

# California State Auditor

B U R E A U O F S T A T E A U D I T S

## Department of Corporations' Regulation of Health Care Plans:

*Despite Recent Budget Increases, Improvements  
in Consumer Protection Are Limited*



April 1999  
97118.2

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# CALIFORNIA STATE AUDITOR

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April 5, 1999

97118.2

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 whether recent budget increases for the Department of Corporations (department) led to improvements in the protection of consumers of health care service plans (health plans). This report concludes that despite a budget increase totaling \$6.5 million, improvements have been limited. For example, although results of the department's enforcement and complaint resolution functions show some recent improvement, results of other functions do not. Specifically, consumer protection was less than expected because the department had not completed by December 1998 nearly half of all required medical surveys. Similarly, consumer protection was less than expected because the department had a modest backlog of one type of financial examination. Further, as of March 5, 1999, more than 200 complaints from consumers were still open even though the department had exceeded the statutorily required 60 days to resolve complaints. We believe that the primary cause of these weaknesses is inadequate management.

We also determined that, during fiscal years 1996-97 and 1997-98, the department did not spend substantial portions of its budget allotted for health plan regulation. Since the largest single source of revenue for such regulation is assessments collected from health plans, large balances at year end result in health plans paying more fees than necessary for the costs of the regulation actually provided by the department.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Kurt Sjoberg".

KURT R. SJOBERG  
State Auditor

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# SUMMARY

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## Audit Highlights . . .

*Our review of the Department of Corporations' (department) implementation of a fiscal year 1997-98 budget increase revealed that:*

- The department's Health Plan Division (division) has not met intended staffing and performance levels.*
  - A lack of leadership is at the core of the division's shortcomings.*
  - Poor department estimates of revenues and expenses led to health plans paying more than necessary for the cost of their regulation.*
- 

## RESULTS IN BRIEF

Despite receiving a \$6.5 million budget increase in August 1997 to enhance its regulation of health care service plans (health plans), the Department of Corporations (department) has shown only limited improvements in its efforts to protect health plan enrollees from inadequate medical care. Our audit revealed that, during fiscal year 1997-98 and the first half of fiscal year 1998-99, the department failed to produce appropriate reports and to resolve promptly enrollee complaints against their health plans. Furthermore, evidence from our review suggests that the lack of competent leadership during these periods contributed significantly to the poor performance in the department's Health Plan Division (division), which is largely responsible for ensuring that health plans comply with the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). This Act includes laws designed to ensure the provision of adequate health care by financially sound health plans. Further, our audit disclosed that the department's Health Plan Program (program) did not spend millions of dollars in its budgets for fiscal years 1996-97 and 1997-98 partly because the program did not meet intended staffing and performance levels. Because health plan fees comprise a substantial part of the revenues the department collects to cover the costs of regulating health plans, these budget surpluses indicate that health plans paid more fees than necessary for their regulation.

During the period we reviewed, the department's complaint and enforcement functions have shown improved performance in their work to protect health plan enrollees. However, during fiscal year 1997-98 and the first half of 1998-99, the medical survey and financial examination functions continue to have backlogs in the reports they publish covering the department's reviews of health plans. The medical survey function protects consumers from inadequate health care resulting from health plan violations of the Knox-Keene Act. Through the financial examination function, consumers avoid disruptions in health care caused by financially troubled health plans. Weaknesses we identified include the division's failure to complete by the mandated deadline nearly half of all required medical surveys.

Also, at the time we conducted the audit, the division had a modest backlog of six follow-up financial examinations it had not yet conducted. Further, as of March 5, 1999, more than 200 complaints from enrollees were still open even though the department had exceeded the statutory 60-day deadline for resolving such complaints.

Various conditions at the department illustrate that a shortage of adequate leadership is at the core of the division's shortcomings. These conditions include the lack of a position to manage one major function, a vacant managerial position for another function, the division's inconsistent reviews of existing policies and procedures for all major functions to evaluate whether changes would improve effectiveness, high vacancy rates for some positions, poor workload estimates, and such other factors as weak administrative controls. Without the necessary focus, direction, and vision provided by qualified leadership, the department cannot ensure that health plan enrollees receive the level of protection expected by law.

Not only is the department failing to fully protect health plan enrollees, but health plans have paid more for the cost of their regulation than the department actually spent. Specifically, we observed that the program had not spent large portions of its budget by the end of fiscal years 1996-97 and 1997-98, and this fact had repercussions for health plans. The program includes the division and positions in the department's other divisions whose work relates directly to health plans. For these two fiscal years, the program's ending balances exceeded desired levels by \$2.6 million and \$5.9 million, respectively. Because the department's primary source of revenue for health plan regulation is the fees it charges health plans, year-end balances higher than desired indicate that health plans have paid more than necessary for the costs of the program's operations. According to the department, its year-end balances were too high for several reasons, including an underestimation of revenues and an overestimation of expenditures for the program.

## RECOMMENDATIONS

During our audit of the department's performance since it received its budget increase, we encountered issues leading us to conclusions similar to those we reported in an earlier audit during which we compared the department's responsibilities with those of other state entities to determine whether one or

more of the other entities could administer and enforce the Knox-Keene Act. Therefore, it seems appropriate to reiterate for legislative consideration the following recommendation that appears in our 1998 report: The Legislature should move the division's responsibilities for regulating health plans from the Business, Transportation and Housing Agency and the Department of Corporations. If the Legislature determines that no appropriate agency or department currently exists within the State's organizational structure, the Legislature should create a new agency or department in which to place these responsibilities.

In addition to repeating this recommendation, we recommend that the State's new governor help correct the concerns we identify in this report. Specifically, the administration should promptly appoint to leadership positions within the department qualified individuals who will provide the necessary direction, focus, and vision to the staff responsible for regulating health plans. We also recommend that the team of experts assembled at the direction of the governor consider our findings and recommendations when preparing its options "for more effective regulation of the managed care industry."

Further, the department should take the following steps to ensure that health plan enrollees receive adequate care:

- Fill the vacant leadership position within the medical survey function as soon as the department can find a qualified individual. The department should also promptly create and fill a leadership position for the financial examination function.
- Examine in depth and revise as necessary the policies and procedures used by staff of the medical survey and financial examination functions.
- Reassess and revise as necessary the department's workload estimates for the medical survey, financial examination, and complaint resolution functions and adjust its budget accordingly. Also, the department should promptly fill those positions necessary for providing consumer protection.

- Establish sound administrative controls, including the development and implementation of adequate workload tracking systems, to ensure the department's compliance with applicable laws concerning the issuing of reports for routine medical surveys.

Finally, to ensure that health plans do not pay more than necessary for the department's costs to regulate the plans, the department should develop and use more accurate estimates of its resources and expenditures.

