of serving all enrollees equally regardless of the class of HMO. We do not consider the department's additional alternative to be equitable because the split between the assessments for full-service and specialized plans would continue to poorly reflect the split in identifiable workload, and large disparities in financial impact would persist among the HMOs.

The alternatives detailed here do not include a flat fee per HMO or a sliding rate scale similar to that included in the current assessment structure. Such refinements would assure that small HMOs pay a minimal amount to cover their share of the department's costs, even if their enrollment or premiums are low. For example, a full-service HMO with 1,805 enrollees was assessed about $14,200 for fiscal year 2001–02. Of this amount, $12,500, or 88 percent, related to the flat fee that the department charges to all full-service HMOs. Although we believe that a flat fee and/or sliding scale is necessary no matter what basic assessment method is used, we did not include such modifications in our study of the various alternatives because it would not significantly change the proportion of assessments or the financial impact on the HMO classes as a whole.

ADDITIONAL USER FEES ASSESSED DIRECTLY TO HMOs WOULD NOT BE BENEFICIAL

All of the alternatives detailed in the previous section would be relatively inexpensive for the department to implement because they use sources of data that are readily available and would not require a complicated billing system. In addition to these alternative assessment structures, we considered a direct billing process that would charge specific regulatory costs back to individual HMOs. Such a process would be similar to billing systems for regulatory functions at the Department of Insurance, which funds some of its activities through charges for examinations and reviews. HMO regulators in Illinois that we interviewed also indicated that they charge fees for the examinations they perform. Currently, the department bills HMOs directly for the cost of performing only additional or nonroutine financial examinations and medical surveys. Thus, there is a precedent for the practice of direct billing to recover the costs of regulatory activity.

Direct billing for financial exams and medical surveys would not be beneficial because it would introduce fluctuations in charges to HMOs.

However, we are not recommending that the department expand its direct billings to cover the costs of other activities, primarily because we do not believe it would be beneficial to do so. If the department were to undertake such billings, we believe that the most administratively feasible areas to expand into would be routine financial examinations and medical surveys because the department already has a direct billing process established for nonroutine activity in these areas. Even in these areas, however, we do not believe that direct

billing would be beneficial because the related services are performed on three- and five-year cycles, and billing for them would introduce fluctuations in the charges to HMOs as well as potential fluctuations in the department's resources. Further, direct billing for the cost of operations for other units would be administratively difficult given that the department performs many tasks of short duration, such as responding to enrollee telephone calls or complaints. For example, the department's Help Center staff answered an average of 915 calls each week in 2001, and tracking the time spent assisting enrollees for each of the 107 HMOs would be cumbersome.

RECOMMENDATIONS

To ensure more equitable assessments of HMOs to support the department's activities, similar to the results from Alternatives B and C presented in this chapter, we recommend that the Legislature:

- Consider changing the department's assessment structure to reflect the proportion of the documented workload that the department devotes to specialized and full-service HMOs and to reduce disparities in the financial effect on HMOs, and

- Require the department to report to the Legislature triennially on the proportion of assessments charged to each class of HMO and the proportion of the documented workload related to each class of HMO. ■

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CHAPTER 2

The Department Is Generally Effective in Meeting Deadlines, But It Must Improve the Timeliness of Financial Examinations and Its Responses to Requested Plan Changes

CHAPTER SUMMARY

The Department of Managed Health Care (department) has increased the output for some of its core functions, has introduced several new services for health maintenance organization (HMO) enrollees, and, in certain instances, is generally better at meeting statutory deadlines when compared to the same functions previously carried out by the Department of Corporations (Corporations). For example, in the first half of fiscal year 2001–02, the department's Division of Plan Surveys (Medical Surveys) completed 20 routine medical surveys (surveys) and ended calendar year 2001 with only 4 backlogged surveys. In contrast, Corporations had an output of 7 surveys in the first half of fiscal year 1998–99 and 40 backlogged surveys at the end of calendar year 1998.

On the other hand, the department's Division of Financial Oversight (Financial Oversight) is having difficulty completing financial examinations on time. Its backlog of 13 examinations at the end of calendar year 2001 compares unfavorably to the backlog of 2 examinations that Corporations experienced at the end of calendar year 1998. Financial Oversight has recently implemented recommendations made by a consultant that may help it reduce its backlog through better planning and the elimination of review procedures unlikely to reveal financial risk. This unit also plans to fill staff vacancies and hire a contractor to keep up with its workload.

Similarly, the Division of Licensing (Licensing) has often failed to promptly notify HMOs of its decisions regarding the HMOs' requests to make significant changes, known as material modifications, to health plans. It was late in sending written notifications for 42 of the 122 material modification filings it received in 2001. Licensing is implementing a new electronic filing system intended to improve the monitoring

of its workflow. However, given the newness of the system it is too early to tell whether it will help Licensing resolve the problem of late notifications.

Based on our review of the department's work related to six core functions, the department appears to have adequate resources to meet its needs. Production is up, backlogs are generally down, and new services have been made available to HMO enrollees. The two functions, Financial Oversight and Licensing, which still need to improve the timeliness of their work, have resources available to them that should help them improve their performance.

We reviewed the following units:

- Standard Complaints and Initial Review unit
- Call Center
- Independent Medical Review unit
- Division of Plan Surveys
- Division of Financial Oversight
- Division of Licensing

FOUR CORE OPERATIONS ARE GENERALLY MEETING DEADLINES OR HAVE GREATLY EXPANDED SERVICES

The department has significantly increased the resources devoted to HMO regulation compared to those spent by Corporations on similar functions in fiscal year 1998–99, increasing output and generally meeting statutory requirements. For four of the six units we reviewed—the Standard Complaints and Initial Review unit (Complaints unit), the Call Center, the Independent Medical Review unit, and Medical Surveys—the department is meeting deadlines and/or has greatly expanded the services it provides to HMO enrollees. Improvements in the timeliness of complaint resolutions and medical surveys are particularly dramatic.

