HEALTH ACCESS
California's Health Consumer Advocacy Coalition

FACT SHEET

California Patient Protections at Risk:

Federal Proposals to Allow Sales Across State Lines and Federal Preemption of State Laws Would Gut Health Insurer Accountability to Consumers

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California has a long, proud tradition of providing strong consumer protections in health insurance. These protections ensure consumers get the care they need, when they need it, and without facing unfair costs. Consumers can turn to state regulators if they have problems with their health plan or insurer. California has implemented these consumer protections over the last four decades, beginning with the Knox-Keene Act of 1975. Since then, we have built on these protections in the HMO Patient Bill of Rights (1996–1999) and in our work to implement and improve upon the Affordable Care Act (2010–2014). California has also adopted numerous other consumer protections over the years, including timely access to care, provider directories, and surprise medical bills. Our consumer protections are much stronger than those found in many other states, and stronger than those provided under federal law.

Federal Proposals Would Undermine or Eviscerate State Consumer Protections

California's patient protections are at risk – not just through repeal of the ACA and its provisions holding insurers accountable, but also through federal proposals to allow insurance companies to sell across state lines or preempt state consumer protections. These efforts put at risk over four decades' worth of consumer safeguards.

States have historically regulated their own health insurance markets, and most consumer protections are found in state law. State regulators enforce state law, not federal requirements. In order to enforce federal requirements, California has imported federal consumer protections, such as the COBRA requirement and mental health parity into state law, and also improved upon federal requirements in the process. Any health insurance company can sell in California if they are licensed by state regulators.

Our state consumer protections are at risk in three ways:

1. Federal proposals to allow insurance companies to "sell across state lines" or to preempt state consumer protections would eliminate or eviscerate California's protections. Insurance companies would be able to choose to be licensed in states with little or no consumer protection and then offer seemingly low cost plans that provide few benefits, rather than comply with the patient protections that California has adopted for itself. As a result, insurance companies would be less accountable and state regulators would not be able to assist consumers in their states.
2. Specific repeal of federal consumer protections, such as those provided in the Affordable Care Act, which could in turn trigger off some state statutes.
3. Other federal proposals (for example, requiring health savings accounts, promoting high-deductible health plans and allowing balance billing) will impose mandates on states that are bad for consumers, or otherwise conflict with or preempt specific state protections that Californians enjoy today.

California Law Protects Consumers

The following is a partial list of consumer protections in California law. Some protections apply to all insurance market segments (individual, small employer, and large employer), while other protections apply to one market segment or another.

California Consumer Protections in place since 1975

The Knox-Keene Act, adopted in 1975 and enforced by the Department of Managed Health Care (DMHC), provides basic consumer protections for 95% of California consumers with state-regulated health coverage, including both Medi-Cal managed care and commercial coverage. These protections apply to all HMOs and most PPOs. All of the protections (except the last two) in this section apply to all three market segments: individual, small employer, and large purchasers. The last two bullets relate to small employer coverage.

- **Financial Solvency Requirements:** Ensures health plans and insurance companies can pay claims. If they don't pay the doctor, the hospital, the lab, or the imaging center, then the consumer is left on the hook for care they thought was covered.[1]
- **Medically Necessary Care:** Requires health plans to cover medically necessary care, including doctors, hospitals, lab services, and imaging.[2]
- **Maternity and Reproductive Services:** Requires coverage of maternity care and the full range of reproductive services provided by doctors and hospitals, including family planning and abortion.[3]
- **Adequate Networks:** Sets standards for time and distance for primary care and hospitals.[4]
- **Specialists:** Requires health plans to cover medically necessary specialty care at in-network cost sharing regardless of whether the specialist is in-network or not.[5] The first fine ever levied on a health plan was $500,000 in 1995 for lack of access to a surgeon that was an expert in pediatric kidney tumors, a pretty specialized specialist.
- **Timely Access to Care:** Requires health plans to provide medically necessary care in a timely manner.[6]
- **Guaranteed Renewal:** Ensures that every consumer, no matter how sick, is guaranteed to have their coverage renewed so long as they pay their premium on time.[7]
- **Small Business Market Rules:** Requires insurers and health plans, since the 1990s, to sell to every small business and limited the use of health status as the basis for setting premiums.[8]
- **CalCOBRA:** Extends the protections of federal COBRA to employees of smaller businesses so individuals who lose their job-based coverage may keep that coverage if they can afford to pay the premium.[9]

The HMO Patient Bill of Rights Provide More Protections and Specificity

From 1996-1999, two Governors and the Legislature adopted more consumer protections for Californians in managed care, including both HMOs and most PPOs:

- **A New Department to Regulate HMOs and Most PPOs:** In 1999, California created the Department of Managed Health Care to protect consumers in HMOs and most PPOs[10].
- **The HMO Help Center:** The new Department of Managed Health Care was required to create an HMO Help Center to quickly resolve consumer complaints and to track consumer complaints to identify and address emerging issues.[11]
- **Independent Medical Review:** Consumers have a right to appeal coverage denials, where independent doctors use medical records, their medical expertise, and scientific and medical evidence, to make a determination about whether the disputed service was medically necessary.[12] Examples of care found medically necessary include bariatric surgery (without the need to diet for a year), botox for migraines, and transgender care.[13] (Applies to DMHC and CDI.)
- **Grievances:** Health plans are required to have internal grievance procedures to resolve consumer complaints, with clear timeframes and standards for resolving them. Complaints not resolved by the next business day must be followed with a written explanation of the basis for the plan's decision. This structure created an incentive for health plans to resolve complaints promptly. Grievances include not only unpaid claims but also denials and delays of medically necessary care.[14] (Applies only to DMHC.)
- **Public Disclosure of Criteria for Denial of Care:** Before this law, health plans and insurers were not required

to disclose the criteria for denying care to the insured. Only licensed, competent medical personnel may deny or modify requests based on medical necessity.[15] (Applies only to DMHC.)

- **Utilization Review Standards:** Without this law, health plans and insurers can delay care by imposing utilization review without any standards or oversight.[16] (Applies to DMHC and CDI.)
- **Right to a Second Opinion:** Every consumer has a right to a second opinion, including one from outside their network if they already received one from an in-network doctor.[17] (Applies to DMHC and CDI.)
- **Pediatricians and Obstetrician-gynecologists as Primary Care Doctors:** Consumers have a right to see their pediatrician or ob-gyn as a primary care doctor without having to see another primary care doctor first.[18] (Applies only to DMHC.)
- **Mental Health Parity:** Requires equal coverage for mental health care. Health plans and insurers cannot limit mental health care more than physical health care. Must cover "severe mental illnesses" for adults, including depression, schizophrenia, and autism.[19] (Applies to DMHC and CDI.)
- **Contraceptive Coverage:** Requires coverage of contraceptive drugs and devices.[20] (Applies to DMHC and CDI.)

Additional California Consumer Protections Built upon the Foundation of Earlier Laws:
These protections apply to individual and employer coverage, and apply to HMOs and PPOs regulated by DMHC. Most, but not all, also apply to PPOs regulated under the Insurance Code.

- **Timely Access to Care: Measurable and Enforceable Standards for HMOs, PPOs, and Medi-Cal Managed Care:** A series of bills strengthened consumers' right to timely access to care by specifying clear, measureable, and enforceable appointment wait-time standards. As a result, consumers have a right to see a primary care doctor within 10 days, a specialist within 14 days, and to speak to a qualified health professional to determine if their condition is urgent within 30 minutes.[21] These standards apply to all state-regulated coverage—and in 2016, legislation was enacted requiring health plans and insurers to inform consumers about these rights.[22] (Applies to DMHC and CDI.)
- **Language Access: Care and Coverage in the Language You Speak:** Both Medi-Cal managed care plans and commercial plans are required to translate documents and to provide consumers with care in the language they speak, and to do so at the same time as the timely appointment.[23] (Applies to DMHC and CDI.)
- **Non-discrimination Based on Race, Color, National Origin, Ancestry, Religion, Sex, Marital Status, Sexual Orientation, or Age.** Protections for some protected classes date back to 1990.[24] (Applies to DMHC and CDI.)
- **Gender Rating Prohibited from 1990 to 2005 and Since 2009:** California law long prohibited basing premiums on gender or otherwise discriminating based on gender. (DMHC and since 2009, CDI)[25]
- **Ban on Balance Billing/Surprise Medical Bills:** In 2009, the California Supreme Court found that California consumers with HMOs and most PPOs were protected from balance billing for emergency care.[26] (Applies to DMHC only.) In 2016, Governor Brown signed AB 72 (Bonta et. al), which protects consumers who go to in-network hospitals from being billed by out-of-network doctors at those facilities for anything other than the in-network cost sharing.[27] (Applies to DMHC and CDI.)
- **Provider Directories:** California requires health plans and insurers to have provider directories that accurately list the providers in a particular network, including their contact information and whether they are accepting new patients. In 2015, audits found a majority of the listings for Anthem Blue Cross and Blue Shield, two of the largest insurers in California, were inaccurate.[28] (Applies to DMHC and CDI.)
- **Prescription Drug Formulary Standards:** California requires that all health plans and insurers publicly post their prescription drug formularies and update these regularly.[29]
- **Continuity of Care: Termination of Individual Physician or other Health Professional:** A consumer with a serious medical condition, in the midst of a course of treatment, during prenatal care, a terminal illness or with a scheduled surgery may continue to be seen by their treating physician even if that physician no longer has a contract with the insurer or if the physician agrees to accept the contract rate for that patient.[30]
- **Continuity of Care: Termination of Hospitals or Physician Groups:** If the contract between a health plan or insurer and a hospital or physician group is terminated, 75 days' notice is required, along with a plan for the transition of care. Advertising by either party must be pre-approved.[31]