### AGENCY COMMENTS

The Business, Transportation and Housing Agency (agency) agrees that operational problems exist within the department's Health Plan Division. The agency states that the backlogs for the medical survey and complaint functions are unacceptable and that it has instructed the department to aggressively manage the workload and to redirect resources to eliminate the backlogs. The agency has also directed the department to make filling the critical positions a top priority. ■

# INTRODUCTION

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## BACKGROUND

**A**s an entity within the State’s Business, Transportation and Housing Agency, the Department of Corporations (department), led by its commissioner, regulates three unique types of businesses in California: securities and franchise investments, financial lenders, and health care service plans (health plans), sometimes called *health maintenance organizations* or *HMOs*. In addition to fulfilling other responsibilities, the department licenses health plans to operate in California and enforces laws and regulations applicable to those plans. Further, to help protect consumers, the department’s Health Plan Division (division) conducts medical surveys and financial examinations of health plans and also receives and resolves consumer complaints, as directed by the State’s Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

The division’s mission is to “assure the accessibility and availability of medically necessary health care, delivered with appropriate quality-of-care oversight, to Californians through financially sound managed care systems.” The division regulates more than 115 health plans throughout the State, including “full-service” plans such as health maintenance organizations and “specialized” plans that deliver dental, vision, mental health, or chiropractic services. Division information shows that the number of Californians enrolled in full-service health plans licensed by the division was 24.8 million as of June 30, 1998, while enrollment in specialized health plans totaled 34.6 million.<sup>1</sup> For fiscal year 1998-99, the division estimated its expenditures to be \$10.4 million. The division has 135 budgeted positions, and it maintains offices in Sacramento, San Francisco, and Los Angeles.

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<sup>1</sup> Readers should note that individuals can concurrently enroll in more than one type of health plan. For example, one person could simultaneously enroll in five separate health plans: full-service, dental, vision, mental health, and chiropractic. Therefore, the enrollment amounts listed here do not indicate how many Californians are enrolled in health plans.

## The Department Has Consumer Protection Responsibilities

The Knox-Keene Act requires the department to perform various activities to ensure that health plan enrollees have adequate protection from health plans' violations of the Knox-Keene Act. For instance, to assess a health plan's performance in providing health care benefits and meeting the health needs of enrollees, the Act requires the department to conduct on-site evaluations, or *medical surveys*, of all health plans no less frequently than once every three years. Depending on the type of medical survey required and on whether a health plan is full-service or

specialized, division staff or contractors perform these evaluations. The culmination of a medical survey is the division's release of a final, public report describing the survey's results. If the division identifies weaknesses during a routine medical survey, the division's report will discuss those deficiencies and any actions the health plan has taken or plans to take to correct the problems.

To ensure that enrollees are protected from health plans that are financially unsound, the Knox-Keene Act requires the department to review every health plan's financial status no less frequently than once every five years. These reviews, performed by division staff, are called *financial examinations*. A financial examination ends with the division's issuing a final, public report describing the results found. If the division identifies weaknesses during a routine financial examination, the division's report will describe those deficiencies and any efforts the health plan has made or plans to make to correct the weaknesses.

### Types of Medical Surveys

**Routine**—These periodic, scheduled reviews assess a health plan's quality assurance procedures, its enrollees' access to health care services, and its provision of continuity of care (for example, referrals of patients to specialists).

**Follow-up**—These surveys evaluate a health plan'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 after the department's release of the public report.

**Nonroutine**—The division conducts these surveys when it has information indicating that a health plan has committed an egregious violation of the Knox-Keene Act. The division can immediately pursue alleged violations; it does not have to wait until it starts the next scheduled routine or follow-up medical survey.

Yet another consumer protection function the division administers is responding to enrollee complaints about their health plans. Specifically, the division's Consumer Services Unit operates a toll-free telephone hotline to receive complaints from health plan enrollees. Based on its review of issues raised in a complaint and any relevant information, the division will decide whether a health plan has violated the law. If it determines that a health plan has violated the law, the division can refer the plan 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 all affected parties typically within 60 days of receipt of the complaint. When the department's commissioner believes that additional time is necessary to fully and fairly evaluate the complaint, the commissioner can authorize an extension of the 60-day deadline.

#### Types of Financial Examinations

**Routine**—These periodic examinations evaluate a health plan's financial reports, accounting records, and controls related to the health plan's various activities.

**Follow-up**—These reviews assess a health plan's efforts to correct deficiencies identified in the public report for the routine financial examination. The division's goal is to follow up on uncorrected deficiencies within 12 months after the department releases the public report.

**Nonroutine**—The division conducts these examinations when it identifies problems at health plans during the course of its staff's other work or when other state agencies refer possible issues to the division. The division can promptly pursue the allegations without having to wait until it starts scheduled routine or follow-up financial examinations.

Although responsible for regulating health plans under the provisions of the Knox-Keene Act, the Health Plan Division does not enforce the Act. Rather, primary responsibility for enforcing the Knox-Keene Act rests with the department's Health Plan Enforcement Division. This division, created in August 1998, investigates possible violations of law and brings civil and other types of legal actions against health plans. Before August 1998, the department's Enforcement Division enforced not only the laws associated with regulation of health plans but also laws related to regulation of securities and franchise investments and of financial lenders.

#### The Department Received a Substantial Budget Increase During Fiscal Year 1997-98

Effective in fiscal year 1997-98, the department's \$6.5 million budget increase would, the department claimed, allow it to "meet statutory and/or internal performance standards . . . meet anticipated increases in workload . . . and enhance enforcement oversight of health care service plans." The increase authorized the department to add to its existing staff 94 new positions, including 63 positions, at an estimated cost of \$3.7 million, for accomplishing work directly associated with the division. The \$2.8 million balance of the budget increase was to fund 31 support, administrative, and policy positions, and to pay for other costs unrelated to personnel. In essence, the budget increase expanded by more than 70 percent the size of the department's staff devoted to health plan regulation.

## SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee directed the Bureau of State Audits to review the department's administration and enforcement of the Knox-Keene Act. In partial response to this request, we issued in May 1998 an audit report, number 97118.1, titled *Department of Corporations: To Optimize Health Plan Regulation, This Function Should Be Moved to the Health and Welfare Agency*. As part of that audit, we reviewed and compared the responsibilities of the department with those of other entities to determine whether one or more of the other entities could administer and enforce the Knox-Keene Act. For our current audit, we were to determine whether the department improved its protection of health plan enrollees after it received the \$6.5 million budget increase starting in fiscal year 1997-98.

To identify departmental responsibilities most directly related to the protection of health plan enrollees, we interviewed division staff and reviewed information concerning the five principal functions associated with the department's health plan regulation: medical surveys, financial examinations, enforcement, complaint resolution, and health plan licensing. We then eliminated the licensing function from further review because it is less directly associated with consumer protection than are the remaining four functions. For each of these four functions, we then identified related performance indicators that we believe gauge changes in the department's protection of health plan enrollees. Generally, the performance indicators we used measured work completed, such as the number of reports issued or the number of complaints resolved, both before and after the budget increase.

To determine the extent to which factors other than the budget increase may have affected the amount of work the department completed, we also reviewed changes over time for information related to departmental resources, including budgets, expenditures, and staff size; workload requests, such as the number of complaints received by the division and the number of enforcement action referrals made to the division responsible for enforcing the Knox-Keene Act; and measures of existing workload size, such as the number of open complaints and the number of active enforcement cases, including any work backlogs.

