



California Consumer Protections At Risk If Out-of-State Insurers Are Allowed In

California health care consumers have certain basic patient protections under state law that would be undermined or altogether lost under some federal proposals to allow out-of-state health insurers to sell its policies without state licensure.

California has many consumer protections because of a history of abuses by HMOs and health insurers, while other states may provide few. California is one of seventeen states--encompassing over half of the population--that have benefit mandates and consumer protection regulations that may be adversely affected.¹ This, as President Obama pointed out happened in the credit card industry,² would result in a "race to the bottom" where insurers would rush to states with the least regulation and fewest consumer protections.

Comprehensive health reform proposals supported by President Obama do allow insurers to sell across state lines, but only under explicit agreement by the impacted states, under the proposed "interstate compacts." In contrast, other Republican proposals would allow insurers licensed in any state—including ones with weak protections—to sell in California without any deference to California law. If Californians were to buy these plans, the consumer protections in California law would not apply, leaving them with little, if any, recourse. They would even need to go to a regulator in another state to make a complaint.

This factsheet outlines current consumer protections in California, to identify what is at stake for consumers if out-of-state health insurers were allowed to enter California markets without a license. Neither federal nor state policymakers should endanger these protections:

- **FISCAL SOLVENCY OF INSURERS:** Most privately-insured Californians (about two-thirds) get coverage from insurers domiciled in the state of California. Other major insurers are domiciled outside the state, but offer plans subject to current California regulations. Under these regulations, insurance companies, accountable care organizations, and medical groups that accept fiscal risk must meet certain fiscal solvency requirements. These standards came about after a wave of HMO insolvencies in the 1980's to ensure that an insurer will have enough resources and reserves (i.e., be solvent enough) to cover the health claims of their members, and that consumers can trust that their insurer will be able to pay. Since insurers are exempt from federal bankruptcy laws, strong fiscal solvency standards under California law are key. Insurers domiciled in other states may not be subject to the same basic financial management standards and be less able to cover their obligations and the needs of their members.
- **BASIC BENEFIT PROTECTIONS:** About 80 percent of Californians are in managed health care plans and are provided comprehensive protection under the Knox-Keene Health Care Service Plan Act of 1975 and subsequent legislation. The Knox-Keene Act requires all health care service plans, except specialized health care service plans, to provide coverage for "all medically necessary basic health care services", which include:
 - (1) Physician services;
 - (2) Hospital inpatient services and ambulatory care services;
 - (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services;
 - (4) Home health services;
 - (5) Preventive health services;
 - (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the "911" emergency response system; and
 - (7) Hospice care.



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In addition, California law requires insurance plans to provide coverage for (or the offer of) many specific benefits. The purpose of these mandates are to ensure that certain services are (or can be) covered so that California consumers know they have protection and certain minimum standards when they purchase a plan. According to the California Health Benefits Review Program (CHBRP), there are now 44 mandates to cover or offer coverage for specific benefits under the Knox-Keene Act, and 41 benefit mandates for products regulated by the Department of Insurance. Listed below are a sample of mandated benefits that all plans are required to provide coverage for and would not be required of plans that were sold across state lines.³ (Note: There are other benefits that plans must *offer* coverage for and benefits that only apply to some plans in the state, depending on which agency has regulatory jurisdiction.)

- *Preventive care for children*
 - Comprehensive preventive care for children under 16 years
 - Screening children for blood lead levels
- *Cancer screening and treatment*
 - Mammography and breast cancer testing and treatment
 - Cervical and prostate cancer screenings
- *Treatment of chronic conditions*
 - Diabetes management and treatment
 - HIV/AIDS testing and vaccine
 - Transplantation services for persons with HIV
 - Osteoporosis treatment
 - Phenylketonuria (PKU) treatment;
- *Mental health care and substance abuse treatment*
 - Coverage of severe mental illness
 - Mental health coverage for people with physical or mental impairments
 - Nicotine treatment in licensed chemical dependency facilities
- *Orthotics and Prosthetics*
 - Orthotic and prosthetic devices and services
 - Prosthetic devices for laryngectomy
 - Special footwear for persons suffering from foot disfigurement
- *Pain management & surgeries*
 - General anesthesia for dental procedures
 - Reconstructive surgery and jawbone surgery
- *Provider reimbursement*
 - Emergency 911 and medical transportation services
 - OB-GYNs as primary care providers
- *Reproductive services*
 - Contraceptive devices requiring a prescription
 - Maternity care (minimum length of state and amount of copayments and deductible for inpatient services)
- **RIGHT TO REVIEW AND RECOURSE:** California law has strong protections for consumers and provides opportunities for reviews and recourse from consumers so they are not left solely at the mercy of insurance companies. Securing these consumer protections and standards was hard won in California and should not be undermined by plans issued by companies in states where consumers are less protected. Specifically, virtually all plans regulated by the Department of Managed Health Care (DMHC):
 - Have standards for Utilization Reviews;
 - Must allow consumers the right to a second opinion;
 - Are required to publicly disclose the criteria for denial of care;
 - Have a “reasonable person standard” for emergency care (which is more consumer-friendly than prudent layperson standard);
 - Allow consumers to request an Independent Medical Review (both about “Medically Necessary” care and Investigational or Experimental Treatment);
 - Have outlined Grievance and Appeal Procedures (including urgent appeals),