The Affordable Care Act: Improving on the ACA With Even More Consumer Protections

California adopted a number of state laws during implementation of the federal Affordable Care Act. In most instances, California went beyond the bare minimum required by federal law. All of these protections apply to coverage regulated by DMHC and CDI.

- **No Denials for Pre-existing Conditions:** California adopted strict rules preventing health plans and insurers from denying coverage to individual consumers based on pre-existing health conditions. Before the ACA, health plans and insurers could deny consumers coverage if they had major conditions like cancer, MS, or because they had a heart attack, as well as if they had minor conditions like acne, ear infections, or any other condition at the insurer's discretion.[32]
- **Guaranteed Issue:** Requires health plans and insurers to enroll consumers regardless of health status, age, gender, or other factors that might predict the use of health services.[33]
- **Premiums Based on Age and Region, Not on Health Status for Individual Consumers and Small Businesses:** Pre-ACA, health plans and insurers based premiums for individual consumers on their health status as well as age and geographic region.[34] Age bands of 3:1, meant someone who is 64 years-old pays a premium 3 times as high as someone who is 19 years-old.[35] Pre-ACA the age bands were decided by each insurer and were not publicly known.
- **Tobacco Rating Not Permitted in California for Individual Coverage or Small Employer Coverage**. The Affordable Care Act allows just 4 factors to increase premiums: 1) Age, 2) family size, 3) location; and 4) tobacco use. California chose **not** to allow rating based on tobacco use because doing so would make health insurance unaffordable for many, especially those with lower incomes.
- **Transparent, Publicly Knowable Premiums for Individual Consumers:** Pre-ACA, premiums were confidential because they were based on protected health information for each consumer and non-standardized company rules decided by each insurer.[36] Now, anyone can look premiums up online for coverage in the individual market and do apples-to-apples comparisons when shopping for a health plan.[37]
- **Annual Rate Increases for Individual Consumers and Small Businesses:** Pre-ACA, insurers could increase the cost of premiums every 30 days. Now, rates including both premiums and cost sharing, can only be changed annually.[38]
- **Essential Health Benefits: Individual and Small Employer Coverage**
    - **Improving on the ACA: Medically Necessary Care, No Substitution of Benefits:** California law requires individual and small employer coverage to cover medically necessary care and does not allow substitution of benefits as allowed under federal regulation.[39]
    - **Elimination of Skeleton Benefits that Covered Only Hospitals and Nothing Else:** Pre-ACA, health insurance sold to individuals covered only hospitals, and not doctors, labs, imaging, or prescription drugs. HMOs and PPOs regulated by Knox-Keene were required to cover medically necessary doctors and hospitals but health insurance regulated under the Insurance Code did not.[40]
    - **Maternity Care:** Pre-ACA, 80% of California consumers in the individual market did not have coverage for maternity care. Maternity care became a mandated benefit in the individual and small employer markets on July 1, 2012.[41]
    - **Prescription Drugs:** Pre-ACA, most employer coverage included prescription drug coverage but coverage purchased by individual consumers did not, or covered only a few generic drugs. Essential health benefits include prescription drugs and California law improved on that by requiring coverage of all medically necessary drugs, whether on the formulary or not.
- **Preventive Services:** A key provision of the ACA is the requirement that private insurance plans cover recommended preventive services without any patient cost-sharing. Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated and debilitating conditions.[42]
- **Elimination of Annual and Lifetime Limits for Individual Consumers and Employers Both Large and Small:** Pre-ACA, health insurers were allowed to set annual limits of $75,000 or $100,000 or in a lifetime ($1 million or less). This appears to be a lot of coverage, but in reality, is wholly insufficient for people who face serious

conditions such as cancer or hemophilia.[43]

