LITTLE HOOVER COMMISSION

# REVIEW OF GOVERNOR'S REORGANIZATION PLAN FOR REGULATORY OVERSIGHT OF MANAGED HEALTH CARE IN CALIFORNIA

*June/July 1998*

*State of California*

# LITTLE HOOVER COMMISSION



June 25, 1998

The Honorable Pete Wilson
Governor of California

The Honorable John Burton
President Pro Tempore of the Senate
and members of the Senate

The Honorable Ross Johnson
Senate Republican Leader

The Honorable Antonio Villaraigosa
Speaker of the Assembly
and members of the Assembly

The Honorable Bill Leonard
Assembly Republican Leader

Dear Governor and Members of the Legislature:

The Little Hoover Commission rejected Governor's Reorganization Plan No. 1 of 1998 by a vote of 5 to 4 at a meeting on June 25, 1998.

In discussing the merits of the plan, individual Commissioners raised a number of issues: Some Commissioners were concerned that the plan does not consolidate the State's oversight of health plans into the new department. Some Commissioners were concerned about placing the new department within the Business, Transportation and Housing Agency, rather than within the State and Consumer Services Agency or the Health and Welfare Agency. Other Commissioners believed the new entity should be an agency unto itself or should be governed by a board.

The concerns raised by individual Commissioners appear in the transcript of the Commission's deliberations, which will be made available as soon as possible.

Sincerely,

Richard R. Terzian
Chairman

Milton Marks Commission on California State Government Organization and Economy ✦ http://www.lhc.ca.gov/lhchtm

660 J Street, Suite 260✦Sacramento, CA 95814✦916-445-2125✦*fax* 916-322-7709✦*e-mail* little.hoover@lhc.ca.gov

*State of California*

# LITTLE HOOVER COMMISSION

Richard R. Terzian
*Chairman*

Michael E. Alpert
*Vice Chairman*

Marjorie M. Berte

Carl D. Covitz

Daniel W. Hancock

Sally Havice
*Assemblymember*

Gary H. Hunt

Quentin L. Kopp
*Senator*

Gwen Moore

Angie Papadakis

Charles Poochigian
*Assemblymember*

John Vasconcellos
*Senator*

Stanley R. Zax

Jeannine L. English
*Executive Director*

July 31, 1998

The Honorable Pete Wilson
Governor of California

The Honorable John Burton
President Pro Tempore of the Senate
and members of the Senate

The Honorable Ross Johnson
Senate Republican Leader

The Honorable Antonio Villaraigosa
Speaker of the Assembly
and members of the Assembly

The Honorable Bill Leonard
Assembly Republican Leader

Dear Governor and Members of the Legislature:

In late June, the Little Hoover Commission reviewed Governor's Reorganization Plan No. 1 of 1998, which would have created a new Department of Managed Health Care, and recommended rejection of the plan. In early July, the Senate rejected the plan.

The Commission, however, believes that in order to restore public confidence, the State should act now to correct the serious deficiency in the regulation of managed care providers. At the request of the Governor and using the Reorganization Plan as a basis, the Commission is now recommending that the Administration and the Legislature create a new managed health care regulatory entity that will be efficient, effective and accountable to the public. Specifically, the Commission recommends the following:

- ***Create a New Managed Health Care Regulating Entity.*** California needs a high-profile and well-equipped regulating entity focused solely on managed health care. The Commission did not reach a consensus on whether the new entity should be a department or an agency. However, there was agreement that the new entity should not be hidden within the bureaucracy. Two factors are critical to the success of the new entity:

  1. ***Provide for Strong Leadership.*** To accelerate reform and focus accountability, the new entity should be governed by a single gubernatorial appointee confirmed by the Senate Rules Committee. The appointee should be of the highest quality, have an extensive background in managed care and proven leadership skills.

  2. ***Provide Adequate Resources.*** The resources dedicated to regulating managed care organizations have not kept pace with the growth in the industry and the numbers of Californians relying on managed care providers. The Governor and the Legislature should commit to adequately funding the new entity.

- ***Coordinate and Consolidate.*** The State should coordinate the data collection, complaint resolution and public education of all agencies involved in health care plan oversight. This coordination would improve government efficiency and consumer convenience in the short run and provide for the consolidation of health care plan oversight in the shortest time practicable.

- ***Formalize a Public Process.*** To enhance decision-making and increase legitimacy, public procedures should be established and the role of the advisory committee should be expanded to provide for meaningful public comment, review of proposed policies and scrutiny of the regulatory entity.