THE DEPARTMENT RESOLVES MOST WRITTEN COMPLAINTS ON TIME

The department's Complaints unit has greatly reduced the backlog of written complaints. As shown in Table 4, under Corporations there were 305 backlogged complaints at the end of calendar year 1998; by the end of calendar year 2001, the Complaints unit had a backlog of only 9 complaints. This turnaround came despite the fact that the department now faces a tighter 30-day deadline for the resolution of written complaints, as opposed to the 60-day deadline in effect in 1998. Moreover, 84 percent of the Complaints unit's closed cases in 2001 were resolved within the 30-day time frame, and less than 1 percent took longer than 60 days to resolve.

The improvement in the unit's on-time performance has come at a cost, however. The costs for staff devoted to resolving written complaints have more than doubled since 1998, but the volume of complaints closed has increased by only 36 percent.

TABLE 4

Performance Indicators for the Resolution of Standard Complaints Against HMOs

	Department of Corporations July Through December 1998	Department of Managed Health Care July Through December 2001	Percent Change
Backlog at end of period	305	9	-97%
Complaints closed	1,430	1,942	36%
Cost of Complaints unit staff	$132,320	$304,945	130%
			111%*

Sources: Bureau of State Audits report 97118.2, issued April 1999, for 1998 closed complaints and backlog information. Help Center organization chart and reports on 2001 open and closed complaints. State Controller's Office payroll records.

* Adjusted for inflation.

The Department Has Significantly Reduced Its Backlog of Medical Surveys

The department's Medical Surveys unit has also greatly reduced its backlog. As shown in Table 5 on the following page, backlogged medical surveys fell from 40 at the end of calendar year 1998 to 4 at the end of calendar year 2001. The law requires the department to complete a medical survey for each HMO at least every 3 years. Thus, we consider surveys to be backlogged when Medical Surveys does not publish a new survey report for a given HMO within 3 years of its last published survey report.

In addition, Medical Surveys has done a better job of publishing survey reports within 180 days of the end of the survey, which is the statutory deadline unless the director decides that more time is necessary to complete a full, fair report. During the 3 years ending December 31, 1998, the related unit at Corporations issued 44 late reports that missed the 180-day deadline by an average of 6 months. In contrast, for reports initially due during the first 18 months of the department's operations, ending

December 31, 2001, Medical Surveys issued 14 late reports that missed the deadline by 77 days on average. Only 2 of these late reports related to output during fiscal year 2001–02.

Table 5 shows that Medical Surveys increased its output of surveys during the first 6 months of fiscal year 2001–02 over the same period in fiscal year 1998–99. Labor hours devoted to surveys have also increased but at a much slower pace. By reducing backlogs and improving its compliance with the publishing deadline, Medical Surveys has decreased the risk that the HMOs that are the subjects of these surveys will have uncorrected deficiencies that violate laws and regulations, and it has also improved the timeliness of the information available to the public regarding the quality of HMO services.

TABLE 5

Performance Indicators for Routine Medical Surveys

	Department of Corporations July Through December 1998	Department of Managed Health Care July Through December 2001
Backlog at end of period	40	4
Hours spent on medical surveys	1,702	2,774
Public reports issued	7	20

Sources: Bureau of State Audits report 97118.2 issued April 1999, for 1998 data. Department accounting records and Medical Survey tracking logs and files for 2001 data.

Note: Because surveys take several months to complete, reports in one year may have been started in another year.

The Department Has Significantly Expanded Other Services for Enrollees

The department has also devoted more resources to answering enrollee requests for assistance and has established a new program to address enrollee requests for independent medical reviews. As detailed in Table 6, costs have gone up significantly at the department's Call Center. This unit is, however, responding to many more calls and providing consumers with a broader array of services. In fiscal year 1998–99, staff answered enrollee calls only during normal business hours. In contrast, the Call Center now provides around-the-clock service through an external contractor and also offers "urgent" and "quick-

resolution" services for resolving complaints. Urgent complaint-resolution services relate to issues of denial or delay of medication, premature release from a hospital, or inappropriate care. According to the chief of the HMO Help Center (Help Center), the Call Center has a goal of resolving these issues within seven days. Quick-resolution complaint services relate to nonurgent issues, such as payment of claims, problems scheduling appointments, and enrollment in an HMO, which Call Center staff believe can be resolved quickly. Currently, nine HMOs have agreed informally to participate in the Call Center's quick-resolution program. The goal of the program is to resolve complaints in three days. By using these processes, enrollees can bypass the written complaint process and get complaints resolved more quickly. The Call Center has also instituted an interactive voice response (IVR) system that gives phone callers general information, such as telephone numbers for the complaint units of HMOs, which reduces the number of calls that staff or the external contractor must answer.

As Table 6 indicates, call volume increased by 62 percent between the first half of fiscal year 1998–99 and the first half of fiscal year 2001–02, while costs increased by 118 percent, after adjustment for inflation. By offering urgent and quick-resolution services, the Call Center probably reduced the workload of the

TABLE 6

Performance Indicators for the Call Center

	Department of Corporations July Through December 1998	Division of Managed Health Care July Through December 2001				
		By Department Staff	Interactive Voice Response System	By Contractor	Total	Percent Change
Calls answered	41,479	21,362	24,697	21,197	67,256	62%
Quick resolutions handled	Not offered	279				
Urgent complaints handled	Not offered	672				
Cost	$145,492	$204,808	$6,576	$134,646	$346,030	138%
						118%*

Sources: Bureau of State Audits report 97118.2, issued April 1999, for 1998 call data. Help Center organization chart and reports on services performed in 2001. State Controller's Office payroll records.

* Adjusted for inflation.

Complaints unit, but more importantly, it helped consumers resolve issues more quickly by not requiring them to submit written complaints.