To assess whether changes had occurred that would indicate increases in consumer protection, we compared the amount of work completed that applied to fiscal year 1996-97 to the amount that related to fiscal year 1997-98. To determine whether improvement occurred more recently than June 30, 1998, we also reviewed similar information that applied to the period from July 1, 1998, through December 31, 1998. ■

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# CHAPTER 1

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## *The Department Needs to Improve Protection of Health Plan Enrollees*

### CHAPTER SUMMARY

**D**espite receiving a substantial budget increase in August 1997, the Health Plan Division (division) within the Department of Corporations (department) achieved by the end of fiscal year 1997-98 only limited success in its efforts to improve its protection of enrollees in health care service plans (health plans). For example, although efforts by the division's complaint resolution and enforcement functions show some recent improvement, the backlog of reports that the division's medical survey function needs to complete is still too large. Specifically, the division did not issue medical survey reports for 40 (48 percent) of the 84 medical surveys required by December 1998. As a result, the department did not significantly improve the protection of health plan enrollees from threats of inadequate care provided by health plans that violate the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Other problematic conditions we observed at the division include backlogs in its issuing one type of financial examination report and its inability to resolve within the time specified by the Knox-Keene Act enrollee complaints against their health plans.

Our evidence suggests that inadequate leadership has caused the division's failure to show marked improvement in consumer protection. This shortcoming is apparent in the division's lack of a position to manage one function, a vacant managerial position for another function, the division's inconsistent reviews of existing procedures for the major functions to see if changes could improve effectiveness, high vacancy rates for some division positions, insufficient administrative controls, and poor workload estimates. Only qualified leadership can supply the focus, direction, and vision that the department needs to ensure that health plan enrollees receive the level of protection expected by law.

## IMPLEMENTATION OF A LARGE BUDGET INCREASE HAS PRODUCED ONLY LIMITED RESULTS

Although the department received a \$6.5 million budget increase during fiscal year 1997-98 to improve its regulation of health plans, the department's work in this area does not yet show significant progress. Because only limited improvements in consumer protection have occurred, health plans may not correct deficiencies that could result in the provision of inadequate care to enrollees. The department intended that nearly three-fourths of the budget increase would fund the salaries and benefits for 94 additional staff positions. The department believed that adding these positions would enhance several of the division's functions, including its conducting of medical surveys, financial examinations, and complaint resolution, and also the department's enforcement efforts. However, our comparison of the division's performance after the budget increase with its performance before the increase shows that the division improved consumer protection only in limited ways. For example, the division continued to have backlogs of some types of medical survey reports and financial examination reports, and it still had not resolved some complaints within the time frame mandated by law.

### Delays in Completing Medical Surveys Weaken the Protection of Health Plan Enrollees

Although the division increased the number of reports issued for its routine and follow-up medical surveys after the budget increase, our review of the medical survey function indicates that health plan enrollees still do not receive sufficient protection from health plan weaknesses. For example, because it has not eliminated a backlog of routine medical surveys for 40 health plans, the division has inappropriately increased the risk that the health plans that are the subjects of these surveys will have uncorrected deficiencies that violate laws and regulations. Thus, enrollees in these health plans may not receive the level of health care to which they are entitled.

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*The division has not eliminated a 40-health-plan backlog of routine medical surveys.*

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To ensure that health plans give adequate medical care to their enrollees, the division conducts periodic medical surveys of these plans that identify such deficiencies as using unreliable systems for tracking the provision of health care services. This type of deficiency can result in inadequate follow-up on medical groups that have denied services inappropriately. When the division fails to conduct these surveys promptly, delays in identi-

fyng, reporting, and following up on improper conditions at health plans will occur. Such delays will, in turn, lead to delays in the health plan’s correction of the deficiencies. Further, when deficiencies that the division has already identified remain uncorrected for long periods of time, the risk of inadequate health care increases unnecessarily.

To help ensure consumer protection through the division’s completion of medical surveys, the division’s proposal for the budget increase requested 12 additional positions. We estimate the costs associated with hiring the 11 new analyst positions and the 1 new attorney, or counsel, position to be \$746,100. Division analysts perform medical surveys for specialized health plans and prepare the draft medical survey reports. Attorneys for the division review the draft medical survey reports for all health plans before the department releases the reports. Table 1 shows the performance measures related to reports issued by the division for medical surveys in the year before the budget increase and in two periods following the increase.

**TABLE 1**

**The Health Plan Division’s Performance Results for Completing Medical Surveys of Health Plans Before and After the Budget Increase**

Performance Measure	Fiscal Year 1996-97	Fiscal Year 1997-98*	July Through December 1998
Number of routine medical survey reports issued	13	23	7
Number of follow-up medical survey reports issued	0	2	8
Number of nonroutine medical survey reports issued	0	0	0

\* The department received the budget increase in this fiscal year.

As Table 1 indicates, in the year it received the budget increase, the division nearly doubled the number of routine medical survey reports, and it raised the number of reports for follow-up medical surveys issued from none to two. This table also shows that, from July through December 1998, the division issued several more

reports for routine medical surveys and follow-up medical surveys. The increase in the number of reports issued initially suggests that the division increased its oversight activities for two of the three performance measures displayed.

However, as of December 1998, the division did not consistently comply with the statutory requirement to conduct medical surveys of all licensed health plans no less frequently than once every three years. Specifically, the division did not issue reports of routine medical surveys for 40 (48 percent) of the 84 health plans that it should have surveyed from January 1996 through December 1998. For these 40 health plans, the mean length of time since the last medical survey report, or since the date of licensure for those that had never been surveyed, was 4.4 years; the range was 3 years to 8.1 years.

#### The Division Rarely Issues Public Reports Promptly

Besides failing to issue reports for all required routine medical surveys, the division did not comply with a provision of the Knox-Keene Act requiring the issuing of a public report within 180 days of completing a survey. Specifically, of the 45 reports released from January 1996 through December 1998, the division issued 44 late. On average, the division released these 44 reports more than six months late. The number of days that the division was late in issuing the reports ranged from 25 to 435, and the average was 197 days.

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*All but one of the 45 reports issued over a three-year period were more than six months late.*

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When the division does not issue medical survey reports promptly, consumer protection does not reach the level the Knox-Keene Act's authors envisioned or expected. We believe the intent behind this deadline is to ensure that the division provides consumers with timely information necessary for decision making. For example, if a consumer reads a report about a routine medical survey and discovers that a health plan has a large number of deficiencies, the consumer may decide not to enroll in that health plan. Further, if health plans delay correction of identified deficiencies because the division inappropriately delays releasing the final survey reports, enrollees may receive inadequate health care unnecessarily.

Delays in issuing reports also mean that consumer protection is not at the level envisioned by the division's proposal for the budget increase. As we mentioned earlier, the proposal states that the division needed the increase partly to help it meet

statutory deadlines pertaining to medical surveys. Specifically, the division indicated that it needed an additional \$746,100 and 12 positions, in part, to improve its medical survey function. By approving this budget increase based on the division's proposal, the Legislature agreed that the additional funding was necessary for the division to achieve compliance with provisions of the Knox-Keene Act. Therefore, the division created an expectation that it would be able to comply with the Act once it received the funds.

Another provision of the Knox-Keene Act allows an extension to the 180-day deadline if the department's commissioner believes that additional time is necessary to report fully and fairly the results of a medical survey. According to the supervising counsel of the division's licensing and compliance unit, the former commissioner provided "blanket approval" for the division to exceed the 180-day deadline because the division had a large backlog of surveys on which it needed to report. However, we believe that the former commissioner's blanket approval was an inappropriate use of the Act's allowance and did not comply with the spirit of the law. We hold that the commissioner should only approve an extension beyond the 180 days for a specific survey report on an individual health plan when an extraordinary situation exists; the commissioner should not grant extensions when the division simply has problems keeping up with its work.

