



# California Medical Association

*Physicians dedicated to the health of Californians*

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March 4, 2011

Secretary Kathleen Sebelius  
Office of Consumer Information and Insurance Oversight  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, D.C. 20201

**RE: Planning and Establishment of Consumer Operated and Oriented Plan Program (CO-OPs);  
Request for Comments Regarding Provisions of Consumer Operated and Oriented Plan  
Program (File Code OCIO-9983-NC).**

Dear Secretary Sebelius:

The California Medical Association (CMA) appreciates the opportunity to provide comments and respond to the Department of Health and Human Services' questions regarding Section 1322 of the Patient Protection and Affordable Care Act related to the Consumer Operated and Oriented Plan Program (CO-OPs).

**CMA Supports the Comments of the American Medical Association**

The CMA and its physician members have been working with the American Medical Association and we strongly concur with the extensive comments provided by the AMA. The CMA is providing additional comments on the California-specific issues.

**CMA's General Position on CO-OPs**

CMA believes that the not-for-profit, local-governance CO-OP model will be attractive to California physicians and patients. CO-OPs could increase market competitiveness in the Health Insurance Exchanges which could increase patient access to physicians and reduce premiums. However, there will be many barriers to entering the complex California insurance market. Therefore, CMA urges HHS to allow flexibility in the ACA's loan and grant provisions to help CO-OPs develop in local communities. Moreover, giving CO-OPs access to a national purchasing pool for administrative services, national reinsurance for quantifiable risk and perhaps reinsurance sponsored by the federal government for unquantifiable risk would significantly help CO-OPs develop.

Several rural and suburban-rural communities in California are interested in forming CO-OPs. In fact, one community attempted a CO-OP in the past but few re-insurers would enter their market because of the high numbers of Medicaid and high-risk uninsured. Most of these communities are lucky to have a health plan choice at all. The key to helping these

communities bring affordable health insurance to their local residents could be the CO-OP program with its loans and grants, flexibility in the regulation and access to national purchasing power. CO-OPs may be the only entities truly interested in insuring and serving their local rural residents. Therefore, if the ACA's goal is to expand access to affordable coverage options for the uninsured, particularly in rural areas, HHS should help to foster the CO-OP model.

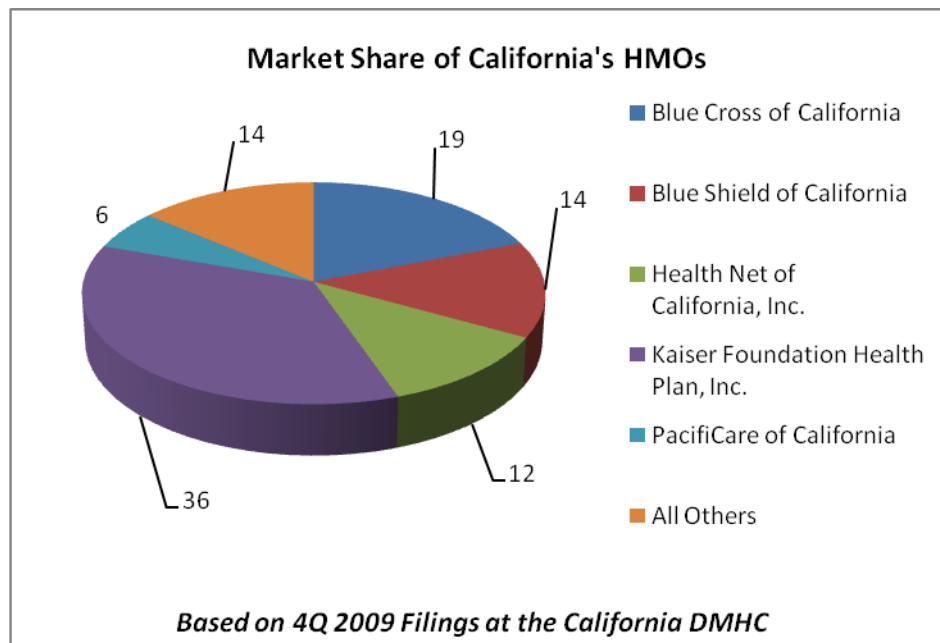
Finally, CO-OPs provide a unique opportunity for physicians to be involved in the local health care delivery system decisions as well as the hands-on care in their offices. California physicians have broad expertise in managing the care of patients and their involvement and experience will be crucial to the success of CO-OPs in California and the provision of quality care.

During the health care reform debate, CMA advocated for insurance market reforms that would expand patient choice of affordable coverage and protect the sanctity of the physician-patient relationship. The CO-OP program in the ACA meets these two goals. It creates an organization that is accountable and responsive to local communities and the patients it serves and ensures that medical decisions are made by physicians and their patients, not for-profit insurance companies or the government.