In addition to these expanded services, the department began processing enrollee requests for independent medical reviews (IMRs) in 2001, as required by law. The Independent Medical Review unit (IMR unit) within the Help Center helps consumers resolve issues related to medical necessity and experimental or investigational therapies. IMR staff collect requests for IMRs and related paperwork, determine whether the requests meet minimum criteria for review, and send qualified requests to independent, contracted health care professionals, who decide whether HMOs have inappropriately denied services. During 2001 the IMR unit closed 513 standard IMR requests. Of this total, the IMR unit answered 438 or 85 percent of the requests within the department's own 30-day deadline. As of December 31, 2001, only 1 of 38 open IMR cases had been outstanding for more than 30 days.

The department answered 85 percent of requests for Independent Medical Reviews within its 30-day deadline.

TWO CORE OPERATIONS ARE HAVING DIFFICULTY MEETING DEADLINES

While four of the six operating units we reviewed showed marked improvements in effectiveness and/or a significant expansion in services, two others—Financial Oversight and Licensing—are not meeting statutory deadlines. Financial Oversight has seen a large increase in its routine workload which, combined with staff vacancies and an increase in nonroutine work, has led to a backlog in completing routine examinations. Licensing has sometimes failed to notify HMOs within statutory time frames of the status of its decisions regarding their requests for major plan changes, known as material modifications. When the department does not complete examinations on time, the public is not fully informed of the financial status of HMOs, and when it does not notify HMOs of delays in approving their requests for changes, they are not able to respond to department concerns, resulting in delays in changes that the HMOs believe are necessary and significant.

The Backlog of Financial Examinations Has Increased Despite an Increase in Examinations Completed

Financial Oversight recently increased its output of reports on the results of routine financial examinations, yet its backlog of reports to complete also increased. These examinations assess the financial condition of each HMO every 5 years, as required by law, to ensure that consumers receive adequate protection from financially weak HMOs. As shown in Table 7, this backlog amounted to 13 reports at the end of calendar year 2001, compared to 2 at the end of calendar year 1998. Examinations for all of the reports in the current backlog were in progress as of December 31, 2001, but Financial Oversight had not yet issued the public reports. When the department does not publish reports on time, enrollees do not receive up-to-date analysis that could assist them in making appropriate decisions about their HMOs.

TABLE 7

Performance Indicators for Routine Financial Examinations

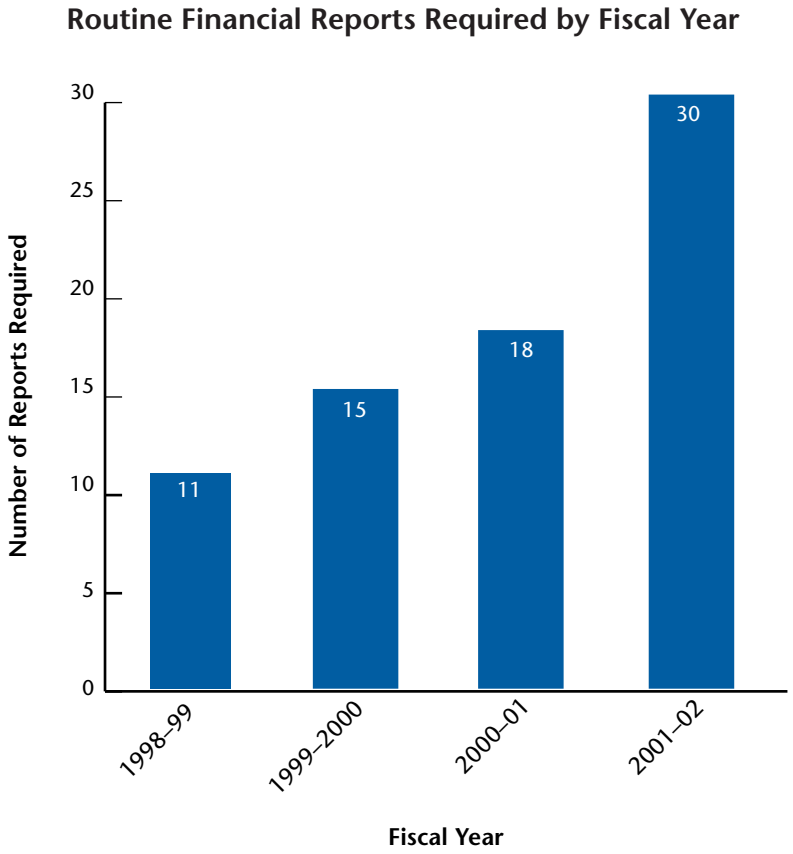
	Department of Corporations July Through December 1998	Department of Managed Health Care July Through December 2001
Hours spent on routine financial examinations	7,624	10,476
Routine public reports issued	5	13
Backlog at end of period	2	13

Sources: Bureau of State Audits report 97118.2, issued April 1999, for 1998 data. Department accounting records and Financial Oversight tracking logs and files for 2001 data.

Note: Because examinations take several months to complete, reports issued in one year may have been started in another year.

As shown in Figure 4 on the following page, the number of reports that Financial Oversight needed to complete surged in fiscal year 2001–02. Several factors contributed to this significant increase in workload and Financial Oversight's inability to keep up with it. First, the large number of HMOs licensed in fiscal year 1996–97 had their first reports come due in fiscal year 2001–02. In addition, the department explained that staff vacancies reduced its ability to complete examinations. For example, as of December 7, 2001, department records show that 3 of

FIGURE 4



Source: Financial Oversight Aging Report.

Financial Oversight's 15 budgeted examiner and auditor positions for routine financial examinations were vacant. According to the chief of Financial Oversight, these positions have not been filled because of a lack of qualified candidates and a statewide hiring freeze that began in October 2001. Financial Oversight has, however, applied for an exemption from the freeze and indicates that it plans to hire additional workers in fiscal year 2002–03. It is also in the process of hiring private auditing firms to complete 4 to 6 financial examinations. According to the chief of Financial Oversight, it plans to have these firms begin their work in spring 2002. Finally, he explained that Financial Oversight delayed work on routine examinations in order to undertake several large, nonroutine examinations of financially troubled HMOs. During the first half of fiscal year 2001–02, for example, Financial Oversight logged over 1,300 hours for nonroutine examinations, close to the amount of time required for two routine examinations. This compares to

988 hours spent on nonroutine examinations in all of fiscal year 1997–98 and 15 hours spent on them in the first half of fiscal year 1998–99.