In this letter, the Commission details these recommendations, and provides some background on the Reorganization Plan and the Commission's review process.

## *Background*

On April 30, 1998, the Secretary of the Business, Transportation and Housing Agency submitted Governor's Reorganization Plan No. 1 of 1998 (Plan) to the Little Hoover Commission. On May 27, 1998, he provided the Commission with an amended version of the Plan. On June 25, 1998, the Commission voted to recommend that the Legislature reject the Plan and on July 2, 1998 the Senate passed a resolution rejecting the Plan.

The Plan would have dissolved the Department of Corporations (DOC) and would have transferred the DOC's health-care related regulatory programs to a new Department of Managed Health Care. The Plan would have transferred DOC's investment and lender-fiduciary programs to the Department of Financial Institutions, which would have been renamed the Department of Financial Services. Both the Department of Managed Health Care and the Department of Financial Services would have remained within the Business, Transportation and Housing Agency. Both departments would have been managed by a single gubernatorial appointee subject to Senate confirmation. While the Administration would have begun implementing the change in the second half of 1998, the plan would not have formally gone into effect until July 1, 1999.

The reorganization would have left substantially unchanged the budgetary resources. Notably, the Department of Managed Health Care would have inherited the substantial budget increases that were appropriated in fiscal year 1997-98 to the managed-care regulatory program.

The Administration stated that the Plan would have realigned the State's oversight to match the evolution in the regulated industries. Historically, most managed care providers have been regulated under the Knox-Keene Health Care Service Plan Act of 1975. That statute charged the DOC with licensing providers, conducting compliance reviews and investigating health care service plans. The DOC was selected as the

oversight entity because a primary concern at the advent of managed care was the financial solvency of the service plans.

Today, more than half of all Californians have come to rely on managed care services, increasing the work of regulators and raising public concerns about the effectiveness of that regulation. In addition, the cost-controlling strategies of managed care providers, along with advances in medical science, have given rise to new issues about the quality of medical care, the rights of patients and access to services.

In recent years, the State has been criticized for failing to keep pace with trends in the market, and a regulatory structure that is perceived as inadequate in addressing the evolving public interest.

This debate inspired the Legislature and the Governor to establish the Managed Health Care Improvement Task Force which, earlier this year, made more than 100 recommendations on ways the State could improve its role in ensuring high-quality and affordable services from financially responsible managed care providers.

Structurally, the Task Force identified two significant problems -- both resulting from the State's divided oversight of health plans. While the DOC is the primary regulator for many of the managed care providers, some medical groups and employer self-funded plans are not regulated at all, and some indemnity-based plans are regulated by the Department of Insurance. In addition, facilities are licensed by the Department of Health Services, the Department of Industrial Relations is responsible for managed care providers associated with workers' compensation programs, and the healing arts boards within the Department of Consumer Affairs license medical professionals.

The first problem resulting from this fractured oversight falls to consumers: Where do you go with a problem? Where do you go when that agency does not resolve the problem? The second problem falls to providers -- who are subjected to subtle, but potentially market-altering differences in how they are regulated.

The overriding recommendation of the Task Force was to establish an entity focused on managed care oversight and to consolidate in that entity as much of the State's regulatory programs as is feasible.

The Plan sought to implement some of the recommendations made by the Task Force concerning the State's organizational structure, most importantly the creation of a new state department for regulating the managed care industry. At least one of the controversies involving the plan -- the proposed governance by a single gubernatorial appointee, rather than a board -- had not been resolved by the Task Force.

The other function addressed in the Plan concerned the State's regulation of certain financial services by the DOC, including oversight

of financial advisers, mortgage bankers, escrow agents and certain types of securities and investments. Generally speaking, these programs have two purposes. The first purpose is to encourage efficient transactions that nurture economic growth. The second purpose is to protect consumers as they invest, borrow and rely on the services provided by these businesses.

The financial aspects of the reorganization would have continued a consolidation that began several years ago when the licensing and supervisorial responsibilities of the State Banking Department and the Department of Savings and Loans were consolidated, along with some of the regulatory functions of the DOC.

As with health care, these proposed changes in the regulatory structure reflect changes in the private sector. As state and federal rules have allowed for banks, savings and loans and other financial companies to offer a broader range of services, government regulators have redrawn their jurisdictional lines to remain efficient and effective.

The Governor proposed the reorganization under the authority granted to his office (Government Code §12080 *et seq*). The statute provides for a reorganization plan to go into effect 60 days after it is submitted to the Legislature unless either the Assembly or the Senate passes a resolution by a majority vote rejecting the plan. However, the Plan submitted this year specified that the new department would not be created until July, 1999.