#### **CO-OPs Could Provide More Competition in the California Private Health Insurance Markets Improving Premiums and Access to Care.**

In California, most insurance markets are not competitive and therefore, California patients do not have many insurance options. In many communities there is only one health plan choice. Lack of choice in the health care marketplace is driving up premiums and limiting access to physicians ("Are Health Insurance Markets Competitive?" *American Economic Review*).

Five Health Plans control 80% of the health care market in California. This market domination has allowed for-profit plans to engage in unfair and non-competitive practices that have caused severe hardships for physicians and their patients - jeopardizing physician supply and patient access. A recent study shows the larger the California HMO consolidation, the fewer medical specialists there are to treat patients (*HSR: Health Services Research* 41:2). Additional studies show that patients enrolled in California plans are having trouble accessing care (*UCSF 2002, "Access to Doctors" survey by Consumer Reports 2005*).



Such market concentration and dominance has made it extremely difficult for new plans and insurers to enter the market. Overwhelming testimony before the COOP Advisory Board was that the development of provider networks is one of the most costly and formidable challenges facing start-up insurance entities. Christine Varney, Assistant Attorney General, stated in recent remarks (May 24, 2010) before the American Bar Association, that established insurers can use their substantial market clout to demand lower provider rates, putting entrants at an immediate and competitive disadvantage. Physicians are then less able to accept similar discounts from small start-ups.

Significant start-up costs are also a barrier to entering the insurance market, including the creation of billing systems and claims administration, provider network formation, eligibility determination, disease management programs, utilization management, quality reporting programs, benefit administration, actuaries, brokers, sales and marketing. And finally, established insurers have spent years amassing financial reserves that allow them to address catastrophic cases. New insurers have difficulty assuming the financial risk for unexpected, catastrophic claims. These barriers have allowed large established insurers to remain dominant.

Therefore, CMA urges HHS to encourage competition from CO-OPs within the Health Insurance Exchanges by providing assistance to overcome these obstacles.

#### **Physician Involvement in CO-OPs**

CMA urges HHS to promote the involvement of physicians in CO-OPs – on their governing boards, in their management and their provider networks. Physicians should be eligible to seek

out the loans and grants under Section 1322 and form CO-OPs with patients and others in their local communities. Physicians and medical groups in California have a great deal of experience and expertise with operating claims processing systems, quality programs, disease management, health information technology, electronic medical records, utilization management and peer review. Most of California's health plans delegate these responsibilities to contracting medical groups now. Therefore, physicians will be essential to the successful operation of CO-OPs in California.

Moreover, California history has demonstrated that physician involvement in local California plans has led to a less adversarial and more successful relationship between the plan and its physicians. The physician experience with the Monterey Community Health Plan, as well as our local Medicaid managed care plans, have shown that when physicians are on the governing board and involved in the plan, they are more likely to support the plan and work for its overall success – including a willingness to contract and implement efficiencies. Physician support for the organization will improve the overall quality of care as well.

We also support flexibility for CO-OPs to involve different modes of physician practice and health care delivery systems. California physicians participate in a myriad of health care delivery models, such as highly integrated organizations where medical groups, hospitals and even health plans are part of a single entity. Large multi-specialty medical groups around the state employ physicians and contract with local hospitals. There are a multitude of Independent Practice Associations (IPAs) that contract with independent community physicians and the local hospitals. And there are thousands of solo and small group practice physicians. The regulation should allow flexibility for local community CO-OPs to build on their existing health care delivery systems, networks, and independent physicians to create an organization that meets the needs of their community.

#### Integrated Care Model Definition

We generally agree with the “integrated care model” concept in Section 1322 of the ACA in that it allows physicians to work together to coordinate care, improve quality and reduce clinical variation. We commend you to the AMA's response to Section B-Question 1 regarding integrated care models.

There are many forms of integrated care and as discussed above, most physicians in California participate in such care. In the context of the health care reform, the two most prominent models are medical homes and Accountable Care Organizations. Most medical groups and IPAs in California are integrated, incent adherence to protocols, offer medical homes and are organized like Accountable Care Organizations. Because there are varying degrees of integration, incentives and financial risk associated with such models, we ask HHS to be flexible in allowing many different types of integration but to be clear in defining them.

We urge HHS to adopt the “Joint Principles of the Patient Centered Medical Home” and the CMA Principles for Accountable Care Organizations (see attached) as part of the CO-OP integrated care model. Both of these documents were developed by physicians and stress the importance of maintaining the centrality of the physician-patient relationship.