*The division missed several milestones when preparing its medical survey reports.*

Other provisions of the Knox-Keene Act establish deadlines related to the division's completion of medical survey reports. For instance, the Act requires the department to issue for comment a draft version of the report to the health plan that is the subject of the medical survey at least 90 days before the department issues the final, public version of the report. The Act also requires the department to allow the health plan 45 days to comment on the draft version. Therefore, the division could comply with both these provisions as well as the 180-day requirement stated in the Knox-Keene Act if it adhered to a schedule that includes the following milestones: issuing a preliminary report to the health plan no later than 90 days after the completion of the division's survey, allowing the health plan 45 days to comment on the preliminary report, and then releasing the final, public report within the next 45 days. Further, if the division issues the preliminary version before the 90-day milestone, the division can use the time it saves to meet later milestones.

Our comparison of the division's performance against these milestones showed that the division rarely releases reports on schedule. For instance, of the 45 reports it issued from January 1996 through December 1998, the division delivered after the 90-day milestone 41 preliminary versions to the health plans that were the subjects of the reports. On average, delivery of these 41 draft reports exceeded the 90-day milestone by 114 days, with the number of days ranging from 22 to 213. Further, after the division received comments on the draft versions from the health plans, it typically failed to release the final reports within the expected time, which is normally 45 days. Specifically, for 38 of the 45 reports the division released from January 1996 through December 1998, the division did not meet by an average of 92 days the milestone for releasing a final, public report. The number of days beyond the milestone for these reports ranged from 9 to 273.

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*Follow-up surveys to review deficiencies cited in medical survey reports were also late.*

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Finally, for uncorrected deficiencies at health plans, the division had delays in completing follow-up surveys within 18 months of its release of the corresponding medical survey reports. Thus, the division did not comply with another provision of the Knox-Keene Act. For example, reports for routine medical surveys that we reviewed identified deficiencies requiring the division to complete follow-up surveys by December 1998. The division completed only 3 of the 15 follow-up surveys within the 18-month time limit, and follow-up surveys for the remaining 12 reports were late by as much as 14 months.

### **The Division's Financial Examinations Do Not Fully Protect Health Plan Enrollees**

Problems we identified with the division's financial examination function were less severe than the problems we observed with the medical survey function. Consumer protection through the division's issuing of reports for routine financial examinations of health plans was nearly optimal for the periods we reviewed. Nonetheless, the report backlog for follow-up financial examinations and the absence of more reports for nonroutine financial examinations show that the division must improve its consumer protection.

To ensure that consumers receive adequate protection from financially insolvent health plans, the division periodically examines health plans' financial conditions. Financial trouble at health plans can cause disruptions in the health care services provided to enrollees. For example, if financial troubles force a

health plan to close down abruptly or to reduce services, enrollees may be forced to hurriedly find other health plans through which to obtain services.

Table 2 shows the number of routine financial examination reports issued in fiscal year 1997-98 dropped dramatically from the prior year. This decrease occurred despite the authorization of 14 new financial examiner positions by the budget increase. Further, the number of follow-up and nonroutine financial examination reports issued increased only slightly from one year to the next. At first glance, the figures for the changes in the division's performance indicate that, at best, the division did not improve its performance and may actually have decreased its protection of health plan enrollees.

**TABLE 2**

**The Health Plan Division's Performance Results for  
Completing Financial Examinations of Health Plans  
Before and After the Budget Increase**

Performance Measure	Fiscal Year 1996-97	Fiscal Year 1997-98*	July Through December 1998
Number of routine financial examination reports issued	24	15	5
Number of follow-up financial examination reports issued	0	2	0
Number of nonroutine financial examination reports issued	0	3	2

\* The department received the budget increase in this fiscal year.

Although the number of reports issued dropped dramatically, as of December 1998, the division substantially complied with the Knox-Keene Act requirement that it conduct financial examinations of all licensed health plans no less frequently than once every five years. Further, although we observed that the division had not issued reports for routine financial examinations for 2 of the 17 plans it should have reviewed by December 31, 1998, the division has adequate plans to resolve this backlog without affecting its schedule for other examinations during 1999.

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*The disappointingly small number of follow-up financial examinations indicates a need for improvement.*

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The disappointingly small number of reports covering follow-up financial examinations indicates, however, that areas in the financial examination function still need improvement. Despite the budget increase, the division is currently not issuing more reports for follow-up financial examinations than it did before. For example, in the proposal for the increase, the division stated that the workload for follow-up financial examinations was 26 reports annually. As shown in Table 2, the division released only 2 reports for follow-up financial examinations in fiscal year 1997-98, and it issued none from July 1998 through December 1998. Records further indicate that, as of December 1998, the division had a backlog of six follow-up financial examinations.

Although the division has a modest backlog of follow-up financial examinations it needs to conduct, and even though a discrepancy exists between the workload envisioned by the budget proposal and the division's actual performance, we believe that the shortcomings identified within the financial examination function are not as great as those related to the division's medical survey function. We base this position in part on the division's use of another tool to help ensure the financial well-being of health plans: The division periodically reviews health plans' financial statements. Depending on the risk associated with a particular health plan, the division may review the plan's financial statements as often as monthly, but not less frequently than quarterly. Through these reviews, the division routinely evaluates the health plan's various financial aspects, including tangible net equity, account balances, and other financial ratios, to identify any negative trends. Also, although enrollees may face a significant disruption in their health care if their health plan declares bankruptcy, the risk of actual harm to enrollees has been low historically.

#### **Despite Recent Progress, Consumer Protection Via Complaint Resolution Needs Further Improvement**

Although the division's efforts to respond to consumer complaints against health plans produced better results during the last half of 1998 than in previous periods, enrollees generally did not receive better protection by the division's complaint resolution function in the year after the division received the budget increase.

*Complaint resolution performance worsened during the year the division received the budget increase.*

One of the tools the division uses to help ensure that health plans provide adequate care to consumers is the operation of a toll-free telephone hotline that enrollees can use to file complaints against health plans. When it receives a consumer complaint, the division obtains information from the health plan and any other source, such as a medical consultant, to help the division's staff determine whether the health plan has violated the law. When it upholds an enrollee's complaint, the division can refer the health plan to another division within the department for enforcement action.

To improve the complaint resolution process, the division's proposal for the budget increase requested an additional \$472,400 to support nine new positions. However, as Table 3 shows, health plan enrollees generally did not receive better protection in fiscal year 1997-98, the year the department received the budget increase.

**TABLE 3**

**The Health Plan Division's Performance Results for Resolving Complaints Against Health Plans Before and After the Budget Increase**

Performance Measure	Fiscal Year 1996-97	Fiscal Year 1997-98*	July Through December 1998
Number of complaints closed	2,626	2,180	1,430
Number of complaints still open†	801	960	565
Number of backlogged complaints†	377	556	305
Percentage of backlogged complaints†	47	58	54

\* The department received the budget increase in this fiscal year.

† These amounts reflect the quantity of complaints as of June 30 for each fiscal year, or as of December 31 for the last column.