We also believe that Financial Oversight incorrectly interprets a state law, and this misinterpretation contributes to its problems with publishing financial examination reports on time. The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) requires the department to perform financial examinations of each HMO no less frequently than once every five years. The Chief of Financial Oversight said that the division has a long-standing policy of determining compliance with the five-year cycle according to when it sends notification letters to HMOs at the beginning of financial examinations. He said that using this methodology, Financial Oversight currently has only one financial examination that does not meet the five-year requirement. However, we believe that the Knox-Keene Act requires Financial Oversight to complete a financial examination and issue a final report for each HMO at least once every five years. By using the start date of the notification letter rather than the issue date of the final report, Financial Oversight has extended the time between reports for certain health plans to longer than permitted. For example, because the department licensed a particular full-service HMO on March 22, 1996, we expected to find that it had issued a financial examination report on the HMO by March 22, 2001. Financial Oversight, however, sent a notification letter to the HMO on February 5, 2001, and did not issue a public report until March 29, 2002, one year beyond the five-year limit.

It will be particularly important for Financial Oversight to adequately address its backlog problem because, with recent increases in funding, it has committed itself to examining all full-service HMOs every three years instead of every five years, and it plans to do the same for specialized HMOs considered to be at risk for financial difficulties. Consequently, the number of reports required each year will continue to be high—between 25 and 30. In addition to its plans to hire more staff and use external contractors to deal with this workload, Financial Oversight is implementing new processes, recommended by a consultant, that may also help improve its output. For example, it is using a risk-based approach for planning examinations and is budgeting and tracking the time it spends on examinations. The effectiveness of these processes and of Financial Oversight's hiring plans, however, is still to be seen.

The Licensing Division Often Misses Statutory Deadlines for Material Modifications

The Licensing Division was late in notifying HMOs of its decisions for 42 of the 122 requests for material modifications it received in 2001.

Licensing is also having problems in meeting its statutory deadline to promptly notify HMOs of its decisions regarding material modifications (modifications) to their plans. The law requires the department to approve, disapprove, suspend, or postpone the implementation of these modifications, such as the expansion of a service area or the sale of an HMO, within 20 business days of receiving notice of them, or within such additional time as the HMOs may specify. The department must notify HMOs in writing in cases where it is disapproving, suspending, or postponing the implementation of the modifications. The notifications serve to inform HMOs of the reason for the department's decision. Licensing was late in notifying HMOs of its decisions on 42 of the 122 modifications it received in 2001. As of December 31, 2001, these items were late by 41 business days, on average. The delays ranged from 1 to 139 days, with 12 of the items outstanding at year's end. The department's slowness in notifying HMOs of its decisions regarding modifications may lead to delays in implementing major changes in health care services when HMOs are not aware of and thus cannot address issues the department has with their modifications. Licensing said that it verbally provided its comments to HMOs at an earlier date for 23 of the 42 late modifications. Verbal notifications do not, however, meet the requirements of the law. In addition, by their very nature, verbal notifications leave the department vulnerable to charges that it has not responded to the HMOs.

According to the assistant chief counsel for Licensing, workload issues may be a factor contributing to late notifications. In addition, an August 2001 report studying the feasibility of implementing a new electronic document management system found that limitations in Licensing's manual processes made it difficult to ensure that statutory turnaround requirements were met. The report also found that Licensing had no reliable, consistent means of tracking the status of its workload. Indeed, we found that the system used to track modifications in 2001 often had incomplete data and did not have a mechanism for highlighting overdue items.

To alleviate these problems, Licensing is implementing an electronic filing system intended in part to enhance the department's ability to satisfy statutory requirements through workflow functions. According to the manager for the project, the department completed the pilot phase of the project in

October 2001, began the rollout phase in December 2001, and should complete the project by June 30, 2002. Nevertheless, Licensing appears to face continuing problems with meeting deadlines for notifying HMOs regarding modifications. It turned off an automated feature of the new system that indicates when notifications are close to being overdue because the feature created a tremendous workload for the system administrator, who had to redistribute the filings. Given the newness of the system, however, it is too early to tell whether it will eventually help Licensing resolve the problem of late notifications.

Based on our review of the department's work related to six core functions, the department appears to have adequate resources to meet its needs. Production is up, backlogs are generally down, and new services have been made available to HMO enrollees. The two functions, Financial Oversight and Licensing, which still need to improve the timeliness of their work, have resources available to them that should help them improve their performance.

RECOMMENDATIONS

To ensure that enrollees have up-to-date departmental analysis on the financial status of HMOs, the department should establish deadlines for the publishing of financial examination reports and should closely monitor the success of its efforts to meet deadlines for these reports.

To ensure that HMOs are promptly notified of the status of material modifications to their plans, the department should closely monitor the time elapsed between its receipt of requests for these modifications and the notifications it sends to HMOs, and it should make it a priority to send written notifications within the statutory deadline. ■

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: May 28, 2002

Staff: Lois Benson, CPA, Audit Principal
Jim Sandberg-Larsen, CPA
Ana Clark
Dominic Nadarski
Katrina Williams
Lan Yan

APPENDIX A

The table on the following page compares the amount budgeted for support staff to that budgeted for line staff by division and for the Department of Managed Health Care as a whole. Line staff include employees who provide services directly to health maintenance organizations (HMOs) or HMO enrollees, such as consumer services representatives in the HMO Help Center, corporation examiners in the Office of Health Plan Oversight, and their supervisors. Support staff include managers and clerical employees in operating divisions and all employees in support divisions.

