

DEPARTMENT OF MANAGED HEALTH CARE

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

Audit Highlights . . .

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

- The portion of assessments charged to specialized health maintenance organizations (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.*

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Department of Managed Health Care's response as of May 2003

The Joint Legislative Audit Committee requested that we review the assessment mechanism used to generate funds for the Department of Managed Health Care (department) to determine whether the assessments paid by different classes of health maintenance organizations (HMOs) reflect the level of regulatory activity related to them. It also asked us to propose alternative assessment structures, if necessary, that would more closely reflect the level of regulatory costs and ensure adequate funding to meet the department's statutory responsibilities.

Finding #1: The annual assessments paid by two classes of HMOs—specialized and full-service—are not distributed equitably.

The percentage of the total assessment that the department charges to specialized and full-service HMOs does not match the level of effort the department devotes to these two classes of HMOs. 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 addition, the financial impact of the assessment on HMOs, as represented by the percentage of their premiums that the HMOs are charged for assessments, varied widely between the different classes of HMOs. 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.

We developed four alternative assessment methodologies and found that two would both better reflect actual workload and reduce the disparity in financial impacts. Assessments under these two methods are based in whole or in part on the split in identifiable workload between specialized and full-service HMOs, and on total premiums received by individual HMOs.

We recommended 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. We also recommended that the Legislature require the department to report to it 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.

Legislative Action: Legislation passed.

In May 2003, the governor approved legislation requiring full-service HMOs to pay for a larger share of the department's costs. Effective July 1, 2003, full-service HMOs will be required to pay 65 percent of the department's costs, not covered by other fees and reimbursements. Current law has no provision requiring the department to report triennially to the Legislature on the proportion of assessments charged to or the proportion of documented workload related to each class of HMO.

Finding #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.

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 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 completed 20 routine medical surveys (surveys) and ended calendar year 2001 with only four backlogged surveys. In contrast, Corporations had an output of seven 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 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 two examinations that Corporations experienced at the end of calendar year 1998. The Division of Financial Oversight has seen a large increase in its routine workload which, combined with staff vacancies and an increase in nonroutine work, contributed to the backlog. When the department does not complete financial examinations on time, the public is not fully informed of the financial status of HMOs.

In addition, the department's Division of Licensing has often failed to promptly notify HMOs of its decision regarding the HMO's 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. According to department staff, workload issues may have been a factor contributing to late notifications. In addition, the Division of Licensing had no reliable means of tracking the status of its workload, and limitations in its manual processes made it difficult to ensure that statutory turnaround requirements were met. When the department 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.

We recommended that the department establish deadlines for the publishing of financial examination reports and closely monitor the success of its efforts to meet deadlines for these reports. In addition, we recommended that the department closely monitor the time elapsed between its receipt of requests for material modifications and the notifications it sends to HMOs, and make it a priority to send written notifications within the statutory deadline.

Department Action: Corrective action taken.

The department says it now includes target preliminary report and final report dates on its examination schedule and is making all reasonable efforts to remain compliant with statutory deadlines. It believes no examination reports are currently out of compliance with statutory deadlines. The department says that it has also taken steps to ensure that health plans are promptly notified of the status of their material modifications. Its attorneys are required to issue within the statutory 20-business-day period either (1) an order of approval, denial, or postponement or (2) a deficiency

letter, upon receipt of a written request from an HMO to extend the statutory period. The department says that through the third quarter of fiscal year 2002–03, with three exceptions, it issued orders of postponement or extensions for all material modifications it had not approved or denied within the statutory deadline.