Table 3 indicates that the number of complaints open at the end of fiscal year 1997-98 increased by 159 (20 percent), from 801 to 960; the number of complaints closed dropped by 446 (17 percent), from 2,626 to 2,180; and the complaint backlog increased by 179 (47 percent), from 377 to 556.

The Knox-Keene Act requires the department to send written notice to all affected parties about the final resolution of each complaint within 60 days following the division's receipt of the complaint unless the commissioner authorizes an extension of the deadline because he or she believes that additional time is necessary for staff to evaluate the complaint fully and fairly. However, we saw no instances in which the commissioner had granted such an extension so we considered any complaint 60 days or older a backlogged complaint.

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*For the first six months of fiscal year 1998-99, the division showed signs of improving its complaint resolution process.*

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These performance measures demonstrate that the division's protection of health plan enrollees through the complaint resolution function actually worsened in the year the division received the budget increase. However, during the six months from July through December 1998, the division showed several signs of improvement in this function. For example, as of December 31, 1998, the number of backlogged complaints dropped by 45 percent from June 30, 1998; this figure was lower than the number of backlogged complaints as of June 30, 1997. Further, the number of closed complaints as of December 31, 1998, exhibited that the division's pace for resolving complaints for fiscal year 1998-99 would put the division's final number of closures for this fiscal year well ahead of the number closed during the previous fiscal years. We note that, as of March 5, 1999, the number of backlogged complaints dropped to 201 from the 305 the division had as of December 31, 1998.

Moreover, from July through December 1998, the division focused its efforts on closing "older" open complaints. These efforts resulted in the number of complaints older than 270 days (about nine months) dropping 60 percent between June 30 and December 31, 1998. Similar decreases occurred for those complaints more than 180 days old and for those 60 days or older. Table 4 summarizes these changes in the numbers of open complaints at the division during the last 30 months.

**TABLE 4**

**Ages of Open Complaints by Health Plan Enrollees Before and After the Department’s Budget Increase**

Age of Complaints	As of June 30, 1997	As of June 30, 1998*	As of December 31, 1998
60 days or older	377	556	305
Older than 180 days	114	206	93
Older than 270 days	84	133	53

\* The department received the budget increase in this fiscal year.

Although the reduction in the complaint backlog and the increase in the number of closed complaints are noteworthy, and the division’s focus on closing older complaints is appropriate, we believe that the complaint backlog needs to be even smaller. It is reasonable to expect that a small portion of the 305 complaints would take the division longer than 60 days to resolve due to the unique circumstances associated with the complaints. However, more than half of all complaints open as of December 31, 1998, had not been resolved within the time allowed by the Knox-Keene Act. Further, even though the department’s commissioner can extend the deadline for resolving an individual complaint, he has not done so for any of the 305 complaints.

An odd side effect of the division’s complaint resolution efforts since fiscal year 1996-97 is that the proportion of complaints in which the department determined that a health plan was complying with the Knox-Keene Act was noticeably higher in recent periods. Conversely, the proportion of complaints in which the department determined that a health plan was not complying with the Act was lower. In other words, the department appears to be upholding enrollees’ allegations for a smaller proportion of complaints than it did formerly. Table 5 summarizes these changes.

**TABLE 5**

**The Health Plan Division's  
Disposition of Complaint Resolutions  
Before and After the Budget Increase**

Complaint Resolution Decision	Percentages		
	Fiscal Year 1996-97	Fiscal Year 1997-98*	July Through December 1998
Health plan not in compliance	33%	31%	28%
Health plan in compliance	40	43	47
Indeterminate†	27	26	25

\* The department received the budget increase in this fiscal year.

† In these instances, the division did not have sufficient information or clear statutory support to decide whether a complaint issue involved a violation of the Knox-Keene Health Care Service Plan Act of 1975.

In response to our request to explain why this trend that appears to favor health plans might occur, the department indicated that, although several hypotheses about the trend may exist, without qualitative analysis and evaluation, no data exists to support any hypothesis. The department stated that, for example, health plans may have improved the quality of their decision making in their internal grievance systems, resulting in relatively fewer consumer complaints involving a violation of the Knox-Keene Act or of the department's regulations. The department also stated that the change in complaint resolution results could have arisen because some enrollees may have learned only recently that the department regulates health plans and may have filed complaints that reflect consumer frustration but that do not involve a violation of the Act. A third hypothesis offered by the department is that changes in the division's review processes have resulted in the division's finding that fewer complaints involve a violation of the Knox-Keene Act. The department believes that the last hypothesis is unlikely because of the department's "continuous quality improvement program" for processing complaints and because it has had no policy changes in this regard.

In addition to the budget increase in fiscal year 1997-98 to improve the complaint resolution function, the division received another budget increase for fiscal year 1998-99. Although the complaint backlog has dropped considerably since the division received the first budget increase, protection of

*The division is on pace to receive 44 percent fewer calls and handle 27 percent fewer complaints than estimated.*

health plan enrollees is still not at the level required by law or at the level envisioned within the proposal requesting the second increase. For fiscal year 1998-99, the division received an increase of \$778,100 to support 17 new positions to help respond to 124,700 annual consumer calls the division estimated it would receive and 6,000 complaints it would handle. However, based on the number of calls the division answered and the number of complaints handled from July through December 1998, the division is on pace to answer only 69,600 calls and handle only 4,400 complaints. These amounts are, respectively, 55,100 (44 percent) and 1,600 (27 percent) fewer than estimated.

Further, despite the division's progress in reducing the backlog of complaints against health plans, the division fails to notify consumers when their complaints take longer to resolve than the 60 days allowed by law. According to division staff, if consumers inquire about the status of their complaints, the division will respond; otherwise, it does not take the initiative to contact consumers should the resolution of their complaints take longer than 60 days. The division's failure to take such a simple step is an example of indifferent customer service.

#### A Previous Report Identified Similar Problems at the Department

A previously issued report identified many of the issues we have discussed concerning medical surveys and those concerning the handling of complaints. In May 1992, nearly seven years ago, the former Office of the Auditor General (OAG) issued an audit report titled *The Department of Corporations Can Improve Its Management of Medical Surveys and Consumer Complaints in Its Health Care Service Plan Division*, Report P-115. In this report, the OAG concluded, among other things, that the department had not always effectively managed its medical surveys of health plans, and the department allowed excessive delays in the release of survey reports. Further, the department failed to take follow-up and enforcement actions, and it did not promptly process complaints made by consumers against their health plans. The OAG recommended, among other things, that the department establish management controls to ensure that it conducts the medical surveys as required, track the status of medical surveys conducted, ensure that its analysts have effective direction, routinely monitor the status of complaints, take appropriate action when it does not promptly resolve

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*We identified similar problems with the department's medical surveys and complaint resolution nearly seven years ago.*

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complaints, and reduce the backlog of pending complaints to a level consistent with the department's goals. When the OAG issued its report, the Secretary of the Business, Transportation and Housing Agency concurred with the report's conclusions and recommendations and even pointed out certain corrective actions taken by the department since the review.