TABLE A.1

Comparison of Budgets for Line Staff vs. Support Staff Fiscal Year 2001–02

Divisions	Budgeted Personnel Expenditures	Percentage
Operating:		
HMO Help Center		
Line staff	$2,818	90%
Support staff	320	10
Office of Enforcement		
Line staff	1,010	67
Support staff	494	33
Office of Health Plan Oversight		
Line staff	4,266	79
Support staff	1,144	21
Office of the Patient Advocate		
Line staff	356	57
Support staff	270	43
Support:		
Office of Administrative Services		
Support staff	2,228	100
Office of the Director		
Support staff	1,384	100
Office of Legal Services		
Support staff	1,562	100
Office of Technology and Innovation		
Support staff	924	100
Department Totals		
Line staff	8,450	50
Support staff	8,326	50
Total	**$16,776**	**100%**

Sources: Governor's Budget and Wages and Salaries Supplement for fiscal year 2001–02.

Note: Percentages rounded to the nearest full percent.

APPENDIX B

The steps listed in this appendix detail the procedures we used to calculate assessments for specialized and full-service health maintenance organizations (HMOs) under alternative assessment methodologies B and C in Chapter 1.

Alternative B—Total Cost Allocated by Divisional Workload	
Steps	**Action**
1	Determine the workload split by HMO class.
2	Multiply the total funding need by the workload split in step 1 to calculate the total to be paid by each HMO class.
3	Divide the amount to be paid by HMO class from step 2 by the revenues from premiums, Medicare, and Medicaid (premiums) for the HMO class to calculate the assessment rate for the class.
4	Apply the assessment rate for the HMO class from step 3 to premiums for individual HMOs to calculate the assessment for each HMO.

For example, assuming a department funding need of $31 million, a specialized HMO workload split of 22 percent, and specialized HMO premiums of $4.1 billion, total assessments for specialized HMOs would total $6.8 million and the assessment rate for individual, specialized HMOs would be 0.17 percent of premiums. A specialized plan with $80 million in premiums would be assessed about $136,000.

continued on the next page

Alternative C—Divisional Workload and Premiums	
Steps	**Action**
1	Determine the workload split by HMO class.
2	Multiply the workload split by the funding need for those divisions with an identifiable workload split to calculate the total to be paid by each HMO class.
3	Divide the amounts in step 2 by the premiums for the HMO class to determine the divisional cost assessment rate.
4	Apply the divisional cost assessment rate for HMO class in step 3 to the premiums for individual HMOs to calculate the assessment for each HMO.
5	Divide the remaining funding need by the total premiums for all HMOs to calculate the departmental overhead assessment rate.
6	Apply the departmental overhead assessment rate from step 5 to the premiums for individual HMO to calculate the assessment for each HMO.
7	Add the amounts from steps 4 and 6 to determine the total assessment for each HMO.

For example, assuming a department funding need of $31 million which includes $15.4 million budgeted for divisions with identifiable workload, a specialized workload split of 22 percent, and specialized HMO premiums of $4.1 billion, assessments for specialized HMOs related to divisional costs would total about $3.4 million and the assessment rate for individual, specialized HMOs would be 0.08 percent of premiums. In addition, assuming that total premiums for all HMOs amount to $45 billion, all HMOs would be charged at a rate of about 0.03 percent of premiums to pay for the departmental overhead costs of $15.6 million. A specialized plan with $80 million in premiums would be assessed about $64,000 for divisional costs and about $24,000 for remaining overhead costs for a total assessment of $88,000.

Agency comments provided as text only.

Business, Transportation and Housing Agency
980 9th Street, Suite 2450
Sacramento, CA 95814-2719

May 15, 2002

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Attached is the Department of Managed Health Care's (Department) response to your draft report, The Department of Managed Health Care: Assessments for Specialized and Full-Service HMOs Do Not Reflect Its Workload and Have Disparate Financial Impacts (#2001-126). I appreciate that, in the first chapter of your report, you include the Department's perspective on the rate structure alternatives that you present for the Legislature's consideration. As the Department's more detailed response indicates, there are quite a number of additional factors that the Legislature must consider when analyzing the financial impact that alternative assessment structures will have on Health Maintenance Organizations (HMO), particularly those HMOs whose financial solvency may be affected through an increased assessment. Additionally, fairness to the HMOs and their subscribers, as well as the ease of administering the assessments, certainly will be factors in the decision the Legislature is being asked to make.

In addition to the workload analysis and possible alternative assessment methods presented in the first chapter, the second chapter of your report discusses the Department's performance. I am pleased that four of the six operating units reviewed have significantly improved existing services, such as complaint resolution, while offering several new services to HMO enrollees. In relation to the issue of the timeliness of its financial examinations, I support the Department's placing a high priority on actions to protect consumers, and agree that its change to a three-year examination cycle and its hiring of outside firms will address any concerns regarding the timeliness of conducting the examinations. As

* California State Auditor's comments begin on page 55.

the Department indicates in its response, to improve licensing operations, it has made programmatic changes to focus on its core responsibilities and ensure timely performance, and is developing a new tracking system for improved caseload management that will be integrated with its system for the electronic filing of amendments and material modifications.

I appreciate the opportunity to respond to your audit report. If you need additional information, please do not hesitate to contact me, or Michael Tritz, Chief of the Office of Internal Audits within the Business, Transportation and Housing Agency, at (916) 324-7517.

Sincerely,

(Signed by: Maria Contreras-Sweet)

MARIA CONTRERAS-SWEET
Secretary

Agency's comments provided as text only.

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

May 13, 2002

TO: Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

VIA: Maria Contreras-Sweet, Secretary
Business, Transportation and Housing Agency

FROM: Daniel Zingale, Director
Department of Managed Health Care

RE: BUREAU OF STATE AUDITS DRAFT REPORT

Thank you for giving us this opportunity to respond to the first independent state audit of the Department of Managed Health Care since our July 2000 launch.