## *The Little Hoover Commission's Role*

The Legislature, while providing for the Governor to propose administrative reorganizations, also provided for those proposals to be reviewed by the Commission (Government Code §8523). The statute requires the Governor to submit any reorganization plan to the Commission "at least 30 days prior" to submitting the plan to the Legislature.

The Commission's role in the reorganization process is to evaluate the plan and make recommendations to the Governor and the Legislature within 30 days of the date that the plan is submitted to the Legislature. The Plan was formally submitted to the Legislature on June 1, 1998.

In addition to the required report, the statute provides that the Commission "may, on its own initiative, undertake a study of any reorganization plan submitted to the Legislature and make reports to the Governor and the Legislature as it deems necessary."

In passing the reorganization statute, the Legislature gave the Governor discretion to reorganize executive branch departments. Simultaneously, the Legislature tempered that discretion with the public discussion

implicit in the Commission's assessment and in the Legislature's ability to reject the plan.

During its review of the Plan, the Commission solicited written comments and oral testimony from an array of stakeholders and the public at large. It reviewed the work of the Task Force, and documents gathered by the Conference Committee on managed care legislation.

The time provided for review under the reorganization statute does not afford the Commission the opportunity to evaluate issues and explore options in the same depth that it usually dedicates to such important public policy issues. Nevertheless, the Commission believes the essential characteristics of the Plan and the fundamental alternatives are clear -- particularly in light of the extensive research and debate conducted by the Task Force. The Commission also believes that the information available to it and to the State's top policy makers provides a solid foundation for the Commission's conclusions and, more importantly, for the State to take a meaningful and positive step toward organizational change.

Regarding the financial services aspects of the Plan, the regulated parties stated their belief that the Plan was being driven more by the desire to create a new department of managed care than to consolidate oversight of financial services.

Specifically, the Plan proposed for the second time in recent years to transfer oversight of mortgage bankers to a new agency, without any significant attention being given to the actual licensing program that the industry believes is invalid. Furthermore, some consumer groups expressed concern that the State should increase its oversight of some lenders and service providers that target low-income citizens, who do not have access to, or cannot qualify for, services offered by larger institutions.

In any case, the Commission concentrated its attention on the managed care aspects of the Plan. On June 25, 1998 the Commission voted 5 to 4 to recommend that the Legislature reject the plan. The Senate adopted a resolution on July 2, 1998 rejecting the Plan.

At the request of the Governor and in consideration of legislative proposals to reform California's managed care oversight, the Commission met on July 28, 1998 to discuss the options for reform and to formulate its recommendations to the State's top policy makers.

Foremost, the Commission urges the Governor and the Legislature to make every effort to craft an organizational reform in the remaining weeks of the legislative session. To assist in that effort, the Commission by a unanimous vote makes the following recommendations:

## *Recommendation 1: The new managed health care regulator should be governed by a single gubernatorial appointee of the highest caliber -- experienced in all aspects of managed care, possessing proven leadership skills and dedicated to defining and protecting the evolving public interest.*

All of the reform proposals, including the Plan, would establish a new state entity charged with the sole responsibility of regulating managed health care providers. As expressed by the Task Force and others, significant improvements could be expected by removing this regulatory function from the DOC and assigning it to a new organization focused solely on this complex industry and the evolving public interests.

One controversy has involved the placement of this organization within State government. More specifically, should the new regulator be a department -- and if so, within which cabinet-level agency -- or should the regulator be a cabinet-level agency itself? After considerable discussion, the Commission could not reach a consensus on this issue. Commissioners, however, expressed a widely shared belief that the new organization should be placed as high in the hierarchy as possible to ensure its political visibility. The Commission, however, leaves the details of that important element to be negotiated in the legislative process.

A second controversy has involved the governance of the entity: Should a single director or a board assume responsibility for regulating managed care? In this regard, the Commission believes that there is an overwhelming need for strong and decisive leadership and for focused accountability to the Governor, the Legislature and the public to implement needed changes. That leadership and accountability can be best achieved by a single gubernatorial appointee.

Over the last century, the State has grappled with the best organizational structure for providing accountability. The Commission, in this and previous contexts, has also debated the benefits and shortcomings of boards and single agency leaders.

Department directors and agency secretaries focus leadership responsibility and accountability to the appointing power. Single appointees also can accelerate decision making, particularly on difficult issues lacking broad political consensus. They can provide for more consistent decision-making, provided that tenure of leadership is for a substantial period. And without the burdens of collective decision-making, directors can be more responsive to new issues.