### **INADEQUATE LEADERSHIP STANDS OUT AS THE PRIMARY REASON FOR THE DIVISION'S FAILURE TO IMPROVE CONSUMER PROTECTION SIGNIFICANTLY**

Although several factors contributed individually to the division's lack of significant improvement in consumer protection once it received the budget increase, the overall reason for the division's lack of progress appears to rest with deficient management. Specifically, management bears numerous responsibilities, including the establishment and maintenance of an adequate infrastructure, or organizational framework, that allows the department to meet responsibilities and accomplish goals and objectives. An adequate infrastructure includes the following components:

- Capable people occupying key supervisory positions.
- Existing procedures that receive regular review to see if changes would make the procedures more effective.
- The filling of vacant positions when backlogs threaten or actually exist.
- Sufficient administrative controls to track and monitor existing and future workload.
- Reasonably accurate estimates for workload planning that management can use to develop budgets.

During our review, we discovered weaknesses in each of these areas that contribute to the division's failure to achieve better results for health plan enrollees. Because these weaknesses are many and diverse, we believe the department and the division lack the leadership and focus necessary to better achieve the goals and objectives related to protecting health plan enrollees.

## Key Management Positions Are Vacant or Nonexistent

During our review, we observed that neither the medical survey nor the financial examination functions had permanent managers. We believe that such positions are necessary to provide the leadership, direction, vision, and guidance to each function's staff members so that they can successfully achieve their mission and objectives. In the case of the medical survey function, the manager's position has been vacant for the nearly 16 months since the budget increase authorized the position. The division indicated that it had not filled this position because the medical survey function had an insufficient number of subordinate staff to manage and complete the medical surveys. However, management involves more than simply directing the work of others. Managers are partly responsible for developing and ensuring the administrative controls that can lead to an agency's achievement of its mission and objectives.

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*A management position involves more than simply directing the work of others; it also assists in an agency's achievement of its mission and goals.*

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Additionally, the division's organization charts currently show no single position established to manage the financial examination function. Rather, the division uses a team of four supervising examiners to direct the work of subordinate staff. Two of these positions are in Los Angeles, and one each is located in Sacramento and San Francisco. According to one supervising examiner, none of these examiners have been able to assume a leadership position over this function because of their supervisory and other assigned responsibilities.

The division has firsthand experience concerning the value of having a key person in charge of one of its major functions. Specifically, shortly after the division filled a supervisor's position in its Consumer Services Unit in May 1998, results from the division's complaint resolution function began to improve. For example, the percentage of complaints 60 days or older that the unit assigned to consumer services representatives dropped from 15 as of June 30, 1997, to 5 at December 31, 1998. Division staff told us that the assignment of a full-time supervisor for the Consumer Services Unit was a major factor contributing to this improvement in complaint resolution.

## Some Units Have Not Reviewed Their Existing Procedures

Further evidence of inadequate management is the division's inconsistent review of the policies and procedures for some units responsible for consumer protection. One division that conducted such a review, the department's Health Plan Enforcement

Division, implemented procedural changes that, when combined with the budget increase, resulted in improved performance in this division. In contrast, staff of the medical survey and financial examination functions have not followed suit and reviewed their own processes; consequently, these functions show little or no improvement in their performance since the department received the budget increase.

Currently, the Health Plan Enforcement Division, created in August 1998, enforces the provisions of the Knox-Keene Act for the department. When a health plan does not comply with the Act's provisions, the department can take any of several enforcement actions against a plan. For example, it can issue cease-and-desist or temporary restraining orders, levy fines and penalties, or revoke licenses to operate.

Since its creation, the Health Plan Enforcement Division has taken a number of positive steps to establish a sufficient infrastructure to achieve its goals and objectives successfully. These steps include the development and implementation of procedures and forms to help streamline the process of cases referred from the Health Plan Division. For example, rather than waiting for referrals to arrive, as the Enforcement Division did when it had enforcement responsibility, the Health Plan Enforcement Division established a procedure by which it routinely reviews division work products, such as medical survey and financial examination reports, to identify issues for possible enforcement action. The Health Plan Enforcement Division also reviews complaints to identify potential cases for enforcement action. Table 6 reflects how the steps taken by the Health Plan Enforcement Division improved its performance since it took over enforcement responsibility in the last part of 1998.

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*The Health Plan Enforcement Division improved its performance after it reviewed and changed existing procedures.*

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**TABLE 6**

**The Health Plan Enforcement Division's  
Performance Results for Enforcement of the Knox-Keene Act  
Before and After the Department's Budget Increase**

Performance Measure	Fiscal Year 1996-97	Fiscal Year 1997-98*	July Through September 1998	October Through December 1998
Number of referrals	107	51	23	116
Number of active cases <sup>†</sup>	53	29	37	85
Number of enforcement actions	262	24	5	3

\* The department received the budget increase in this fiscal year.

<sup>†</sup> The amounts in this row reflect quantities as of June 30 of each fiscal year, and as of December 31, 1998. The amount in the third column reflects the quantity as of August 31 because the responsibilities of the Enforcement Division transferred to the Health Plan Enforcement Division in September 1998.

As Table 6 shows, the numbers of referrals, active cases, and enforcement actions all dropped significantly in fiscal year 1997-98 from the prior year, but the number of referrals and active cases substantially increased from October through December 1998. We believe that these improvements in performance are attributable not only to the budget increase, which authorized an additional nine positions at a cost of \$540,700, but also to the procedural changes implemented shortly after the creation of the Health Plan Enforcement Division. Further, we expect to see future increases in the number of enforcement actions as a result of these actions.

Similarly, we found that the division's Consumer Services Unit made several procedural changes in the first six months of fiscal year 1998-99 to improve resolving consumer complaints. When combined with the budget increase, these changes significantly lowered the complaint backlog, as reflected in the performance measures mentioned earlier in this report.

*Unfortunately, we found little evidence that the medical survey and financial examination functions conducted internal reviews to improve effectiveness.*

Unfortunately, we found little evidence that the medical survey and financial examination functions conducted similar internal reviews of their policies and procedures to determine whether changes would improve the functions' effectiveness. We believe that, to achieve greater results in the protection of health plan enrollees, staff of these two functions should follow the leads established by

the Health Plan Enforcement Division and the Consumer Services Unit by reviewing their procedures to determine whether changes to policies and procedures would help the department better protect health plan enrollees from violations of the Knox-Keene Act.

### High Vacancy Rates for Some Positions Contribute to Work Backlogs

Another indicator of inadequate management at the department is the high vacancy rates for some positions even though work backlogs exist. For example, as of December 31, 1998, despite the division's attempts to fill analyst positions, 12 (67 percent) of the 18 authorized positions remained vacant, and 10 of these had been vacant for nearly 16 months. The budget increase allowed the department 11 new analyst positions that would be responsible for, among other things, performing medical surveys. We attribute to vacancies in the analyst positions at least some of the division's delays in issuing medical survey reports. Similarly, we believe that at least some of the backlogs for follow-up financial examinations and for delivery of final reports are attributable to vacancies in financial examiner positions and that at least some delays in resolving enrollees' complaints are attributable to vacancies in counsel positions.

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*The division claims it cannot find qualified candidates to fill its analyst positions.*

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The division claims it has not filled more of the analyst vacancies because it cannot find qualified candidates with adequate education and skills. The department believes that the position's minimum qualifications are set too low to attract qualified people. However, a recent classification study by the State Personnel Board indicated that prospective employees meeting the existing minimum qualifications for this position should be able to learn and perform their assigned tasks successfully. According to the department's personnel manager, as a result of the State Personnel Board's evaluation, the division is considering alternative ways to attract and hire people for the analyst positions.