- **Elimination of "Mini-med" Coverage:** Pre-ACA, health insurance could cover as little as $2,000 or $5,000 a year, not enough to cover an emergency room visit, and still be sold as "health insurance" to individuals or employers.
- **Maximum Out-of-pocket for Individual Consumers and Employers Both Large and Small:** Pre-ACA, health insurance had no limit on what the consumer owed so if you had co-insurance of 10% or 20%, you could still end up owing hundreds of thousands of dollars to doctors and hospitals. California law limits a consumer's maximum out-of-pocket to $7,000 per individual per year, better than federal law.[44]
- **$250 Cap on Prescription Drug Copays:** California caps prescription drug copays at $250 per month or per prescription for most coverage and $500 for high deductible health coverage.[45]
- **Rate Review for Individual Coverage and Small Business Coverage, Rate Reports for Large Employers:** Each year, the proposed premiums and cost sharing for individual consumers and small businesses are reviewed by state regulators to see if they are reasonable and justifiable. Since 2011, California consumers have saved hundreds of millions of dollars just from this public scrutiny of rates.[46] Starting in 2016, health plans have also reported on cost drivers and premiums for large employers.[47]
- **Guaranteed Issue for Kids:** California did early implementation of guaranteed issue for kids.[48]

Covered California Actively Negotiating on Behalf of Consumers

Covered California was the first state exchange created in the country, and the legislation was signed by Republican Governor Arnold Schwarzenegger. It negotiates on behalf of individual consumers, including both the 1.4 million Californians who obtain coverage from Covered California and the 1 million plus additional consumers in the individual insurance market outside Covered California. Over 2.5 million Californians have obtained coverage from Covered California since 2014: most have renewed their coverage while the overwhelming majority of those who left Covered California have gone on to job-based coverage or public programs.[49]

Covered California is also engaged with Medi-Cal, California's Medicaid program, and other large purchasers to drive an agenda on cost, quality, and health disparities.

- **Active Purchaser:** Covered California negotiates with health plans and insurers on behalf of consumers. Using this negotiating power, Covered California has reduced rate increases to half the level of the pre-ACA market and has kept rate increases lower than other exchanges without negotiating power.[50]
- **Standardized Benefit Designs: Apples-to-Apples Comparison to Foster Competition on Cost and Quality, Not Consumer Confusion:** Health insurance is one of the most confusing purchases individual consumers are expected to make. Standard benefit designs adopted by Covered California means that a consumer choosing a silver plan can make apples-to-apples comparison because copays, deductible, and benefits are the same whether she picks Anthem Blue Cross, Kaiser Permanente, HealthNet, or Blue Shield. Standard benefit design forces insurers to compete on premium and quality of care, not whether a $7 copay with a $4,000 deductible is better than a $30 copay with a $2,000 deductible and benefit exclusions.[51]
- **Cost, Quality, and Disparities:** Covered California is using its purchasing power and negotiating authority to require health plans to improve quality and reduce health care costs by reducing hospital infections, measuring improvements in diabetes management and asthma control, and encouraging tobacco cessation, among other measures. Covered California is also requiring health plans to demonstrate year-over-year reductions in disparities by race and ethnicity in the treatment of asthma, diabetes, depression, and high blood pressure.[52] Covered California is working in collaboration with Medi-Cal, CalPERS, and other large purchasers on these efforts. No individual consumer would have the ability to negotiate such improvements.
- **Outreach:** Covered California has worked with insurance agents, navigators, and community organizations to reach out to millions of Californians and tell them about their opportunities for coverage under the Affordable Care Act.[53] This vigorous outreach translated into employees accepting job-based coverage at higher rates and over 90% of those eligible for Medi-Cal without other coverage having signed up for Medi-Cal.[54] Without these efforts, individual consumers were not aware of their choices.

- **Subsidies Eligibility Determination, Referral to Medi-Cal:** Covered California has provided eligibility determinations for millions of Californians. People that seek Covered California coverage, but are actually eligible for Medi-Cal, are referred to the Medi-Cal program. Since its creation, Covered California has helped over 2.5 million Californians obtain coverage through Medi-Cal.[55]

Covered California's ability to negotiate on behalf of individual consumers derives from its role as the sole source of subsidies for advanced premium tax credits and cost sharing reduction subsidies. If these subsidies are eliminated, Covered California's ability to negotiate on behalf of consumers would be dramatically reduced or eliminated.

In Summary: California Consumer Protections At Risk From Congressional Proposals

California has had strong consumer protections on the books for four decades. These protections applied to most consumers who got their coverage through their employers. Individual consumers purchasing coverage as individuals had few protections in the "Wild, Wild, West" of health insurance and were at the mercy of the insurance industry, particularly those who purchased insurance regulated under the Insurance Code. Over the years, California has realized both the benefits of these consumer protections and the pitfalls of not having these safeguards. California's regulation of health plans and insurers has been rooted in a firm commitment to consumer protection and fair competition amongst insurers. Congress should not advance any proposal that undermines the protections and progress made for California consumers.