Consistent with these principles, we urge CO-OPs to be physician-led and patient-centered. Indeed, we agree that hospital organizations must be involved in the provision of care but they should not be the lead stakeholder on a CO-OP governing board. *The New England Journal of Medicine* (January 20, 2011) just published an analysis of the Medicare Physician Group Demonstration Projects quoting RTI International that the presence of a hospital (*in an integrated organization*) was “a potential deterrent to achieving savings...since these systems may be unable to reduce avoidable admissions or use lower cost care substitutes without affecting their inpatient revenue.” Alternatively, the non-hospital-integrated medical groups produced meaningful cost savings through care management and coordination among physicians. These results emphasize the benefits of involving physicians in the governance and operational structure of a CO-OP.

#### **CMA Responses to Questions Raised in the Request**

➤ **Section A, Question 1(d) How might funding needs differ for other groups or organizations that do not currently exist, but would be successful in establishing durable qualified plans in the individual and small group markets?**

As referenced above, a new start-up CO-OP should be allowed to outsource many of its administrative functions and operations which could reduce the organization’s costs. The ACA authorizes the establishment of private purchasing councils “to enter into collective purchasing arrangements to increase administrative and other cost efficiencies.” The purchasing power of these councils would help CO-OPs enter the insurance market and increase their viability.

The U.S. Senate appropriately recognized the daunting task of establishing a new insurance entity and therefore, provided \$6 billion in loans and grants to help CO-OPs get started and to fund the necessary reserves. The loans must be repaid within five years of operation and can only be used for start-up costs. The grants to help CO-OPs fund reserves will be more substantial and must be repaid over a 15 year period. These grants and loans are essential components to help CO-OPs develop and finance their risk over time.

However, the purchasing councils and the loans and grant program will not be adequate to ensure the long-term viability of a CO-OP. As noted earlier, CO-OPs may provide the most benefit in very rural areas where traditional, for-profit insurance plans are reluctant to operate. In some areas a non-profit CO-OP may provide the best opportunity for residents to achieve

some level of coverage and access to care. However, rural underserved areas will be the most difficult places to form these new entities. It will be difficult for such communities to raise the initial capital to capitalize their plans and account for medical risk.

Most states require insurers and health plans to establish premiums sufficient to cover anticipated administrative expenses and actuarially-projected medical expenses. California law also requires insurers and plans to have financial reserves to cover incurred but not reported (IBNR) claims and unidentifiable, unexpected catastrophic claims – medical risk. Established insurers underwrite this “risk” from unspent reserves they have built-up over the years in a monopolistic insurance market. CO-OPs entering the insurance market will be faced with covering previously uninsured patients as well as the exposure to catastrophic claims. Thus, CO-OPs will either have to carry large financial reserves or be forced to purchase reinsurance to mitigate unexpected catastrophic losses. CMA believes that CO-OPs will have to purchase such coverage.

However, if a reinsurer does not pay a claim, it remains the CO-OPs ultimate responsibility. The costs and responsibility associated with assuming unquantifiable risk for a new start-up insurer could keep many from attempting to enter the market. Therefore, CMA urges HHS to explore ways the federal government could sponsor reinsurance to CO-OPs and potentially other insurers. Government-private sector partnerships should be considered as well. We believe a national reinsurance pool could foster the entry of CO-OPs into the California insurance market which would promote competition that would in-turn drive down premiums, improve physician participation and increase access to care.

On another part of this same question, CMA would not support allowing CO-OPs to operate across state lines without significant safeguards in place. California has some of the nation’s most comprehensive physician and patient protection laws (California Knox-Keene Act), and they should not be undermined by allowing plans to “shop” for the states with more lenient statutes. If CO-OPs were to be given the ability to cross state lines, they should be required to adhere to the laws of the state in which an enrollee lives, not where the entity is headquartered.

#### ➤ **Section A, Question 12: Medicaid and CHIP Participation**

Under the terms of California’s recently-approved Section 1115 Demonstration Project Waiver (The “Bridge to Reform” Waiver), the state will be expanding the Medicaid (Medi-Cal) Managed Care program. Beginning in July 2011, seniors and persons with disabilities (SPDs) will be required to enroll in managed care plans in 14 of California’s most populous counties. This will have the effect of shifting about 400,000 SPDs into managed care.

Other populations will be enrolled into managed care plans as well. The Waiver creates Low-Income Health Plans (LIHPs) throughout the state to begin the process of providing basic

services to medically indigent adults. California is in discussions with CMS about making Medicare-Medicaid “Dual Eligibles” and children with severe chronic conditions mandatory managed care populations.

These newly-enrolled populations may find it very attractive to have a community-based non-profit option through which to receive treatment. And physicians may be more willing to contract with a locally-based plan.

California’s CHIP program, called Healthy Families, operates exclusively through managed care plans. Each county has several options of plans that enrollees can select. In this program, a CO-OP could provide competition for the existing plan, offering an appealing locally-based non-profit option.