We appreciate your recognition of the Department's efforts on behalf of California's HMO consumers. We have been concerned that previous oversight of HMOs as reported in a 1999 state audit discouraged many frustrated HMO consumers from seeking state help. Thus, we are hopeful that release of this report will help educate more consumers about their new rights and the role the Department can play in protecting and enforcing those rights.

In your 1999 report, you suggested that HMO oversight was failing to meet the needs of consumers and needed to be moved to a new department with new leadership to "provide the necessary direction, focus and vision to the staff responsible for regulating health plans."

In the same year, Governor Davis signed into law the most ambitious and comprehensive HMO reforms in the nation, including the establishment of the Department of Managed Health Care, the first and only organization in the nation solely dedicated to protecting HMO consumers.

In the 1999 report, you suggested that the appointment of new leadership was urgently needed to ensure more responsive and accountable HMO oversight. On the first day of the Department, the Governor filled top positions with patient advocates; he appointed medical professionals to ensure that medical decisions guide our work; and he filled three advisory boards to ensure the input of consumers, health care professionals, employers and other health leaders.

In your 1999 report, you cited "indifferent customer service" for Californians who were trying to resolve their HMO problems. We are pleased your report validates the work of our leadership team and everyone at the Department to make customer service a core principle:

- "Production is up, backlogs are generally down, and new services have been made available to HMO enrollees."

- "[The Department] has significantly increased the output for some of its core functions, has introduced several new services for HMO enrollees, and is generally better at meeting statutory deadlines when compared to the same functions carried out by [the previous regulator] until June 2000."

- "Improvements in the timeliness of complaint resolutions and medical surveys are particularly dramatic."

- "The department's Complaints unit has greatly reduced the backlog of written complaints...This turnaround came despite the fact that the department now faces a tighter 30-day deadline for the resolution of written complaints, as opposed to the 60-day deadline in effect in 1998."

HMO MEDICAL SURVEYS

In 1999, you wrote that "consumer protection was less than expected because the department had not completed by December 1998 nearly half of all required medical surveys."

In 2002, you report: "The department's Medical Surveys unit has also greatly reduced its backlog… By reducing backlogs and improving its compliance with the publishing deadline, Medical Surveys has decreased the risk that the HMOs that are the subjects of these surveys will have uncorrected deficiencies that violate laws and regulations, and it has also improved the timeliness of the information available to the public regarding the quality of HMO services."

HMO LICENSING

Your report says that the Department has not promptly informed HMOs of our decision to approve, postpone or deny their proposed changes in writing.

We have sought to improve communications with health plans by providing more informal forums for sharing information. This more informal approach is similar to the HMO Help Center's informal complaint resolution process, which has helped to expedite the resolution of thousands of consumer complaints.

To improve licensing operations, we have concentrated on establishing a new system for electronic filing of amendments and material modifications. In addition, the Department has begun an aggressive, multi-faceted program of change to focus on our core responsibilities and ensure on-time performance. A new, integrated tracking system is being developed to be used with the e-filing system to enable our staff to manage their caseload effectively and supervisors to review up-to-date caseload information.

HMO FINANCIAL EXAMS

Finances affect patient care. From the moment our financial exams begin, they inform us of potential problems that could affect patient care. Our approach toward financial exams has already yielded record patient rights enforcement results. In fact, three exams resulted in the seizure of three HMOs where poor financial management was gravely threatening patient care. We recognize that, in some cases, we have prioritized actions to protect consumers, over issuing some final reports to HMOs. Additionally, we are moving towards a three-year financial examination cycle, hired outside contractors, implemented exam efficiency measures and applied automation to improve collecting and reporting information.

HMO ASSESSMENTS

We recognize your concerns about the HMO assessment fees that are used to fund the work at the Department. A change to the current assessment formulas would require action from the legislature. The Department of Managed Health Care merely complies with existing law in applying the current assessment formulas.

CONCLUSION

Your report provides us with useful, constructive observations. It also provides an opportunity to inform HMO consumers that they are empowered with some of the strongest patient rights laws in the nation and have a responsive new advocate to assist them in exercising those rights. We put patients first and we will continue to do so.

Thank you again for giving us the opportunity to comment on the report. A technical appendix follows, with minor corrections and other areas of concern. If I can be of any assistance, please do not hesitate to call me directly at 322-2012.

DZ:KG:bs

Attachment – Technical Appendix

Technical Appendix

Below is information relative to specific points raised in the report.

HMO Help Center

The 1,684 includes both the Department's Call Center and External Call

Center.

- Page 12a – Types of Help Center Assistance

Written Complaints – The report said HMO enrollees file a "Request for Assistance," when in fact they file a "formal complaint."

- Page 16 – last bullet and Page 26, first paragraph

These are correct statements, for the time period reflected, however, with the installation of the new computer system, we are now able to capture the call volume for all HMOs. The Department of Corporations' old system relied on agents manually entering data into a Call Center Management Information System via the keypad on the telephone. Because of the volume of information involved in entering data for all health plans, only data for the nine largest plans was captured.

- Page 35 – Call Volumes

Last sentence – The report says 915 calls each week, when in fact the number should be 1,684.

The 1,684 includes both the Department's Call Center and External Call Center.

- Page 39 and 40 – Chart

The report shows that there are 9 complaints backlogged, when in fact

there were 6.

The number of complaints closed from July-December 2001 is 2,664, note

1,942.

- Page 43 – first sentence

The report says "…such as telephone number and addresses…" – we do not provide addresses via the IVR System.

- Page 44 – second paragraph

"During 2001, the IMR Unit closed 513 standard IMR requests. Of this total, the IMR Unit answered 438 or 85 percent of the requests within the Department's own 30-day deadline. As of December 31, 2001, only 1 of the 38 open IMR cases has been outstanding for more than 30 days."

This should be:

"During 2001, the IMR Unit closed 561 standard IMR requests. Of this total, the IMR Unit answered 487 or 87 percent of the requests within the Department's own 30-day deadline. As of December 31, 2001, only 1 of the 38 open IMR cases has been outstanding for more than 30 days."