Apparently, the division recently attempted to mitigate the detrimental effects of vacancies in its medical survey function because analysts are spending a higher proportion of their time on medical surveys than they have in the past. For example, division records show that, from July 1, 1998, through December 31, 1998, the division's analysts spent 58 percent of their available time conducting medical surveys. This percentage is substantially greater than the 45 percent and 44 percent,

respectively, that these positions spent performing medical surveys during fiscal years 1996-97 and 1997-98. Our analysis of the division's time-sheet data shows that analysts spent less time from July 1998 through December 1998 responding to complaints and handling administrative responsibilities than they did during fiscal years 1996-97 and 1997-98.

In addition to the high vacancy rate for analyst positions, several counsel, or attorney, positions are also vacant. As of December 31, 1998, 13 (35 percent) of the 37 authorized counsel positions were vacant. The department's budget increase gave the division 16 new counsel positions, which are responsible for reviewing all medical survey reports before publication and assisting the Consumer Services Unit in resolving complaints. The division's first two attempts at filling counsel positions show mixed results. From its first hiring attempt in September 1997, the division had filled 11 counsel positions by April 1998. Division staff attribute this success to the department's advertising the counsel positions in media it normally does not use. For instance, the division placed advertisements in various business journals. However, its second attempt at hiring additional counsel in early 1998 was not as successful; the division hired only one new counsel who had been previously identified during the division's first hiring attempt. Division staff stated that the department did not advertise the availability of the counsel positions in a manner similar to that used during the first attempt. According to division staff, the division is in the middle of its third attempt to fill more counsel positions; it expected to begin interviewing in March 1999. This time, the department has used the same approach to advertise the availability of the positions as it did during its first hiring attempt and expects the results to be just as good.

#### Weak Administrative Controls and Other Factors Have Contributed to Lower Performance by the Division

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*Inadequate tools for monitoring workload, the absence of a contract, and an incorrect interpretation of the law have led to the division's weak performance.*

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The division's weak administrative controls also correlate to management inadequacies. Specifically, a lack of mechanisms for identifying, tracking, and monitoring existing and future workload have created performance problems for the division. For example, even though the Knox-Keene Act requires the department to perform medical surveys for each health plan no less frequently than once every three years, the division does not have sufficient tools for tracking its compliance with this requirement. Specifically, the division tracks full-service health plans once it starts their

medical surveys, but it has no master schedule of health plans that includes those that it has not surveyed. Other examples of weak controls include inadequate tools for tracking the division's compliance with other statutory requirements concerning the issuing of medical survey reports and for monitoring the need for follow-up and nonroutine medical surveys and financial examinations.

Another factor that contributed to low performance results was the division's inability to obtain a contractor to perform medical surveys of dental health plans. In its May 1997 proposal asking for the \$6.5 million budget increase, the department stated that it could not enter into such a contract for 6 to 9 months. As of February 1999, 21 months later, the department was still resolving contract details for those services but had not yet finalized the contract. Of the 40 routine medical survey reports that the division has delayed issuing, 22 are dental health plans.

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*Although a contract for conducting medical surveys of dental plans was expected within 9 months, contract details remained unresolved 21 months later.*

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Finally, we believe that the division incorrectly interprets a state law, and this interpretation also contributes to the division's insufficient protection of health plan enrollees. The Knox-Keene Act requires the department to perform medical surveys of each health plan no less frequently than once every three years. The division interprets this law as requiring it merely to **start** a survey at least once every three years. However, we believe this law requires the division to **complete** medical surveys for each plan at least once every three years. In other words, the division needs to issue a final medical survey report for each health plan within this three-year time frame. By using the start date of the medical survey rather than the issue date of the final report, the division has extended the time between reports for some health plans to much longer than permitted. As we noted earlier, for the 40 health plans that have not received medical survey reports on time, 4.4 years was the mean length of time since the division issued the last report or, for those health plans without a prior report, since the date of the plan's licensure; the range was 3 years to 8.1 years.

#### The Division Used Poor Workload Estimates to Obtain Budget Increases

In addition to the previously mentioned factors that contributed to the division's poor overall performance, the workload estimates the division used to justify the budget increase were not always accurate; therefore, the division contributed to false expectations regarding improved protection of health plan enrollees. We estimate that the budget increase provided the

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*Because its workload estimates were not always accurate, the division contributed to false expectations regarding improved protection for health plan enrollees.*

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division with an additional \$436,700 in salaries, benefits, and support costs for the seven positions the division estimated it would need for conducting nonroutine medical surveys and nonroutine financial examinations. However, the existence of any significant workload associated with nonroutine medical surveys is doubtful; division staff could only recall the need to conduct 1 nonroutine medical survey recently, and the division plans to incorporate this instance into an ongoing follow-up survey. Therefore, the division cannot substantiate the 29 nonroutine medical surveys it estimated that it would complete and for which it received an increase in authorized positions. The division also could not substantiate the workload for all 20 nonroutine financial examinations it estimated in the proposal for the budget increase.

It appears that the division also did not accurately estimate the workload for resolving complaints. For instance, in its proposal for the budget increase for fiscal year 1997-98, the division erroneously estimated that staff of the Consumer Services Unit would answer about 83,100 complaint calls per year. This figure actually refers to the total volume of calls to the hotline, which includes “abandoned” calls, or those instances in which the caller hangs up before staff can answer the call. By excluding abandoned calls, our recalculation of the estimate shows that the number of answered calls should have been 70,200, an amount that represents nearly 13,000 (16 percent) fewer calls. By overstating the number of answered calls, the division asked for one more position than it really needed. Further, as we indicated earlier, in its budget request for fiscal year 1998-99, the division overestimated the number of calls it would answer and the number of complaints it would handle.

## RECOMMENDATIONS

During our audit to assess the improvements to protection of enrollees in health care service plans by the Department of Corporations, we encountered issues leading us to conclusions similar to those we reached during an earlier audit in which we compared the department’s responsibilities with those of other state entities to determine whether other entities could administer and enforce the Knox-Keene Act.<sup>2</sup> Therefore, it seems appropriate to reiterate for legislative consideration the follow-

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<sup>2</sup> *Department of Corporations: To Optimize Health Plan Regulation; This Function Should Be Moved to the Health and Welfare Agency*, report number 97118.1, issued May 1998.

ing recommendation we made in that earlier report: To better protect health plan enrollees, the Legislature should move the responsibilities for regulating health plans from the Business, Transportation and Housing Agency and the Department of Corporations. The Legislature should place these responsibilities within an agency better suited to understanding the needs of a health care-related organization, such as the Health and Human Services Agency. If the Legislature determines that no appropriate agency or department currently exists within the State’s organizational structure, the Legislature should create a new agency or department in which to place the division’s responsibilities.

Further, now that the executive branch is transitioning to a new gubernatorial administration, we recommend that the new administration take steps to correct the concerns we have identified. Specifically, the governor should promptly appoint qualified individuals for leadership positions within the department who will provide the necessary direction, focus, and vision to the staff responsible for the regulation of health plans. Such leadership positions include the commissioner and the assistant commissioner for the Health Plan Division. Moreover, the team of health care experts called together early in the new administration should consider our findings and recommendations when it, as directed by the governor, prepares options “for more effective regulation of the managed care industry.”