About Health Access California

Health Access California is the statewide health care consumer advocacy coalition, advocating for the goal of quality, affordable health care for all Californians. We represent consumers in the legislature, at administrative and regulatory agencies, in the media, and at public forums. For more information, please visit www.health-access.org.

Endnotes

[1] Health and Safety Code §1347.15
[2] Health and Safety Code §1342(g), §1367(d)(e) and (i), and §1345 (b)
[3] Health and Safety Code §1345(b)
[4] Health and Safety Code §1342(g) and §1367(d)(e)
[5] Ibid.
[6] Health and Safety Code §1342 and §1367.03
[7] Health and Safety Code §1365
[8] Health and Safety Code §1357; Small Employer Group Access to Contracts for Health Care Services
[9] Health and Safety Code §1366.20-1366.29; Insurance Code Article 1.7 commencing with §10128.50
[10] Health and Safety Code §1341
[11] Health and Safety Code §1368.02
[12] Health and Safety Code §1374.30
[13] California Health Care Foundation, Kelch Associates, Ten Years of California's Independent Medical Review Process: A Look Back and Prospects for Change, January 2002.
[14] Health and Safety Code §1368
[15] Health and Safety Code §1367.01
[16] Health and Safety Code §1363.5 and Insurance Code §10123.135
[17] Health and Safety Code §1383.15 and Insurance Code §10123.68
[18] Health and Safety Code §1351(e)
[19] Health and Safety Code §1374.72 and Insurance Code §10144.5
[20] Health and Safety Code §1367.25 and Insurance Code §10123.196
[21] Health and Safety Code §1367.03 and §1367.035; and Insurance Code §10133.5
[22] Health and Safety Code §1367.031 and Insurance Code §10133.53
[23] Health and Safety Code §1367.04, §1367.041, and §1367.07; and Insurance Code §10133.8 and §10133.9
[24] Health and Safety Code §1365.5 and Insurance Code §10140.2
[25] Ibid.
[26] *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, No. S142209 (Cal. 2009).
[27] Health and Safety Code Commencing with §1371.9(a) and Insurance Code §10112.8(a)
[28] Health and Safety Code §1367.27 and Insurance Code §10133.15
[29] Health and Safety Code §1367.205 and Insurance Code §10123.192
[30] Health and Safety Code §1373.96
[31] Health and Safety Code §1373.65 and §1373.95 and insurance Code §10133.56
[32] Health and Safety Code §1399.849(g) and Insurance Code §10965.3(g)
[33] Health and Safety Code §1399.849(a) and Insurance Code §10965.3(a)
[34] Health and Safety Code §1399.855 and Insurance Code §10965.9
[35] Ibid.
[36] Health and Safety Code §1389.25(c)
[37] See CoveredCA.Com under Shop and Compare for the current premiums.
[38] For premiums, Health and Safety Code §1399.845(g) and Insurance Code §10965(g): For cost sharing, Health and Safety Code §1374.225 and Insurance Code §10199.49
[39] Health and Safety Code §1367.005 and Insurance Code §10112.27
[40] Health and Safety Code §1367.005 and Insurance Code §10112.27
[41] Insurance Code §10123.865 and §10123.866
[42] Health and Safety Code §1367.002
[43] Health and Safety Code §1367.001 and Insurance Code §10112.1
[44] Health and Safety Code §1367.006 and Insurance Code §10112.28
[45] Health and Safety Code §1342.71 and Insurance Code §10123.193
[46] Health and Safety Code Commencing with §1385.01 and Insurance Code Commencing with §10181
[47] Ibid, especially Health and Safety Code §1385.045 and Insurance Code §10181.045
[48] Health and Safety Code Commencing with §1399.829 and Insurance Code Commencing with §10954
[49] Covered, California, Health Insurance Companies and Plan Rates for 2017, Updated September 2016.
[50] Government Code §100504(c)
[51] Covered California, Press Release, No Gimmicks, No Surprises: Standard Benefit Designs, February 13, 2013.
[52] Covered California, Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy (Board approved on April 6, 2016); Attachment 14 to Covered California Qualified Health Plan Contract, July 2013.
[53] Covered California, Marketing, Outreach, and Enrollment Assistance Advisory Group.
[54] UC Berkeley Labor Center, Taking Stock: California's Insurance Take-Up Under the Affordable Care Act, October 2016.
[55] Covered California, Assisting Medi-Cal Eligible Consumers FAQ Certified Enrollers.