Licensing Activities

The BSA report states that the Department has not promptly informed HMOs of our decision to approve, postpone or deny their proposed changes known as "material modifications."

Under the new Department, we have sought to improve communications with health plans by providing more informal forums for sharing information. Holding pre-filing conferences with plans, review of draft plan filings, and corresponding by phone and email are efforts we are making to facilitate faster review of filings, and ensure that plans have understood and met the requirements of the Knox-Keene Act and regulations. This more informal approach is similar to the HMO Help Center's informal complaint resolution process, which BSA staff praised in the report.

To improve licensing operations, we have concentrated on establishing a new system for electronic filing of amendments and material modifications. Approximately 50 health plans are now filing documents electronically, and we anticipate all plans will be doing so by June, 2002. At the same time that plans are being certified to file electronically, design changes are being made to enhance performance.

In addition, the Department has begun an aggressive, multi-faceted program of change to focus on our core responsibilities and ensure on-time performance. A new, integrated tracking system is being developed to be used with the e-filing system to enable staff to manage their caseload effectively and supervisors to review up-to-date caseload information.

Financial Examinations

The BSA audit report states that the Department is having difficulty completing financial examinations on time, and that a backlog of 13 examinations exists.

The Department's emphasis has always been on the protection of the enrollee. This has meant that in some cases, the Department has delayed production of a report in favor of more pressing financial issues. This is consistent with the Department's traditional reading of the statute which we believe requires an examination to begin within five years.

Technical Appendix

Beginning with the current year, the Governor and the Legislature provided support in the budget to move to a 3-year examination cycle for full service plans and specialized plans. Thus, the 5-year issue is moot since those reports will clearly be completed with the 5 years.

Regarding the backlogged examinations, the fieldwork on 12 of the 13 examinations has been completed and 9 final reports have been issued. The issuance of the final report in these cases was delayed because staff were diverted to other more pressing workload, primarily non-routine examinations. It is our belief that investigating and resolving issues which prompt non-routine exams, primarily financial solvency-related issues, is more important than completing the routine examinations in question. An analysis of the routine examination reports in question would have shown that there are no potential findings that will negatively impact enrollees.

The Department provides up-to-date financial information to consumers. In keeping consumers informed, the Department has posted 20 financial exam reports on our website since July 1, 2001. Currently, summary financial information is on the website, and as part of the Department's automated financial statement submission, the financial statements of all licensed health plans will soon be added to the Department's web page. In addition, the Department is in the process of automating the financial statement review with the purpose of better targeting potential financial problems. This will allow the Department to address financial problems earlier, with the potential of redirecting examiner time to performing examinations.

To meet increased examination obligations, the Department has contracted with four outside firms to assist with performing limited scope examinations. Additionally, the Department engaged the services of an outside consultant to review and recommend changes to the financial examination and financial statement review processes. The Department has or is in the process of implementing several recommendations. This includes implementing more risk assessments when planning examinations, enhancing preplanning for examinations, reducing work paper volume, expanding the use of technology, creating more structure in the financial statement review process, and establishing the outcome-based indicator model to rapidly classify a plan's financial status.

Assessments

As we have stated in our numerous discussions, the Department has no position, at this time, on the formulas used to assess plans. Our concern is only that the approach chosen provides a proper and timely mechanism to obtain the funding necessary for the Department's operations, and secondarily, that the method be straightforward and simple to administer.

Technical Appendix

We believe a change to the current assessment formulas, which were originally established to fund the HMO licensing and regulatory functions in the Department of Corporations, would be a legislative determination. The Department of Managed Health Care merely complies with existing law in applying the current assessment formulas.

We believe the Legislature should be advised of all different methodologies and their impacts. As we have discussed with BSA audit staff throughout the audit, there are many different formulas which can be used to assess the plans, and a number of ways to evaluate them.

At a minimum, this evaluation could take into consideration the different cost structures associated with various types of plans, as well as the specific impact a revised formula may have on a given plan. We have raised throughout the audit our concern that changing the existing formulas may impact some plans adversely. Increasing assessments to full service plans to the levels recommended by the BSA may raise new concerns with the financial solvency of some of those plans.

Finally, to the extent it is determined that the appropriate methodology for plan assessments is a "cost" driven approach, the method for assigning cost must be fully analyzed. The Department's operations, supported by the Department's "infrastructure," are built on the premise of serving all enrollees equally, regardless of whether an enrollee is in a full service or specialized plan. In fact, based on the BSA's findings, less than 50% of the Department's activities can be attributed directly to either full-service or specialized plans.

It should be noted that the BSA's "cost allocated" assessment option is built on the assumption that the appropriate method of allocating 100% of the Department's costs should be allocated based on the less than 50% of costs that the BSA could associate with a specific plan type. While this type of "cost accounting" approach for "overhead" allocation is not unreasonable, it certainly does not represent the only possible approach. For example, allocating significant portions of infrastructure/overhead based on plan enrollment would generate a very different result. This option and others are not presented for legislative consideration.

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COMMENTS

California State Auditor's Comments on the Response From the Business, Transportation and Housing Agency and the Department of Managed Health Care

To provide clarity and perspective, we are commenting on the responses to our audit from the Business, Transportation and Housing Agency (agency) and the Department of Managed Health Care (department). The numbers correspond to the numbers in the agency's and department's responses.

- We address the department's statements related to assessments at pages 57 through 59, points 14 through 18.

- The department's use of more informal methods to share information with health maintenance organizations (HMOs) is laudable. Nevertheless, as discussed at page 38, the department still needs to adhere to the Knox-Keene Act's requirement that it provide written notification to HMOs within the designated timeframes. We considered notifications by letter or e-mail to be adequate written notification.

- In our report, we have recognized the department's efforts to improve its licensing operations and discuss them at pages 38 and 39.

- In our report, we have recognized the department's efforts to improve its financial examination operations and discuss them at pages 36 and 37.