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- Allow consumers the right to sue an HMO;
- Require continuity of care with an individual's provider if a plan/provider contract dispute results in termination of plan contract with providers; and
- Provide against protection against balance billing (i.e., providers billing both the insurer and the patient) for out-of-network emergency care.

In addition, DMHC has been successful in helping consumers resolve disputes and conflicts with their health insurers. For example, since 2000, DMHC has helped over one million Californians and established a successful 24-hour per day, 7-day per week, 365-days per year HMO helpline to accept complaints and identify problems.⁴ If insurance were to be sold across state lines, California consumers would have no recourse within the state and will be left to pursue legal recourse in another state, with unfamiliar rules, and an Insurance Department that may not help out-of-state consumers because of jurisdictional issues.

- **NETWORK ADEQUACY, LANGUAGE ACCESS, AND TIMELY ACCESS:** Health plans in California regulated by DMHC are required to meet certain standards intended to ensure that consumers will have adequate access to culturally-appropriate care in a timely fashion. Namely, plans must meet certain standards of provider network adequacy that other states do not have and that insurers based in other states may have difficulty assessing. Within those provider networks, consumers in California managed care plans are also guaranteed timely access to care (defined as urgent care within 48 hours, an appointment with a doctor within 10 days, etc.). Since about forty percent of Californians speak languages other than English at home, California passed a first-of-its-kind bill that holds health plans accountable for providing linguistically-appropriate care by requiring that communication with the insurer/HMO is done by the language spoken by the patient.⁵ Losing these protections would have a disproportionate impact on communities of color, and could potentially lead to exploitative and deceptive marketing by insurers.
- **RATING RULES:** Small group and individual health plan rates are regulated at the state level (both by the Department of Managed Health Care and the Department of Insurance). Those plans are subject to rate setting, review, and disclosure rules established by the state, which would be lost if plans were sold across state lines. In fact, a law passed in 2009 ends gender discrimination in insurance pricing,⁶ and if plans were sold across state lines they would not be subject to this law and therefore be allowed to discriminate against women in California, charging them higher rates.



This factsheet was prepared by Health Access, a statewide coalition of consumer, labor, ethnic, senior, faith, and other organizations that has been dedicated to achieving quality, affordable health care for all Californians for over 20 years. Please visit our website and read our daily blog at www.health-access.org

Health Access is leading the California campaign of Health Care for America NOW! (HCAN), a national grassroots campaign of more than 850 organizations representing 30 million people dedicated to winning quality, affordable health care we all can count on in 2009. Visit www.healthcareforamericanow.org or contact Patrick Romano at promano@health-access.org for more about the HCAN campaign

HEALTH CARE FOR AMERICA NOW!

¹ Letter to Speaker Pelosi and Majority Leader Reid from 31 Members of Congress asking them to oppose the interstate compact in federal legislation, dated December 15, 2009.

² Closing remarks of President Obama at the White House Bipartisan Health Reform Summit on February 25, 2010.

³ California Health Benefits Review Program, "Health Insurance Benefit Mandates," Current as of November 3, 2009.

⁴ The HMO Helpline is operated by the Department of Managed Health Care (1-888-466-2219; <http://www.hmohelp.ca.gov/>).

⁵ California Pan-Ethnic Health Network, "A Blueprint for Success: Bringing Language Access to Millions of Californians," (January 2009).

⁶ AB 119 (Jones) prohibits insurers from charging different premium rates based on gender was signed by the Governor on October 11, 2009 and becomes effective January 1, 2011.