Finally, to improve the protection of health plan enrollees, the department needs to take the following actions:

- To ensure that its functions are properly managed, the department should fill the vacant leadership position within the medical survey function as soon as the department finds a qualified individual, and it should promptly create and fill a leadership position for the financial examination function.
- To protect consumers more effectively through its medical survey and financial examination functions, the department should examine in depth and revise as necessary the policies and procedures used by the staff of these functions.
- To bring its budget more in line with its actual costs, the department should reassess its workload estimates for the medical survey, financial examination, and complaint resolution functions. The department should then revise the related staffing levels and its budget as necessary. Further, the

department should promptly fill those positions necessary for providing protection to health plan enrollees.

- To ensure better compliance with applicable laws concerning the release of reports for routine medical surveys, the department should establish sound administrative controls and also develop and implement adequate tracking systems. ■

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# CHAPTER 2

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## ***Health Plans Paid More Than Necessary For the Costs of Their Regulation***

### CHAPTER SUMMARY

**A**s we discussed in Chapter 1, the Department of Corporations (department) received a \$6.5 million budget increase during fiscal year 1997-98 to improve the regulation of health care service plans (health plans). We also pointed out that it achieved only limited improvements in consumer protection because, in part, the department did not attain many of the intended staffing and performance levels established in the proposal for the budget increase. In examining how it used the budget increase, we learned that the department had not spent all of its budget.

Specifically, we observed that the department's Health Plan Program (program) had not spent large portions of its annual budgets for fiscal years 1996-97 and 1997-98.<sup>3</sup> The resulting budget surpluses indicate that health plans paid more fees than necessary to cover the department's actual costs of regulation. The department bases certain fees it charges health plans on the program's estimated expenditures for a fiscal year. The department includes in the program's budget a reserve equal to 25 percent of the program's annual expenditures; however, the difference between the program's revenues and expenditures, called a *fund balance*, for the two fiscal years exceeded the desired 25 percent reserve by \$2.6 million and \$5.9 million, respectively. According to the department, the fund balances exceeded the 25 percent reserve during the last two years partly because the department underestimated revenues and overestimated expenditures.

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<sup>3</sup> The Health Plan Program includes the Health Plan Division and positions in the department's other divisions whose work is directly related to the division (e.g., counsel and other staff who perform enforcement efforts associated with health plans).

## BACKGROUND

According to the department's financial manager, as a hedge against the unexpected costs of potential litigation or enforcement actions against health plans, the department includes a reserve equal to 25 percent of the program's annual expenditures when it develops the program's budget. For instance, if the program proposed annual expenditures of \$10 million, the department would include a reserve of \$2.5 million. The department therefore would require \$12.5 million in resources so that it could meet its annual budget. To examine the department's use of its budget, we reviewed the differences between the amounts of the program's revenues and expenditures during fiscal years 1996-97 and 1997-98 as well as the anticipated difference for fiscal year 1998-99.

## HEALTH PLAN PAYMENTS EXCEEDED THE COSTS OF REGULATION

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*Budget surpluses were \$4.7 million (57 percent) and \$9.1 million (71 percent) for fiscal years 1996-97 and 1997-98, respectively.*

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Information provided by the department shows that, at the end of fiscal years 1996-97 and 1997-98, the program's fund balance substantially exceeded the 25 percent reserve. When the program's fund balance is higher than the reserve the department desires, health plans pay more than the costs of the regulation actually provided by the department. For the two fiscal years, the program spent \$8.3 million and \$13.0 million, respectively. However, the fund balance at the end of the fiscal year was \$4.7 million (57 percent of expenditures) and \$9.1 million (71 percent), respectively. The fund balance for the two fiscal years exceeded the desired 25 percent reserve by \$2.6 million and \$5.9 million, respectively. When fund balances occur, the department typically considers them when it calculates the assessment amounts for the following fiscal year. However, we believe that the fund balances at the end of fiscal years 1996-97 and 1997-98 were excessive.

The largest single source of revenue for the program is the annual assessment, or fee, the department charges health plans. The department bills health plans for this assessment, which is an amount partly based on the number of people enrolled in the health plan. For the 116 health plans licensed in California as of June 30, 1997, the excessive fund balance resulted in each plan paying an average of \$50,800 more than necessary for its regulation during fiscal year 1997-98. Further, because the program bases its assessments for health plans in part on each

plan's number of enrollees, the overpayments equaled about 5.3 cents per enrollee for fiscal year 1996-97 and 10.6 cents per enrollee for fiscal year 1997-98. For fiscal year 1998-99, the overpayment could be as much as 9.8 cents per enrollee.

The department stated that the program's fund balance exceeded 25 percent during the last two years for several reasons. First, because of its higher-than-expected collections of fines and penalties, the department underestimated the revenues that it would earn. In addition, the department also overestimated expenditures, primarily because position vacancies eliminated the associated costs for salaries and benefits and because it had not yet spent an estimated \$3.8 million on an approved computer project.

## RECOMMENDATION

To ensure that health plans do not pay more than necessary for the costs of their regulation, the department should develop and use more accurate estimates of the program's resources and expenditures.

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 governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG  
State Auditor

Date: April 5, 1999

Staff: Elaine M. Howle, CPA, Audit Principal  
Dale A. Carlson, CGFM  
Amari B. Johnson  
Jian Wang

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*Agency's response provided as text only:*

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

April 2, 1999

KURT R. SJOBERG  
State Auditor  
Bureau of State Audits  
555 Capital Mall, Suite 300  
Sacramento, CA 95814

Dear Mr. Sjoberg:

As the newly appointed Secretary of the Business, Transportation and Housing Agency, I am pleased to receive and respond to your report entitled, "State Regulation of Health Plans" (No. 97118.2). The audit report confirms that operational problems exist in the Department of Corporations' Health Plan Division. We recognize that this administration has inherited an organization with deficiencies in key management and operational areas. We agree with the audit report which documents the positions left vacant by the prior administration, the backlog of medical surveys and consumer complaints, and the perceived "failure to monitor health care organizations" consistent with the requirements of law.

With regard to the backlogs – they are unacceptable. I have directed the Department to manage aggressively the workload and further instructed them to redirect resources to eliminate the backlogs.

Health care is essential to an individual's quality of life. In California today, over twenty-five million people receive health care through health care plans. This administration is committed to ensuring that these Californians receive optimum quality of care through health care service plans. It is vital that health plans live up to the expectations of their consumers. The administration is committed to improving the regulation of managed care in California.

Mr. Sjoberg  
State Auditor  
Page 2

I recognize the imperative to have strong management to lead a well-qualified team, while providing clear directions and accountability for results. The Department has suffered from a leadership vacuum and backlogs due to the prior administration's failure to fill critical positions. I have directed the department to make the filling of these positions its top priority.

As specified in the Governor's Budget, I have assembled a team of experts to prepare options for more effective regulation of the managed care industry. That process is well underway. The findings and recommendations of your audit report will certainly be considered seriously as part of that process and you will be notified of the results when this endeavor has been completed.

I want to thank your audit staff for the quality of their work, their professionalism, and their concern for the quality of care that is provided to California consumers.

Sincerely,

*(Signed By:)*

MARIA CONTRERAS-SWEET  
Secretary