- On pages 15 and 17 of our report, we acknowledged that the Legislature established the current assessment structure and that the department has simply implemented this structure. Our recommendations related to assessments, at pages 4 and 27, are addressed to the Legislature.

- Our analysis at page 27 focused on calls answered by the department's HMO Help Center staff, which averaged 915 calls per week, as we reported. We have added wording to the text to clarify this point.

- The department used the terminology "Request for Assistance" in internal reports tracking complaints it received through November 14, 2001. Nevertheless, we have changed the text box at page 10 to refer to "formal complaints," rather than "requests for assistance."

- The department is mistaken. There were nine complaints backlogged at December 31, 2001. Six of these relate to complaints tracked by the department's new database, established November 15, 2001, and three relate to complaints tracked by the department's old database.

- The complaints total cited by the department includes written complaints that the department resolved itself, complaints referred to the HMOs or other agencies for resolution, and quick resolution complaints. To provide data comparable to that which we presented in our 1999 audit report on the Department of Corporations, we only presented the number of written complaints resolved by the department in 2001. Similar to 1999, we did not include referred complaints because the department did not actually resolve them. We presented the number of quick resolution complaints in the table on Call Center performance because the Call Center handles this newly established function. Complaints both resolved by the Department of Corporations and referred to the HMOs or to other agencies totaled 2,505 in the first half of fiscal year 1998–99. Had we compared this total to a comparable figure for 2001, Table 4 on page 31 would have indicated a much smaller increase in output. We do not believe that reporting these numbers would have fairly reflected the department's achievements.

- We have deleted the words "and addresses" from the text at page 33.

- The department's figures do not match those from detailed department reports on independent medical review (IMR) cases closed in 2001. Because department staff did not raise a concern about these figures in discussions we previously held with

them, we were unaware of their concern and did not have the opportunity to clarify what their statistics represent. However, it appears that the department's total includes the 48 IMRs that were withdrawn in 2001.

- We have recognized the department's position at page 37 and disagree with it. We also note that its position appears to contradict the statement on its Internet site, which says, "Pursuant to Section 1382 of the California Health and Safety Code, the Division of Financial Oversight is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan a minimum of once every five years." Further, it is not clear to us how delaying a report in favor of more pressing financial issues is consistent with the department's reading of the statute to require an examination to begin within five years.

- The department is incorrect in dismissing our finding related to the lateness of its financial examination reports. We concentrated our analysis on the department's ability to meet the five-year cycle since that was the relevant timeframe for fiscal year 2001–02. The move to a three-year cycle does not relieve the department of the need to complete, as well as start, financial examinations. Given the fact that the department will receive resources to shorten the examination cycle, we believe it is incumbent on the department to set and adhere to a schedule for issuing financial examination reports every three years.

- It is true that we have had numerous discussions about the assessment structure with the department, which indeed reiterated that it has no position on the formula used to assess HMOs as we indicate at page 16. In these meetings, we discussed the need to change the current structure based on the criteria we discuss on page 17. We believe these criteria are not only reasonable, but practical. We also believe our criteria are preferable to the department's, which do not address the issue of an inequitable distribution of assessments. Because of the department's vigorous response to our proposed criteria, we solicited its response to numerous questions, as we indicate throughout Chapter 1. The department did not address our specific questions, but instead chose to respond with general observations.

- We agree that it is the Legislature, not the department, which will change the current assessment structure, should it conclude the change is necessary. However, we believe the department is

disingenuous when it describes its role as "merely" complying with the law. Instead, we believe it is reasonable to expect that the department will have some input on any proposed changes to the law.

- Although the department states that the Legislature should be advised of "all different" methodologies and their impacts, we believe no value is added by presenting numerous additional methods that do not meet our criteria of reflecting the proportion of workload devoted to each class of HMO, distributing the financial burden equitably among the HMOs, and being cost-effective to administer. We have, however, presented an array of methods that are quite different from one another and that yield very different results, as Table 3 at page 23 indicates, and have recommended two that satisfy our criteria. Further, in its general response to our questions, the department offered four alternatives of its own for our consideration. By the department's own description, three of these were "similar" to three that we have presented. In considering the fourth, we found that it resulted in average assessments very similar to current assessments, which we had already concluded were inequitable and therefore unsatisfactory.

- The department exaggerates the effect of a change in assessment methodology on full-service HMOs. While it is true that full-service HMOs would pay more in assessments under our preferred alternatives, the financial impact as a percent of premiums would be small. On average the percent of premiums that full-service HMOs would pay to the department would increase from 0.04 percent to 0.06 percent, as indicated in Table 3 at page 23. We are at a loss to understand why the department is concerned that changing the existing formula may impact some plans adversely, but is unable to conclude that the kind of disparities in financial impact resulting from the current assessment structure, where specialized plans pay 0.37 percent of their premiums or nine times more per premium dollar than full-service plans, is burdensome. This is one of our questions the department declined to answer directly. With regard to the effect of alternative assessments on specific HMOs, we offered to share with the department the results of alternative methodologies on individual HMOs. The department did not respond to our offer. We are, however, aware of one full-service HMO, with premiums of about $180 million, about which the department has concerns. When we calculated the increase in assessments under our preferred alternatives, even with the addition of a flat fee of $12,500, we found that this HMO would pay only $10,000 or $19,000 more.

- The department is inaccurate when it contends that we did not fully analyze the method for assigning overhead costs. In particular, the department implies that we have not considered enrollment as a basis for allocating overhead. However, the four alternative methodologies we present at Table 3 consider various ways of assigning overhead costs, including by enrollment (Alternative A), by workload (Alternative B) and by premium (Alternatives C and D). In analyzing these methods, however, we considered the financial impact of the method on each class of HMO. As we indicated in the report, the enrollment-based methods result in disparate financial impacts. This is true of the current, enrollment-based, assessment structure, as well as the fourth assessment structure the department proposed, more than half of which would be enrollment-based.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press