In the case of managed care, three fundamental criticisms have been the DOC's inability to reach timely and high-quality regulatory decisions, the lack of public process and public access to officials and records, and the lack of consistent leadership. To consumers, government has not been

sufficiently responsive to their growing concerns about the quality of service they receive from managed care providers.

Dedicating a State entity solely to regulating managed care is an essential first step. Consolidating responsibility in an executive who can make swift decisions and be held accountable for enacting enabling legislation is also a high priority.

The chief of the new entity should have considerable knowledge of the health and financial aspects of the managed care industry, as well as the management experience and the proven leadership skills needed to be an effective, compassionate and responsive regulator.

In turn, steps also should be taken to ensure that doctors, patients and their families have equal access to decision makers as managed care providers. Among the steps that can be taken is an open and formalized advisory committee process as described in Recommendation 3.

Finally, while the new entity would inherit the recent budget increases granted to the DOC's Health Care Division, the success of the new entity will depend in part on adequate resources. One responsibility of the appointee will be to make the case for funding increases that may be warranted. The Commission urges the Governor and the Legislature to support requests from the appointee to increase funding to the new entity.

## *Recommendation 2: The State should immediately develop feasibility plans for combining the health care oversight functions that were identified for possible consolidation by the Managed Health Care Improvement Task Force.*

The Plan stated that the head of the new department "will be directed to study and report to the Governor and the Legislature by January 1, 2001 regarding the feasibility of implementing those task force recommendations concerning government oversight which have not been implemented as of that date."

That directive recognized the importance of the Task Force's conclusions, but reduced the imperative implicit in the Task Force recommendations. The Task Force placed the highest priority on extending regulations to include those medical groups that are not subject to State oversight, and the Task Force wanted that issue resolved within one year.

Also within a year, the Task Force wanted the State to consolidate the health care quality review functions that are now divided among different entities. And within two years the group wanted the State to consolidate into the new entity the Department of Insurance's oversight of indemnity health plans.

The next step in each of these categories would be to develop feasibility plans that would detail how the consolidation will physically take place and identify any problems that will have to be corrected by subsequent legislation.

The Task Force also recommended that for any functions that were not consolidated, electronic technologies be employed to share information and coordinate oversight activities by the different departments. Individually, members of the Task Force and some interest groups have pointed out that this coordination, standardization and sharing of information could begin immediately. As functions are consolidated, that transition will be easier because of the common information systems. In the meantime, the public would receive the benefits of coordination.

### *Recommendation 3: The role of the new entity's advisory committee should be statutorily defined as a forum for public evaluation of trends in the health care industry and for public accountability on the State's efforts to protect the evolving public interest.*

The Plan would have significantly improved the ability of the regulator's advisory committee to function as a venue for public discussion. Currently the committee has 20 members, six of them "public members." The balance of the committee consists of various representatives of the managed care industry (Health and Safety Code §1347).

As proposed, the new committee would have had 20 members, including four "consumer representatives" and four "plan enrollees." The committee also would have included as *ex officio* members the Director of Health Services, the Insurance Commissioner, the Director of Consumer Affairs and the Director of the Office of Statewide Health Planning and Development.

These changes are in response to consumer complaints that the advisory committee is dominated by the health plan industry. They also would have implemented a recommendation of the Task Force that interagency cooperation be encouraged by including other health-related department officials on the committee. The Plan also would have required the committee, in addition to its quarterly meetings, to convene at least two public hearings each year to receive public testimony regarding matters affecting the interests of consumers.

These are all positive reforms, but the advisory committee's potential to bring public participation and accountability to the new regulator should be enhanced. The committee, for instance, should be required to prepare and submit an annual report to the Governor and the Legislature on trends in the industry, on efforts to coordinate activities between the health-related departments, on enforcement actions, and on legislative or regulatory changes that would keep the State's regulatory structure

consistent with changes in the market and aligned with the public interest.

Some of these functions are currently assigned to the Commissioner of Corporations (Health and Safety Code §1346). While nothing in the law prevents the committee from taking on these activities, the statute should more specifically establish a role for an active committee that operates in the open, that advises the organizational chief and serves as an informed public voice on managed care issues.

## *Summary*

The Little Hoover Commission urges the Legislature and the Governor to collaborate on the development of legislation that would provide unified, effective and publicly accountable regulation of managed health care during this legislative session and to adequately fund such measure with bipartisan support.

Sincerely,

Richard R. Terzian
Chairman