While CMA would generally support allowing CO-OPs to provide services to medically indigent, Medicaid and SCHIP patients, medically indigent adults and disabled patients will be higher risk and more costly to treat. Actuaries can appropriately quantify this risk but HHS would need to establish safeguards to ensure that CO-OPs can appropriately manage the care of these patients as well as the financial risk.

#### ➤ **Section A, Questions 4 and 18: Provider Networks**

In order for CO-OPs to provide access to comprehensive, quality patient services, it will be necessary for them to have robust provider networks of primary care and specialist physicians. First and foremost, HHS must ensure that the rates paid to insurers, including CO-OPs, participating in the State Health Insurance Exchanges be risk-adjusted to account for California’s higher practice expenses (rent, non-physician wages) and the socioeconomic and health status of our population. Next, CO-OPs must be able to pay physicians actuarially sound rates. Fair and adequate reimbursement is essential to attracting and maintaining physician participation in a start-up CO-OP. Compensation should also cover any additional care management, care coordination and oversight. Helping physicians acquire and maintain health information technology is important to network development.

Further, CO-OPs must be financially sound and sufficiently funded with IBNR reserves. Physicians must be assured that a CO-OP is financially able to pay claims. Any suspicion of financial insolvency will deter network formation.

In California, it is likely that CO-OPs will partially build their provider networks with contracting medical groups and independent practice associations (IPAs). Most of these groups and IPAs already accept financial risk from health plans for their covered patients. It will therefore be extremely important that these physician organizations are also financially stable enough to accept the amount of risk that they accept. In the late 1990s, California experienced more than

100 medical group bankruptcies that left tens of thousands of sub-contracting physicians with millions in unpaid claims for services they had rendered. California is currently experiencing another wave of physician group bankruptcies. These bankruptcies are detrimental to both physicians and patients. Therefore, if CO-OPs delegate financial risk, they must retain the ultimate responsibility for their covered enrollees. If a risk-bearing physician group is forced to close its doors, the CO-OP should still be required to reimburse providers for services that were rendered.

➤ **Section I, Question 1: Revenues and Benefits**

Given that CO-OPs will be non-profit insurers, CMA supports the concept that their excess revenues should be reinvested to help meet their community benefit goals. We would encourage HHS to define these benefits in such a way that they will improve access to care for patients in the community.

One way to ensure patient access to physicians is to foster strong relationships between the CO-OP and their contracted providers. CO-OPs may find it advantageous to invest their excess revenues in building their provider network, either through increasing their contracted reimbursement rates, or through providing incentives to reward innovation, efficiencies and high quality care. This would have the effect of encouraging physician participation and helping the CO-OPs to build strong networks.

Some CO-OPs may also choose to invest their excess revenues in quality improvement programs to support small practice physicians. These programs could include assisting physicians with implementation of electronic health records (EHRs), supporting local efforts to develop health information exchange (HIE), or building interfaces with clinical laboratories and hospitals. Through these and similar programs, CO-OPs would be helping the quality and efficiency of health care delivery in their entire communities, not just for their patients. We encourage HHS to allow CO-OPs to use their revenues for these programs.

➤ **Section J, Question 1: Requirements for Plan Licensure**

Section 1322(c)(5) of the ACA requires CO-OPs to meet all of the requirements that other insurers meet, including solvency and licensure requirements, rules on payments to providers, network adequacy rules, rate and form filing rules and other state laws. California's insurance companies are regulated by the State Department of Insurance (DOI). California's private health plans are regulated by the State Department of Managed Health Care (DMHC). DMHC oversees enforcement of the Knox-Keene Act, which is California's body of law regulating managed care plans (California Health and Safety Code Section 1322 et seq).



Plans licensed by the DMHC must meet relatively strict requirements on tangible net equity (TNE), plan reserves, IBNR, provider network adequacy, timely payment to providers and limits on administration and overhead.

For new plans, however, the Director of the DMHC is allowed to waive some of these requirements. Through this process, plans can receive a limited license to begin operations. Since almost all of the CO-OP plans will be new entities, it is likely that they would need to pursue a limited license, in order to allow them time to begin enrollment, build their provider networks and meet the financial reserve requirements. Under the Medical Loss Ratio rules recently promulgated by HHS, new plans will be given flexibility in meeting the medical loss ratio standards to help them enter the marketplace to foster competition.

CMA would support giving CO-OPs additional time and flexibility in meeting state requirements but there would need to be strong oversight and monitoring of their financial status.

### **Conclusion**

Thank you for allowing CMA the opportunity to provide preliminary comments. We look forward to working with you to develop the regulatory framework for the CO-OPs. The CMA contact is Elizabeth McNeil, Vice President for Federal Government Relations at [emcneil@cmanet.org](mailto:emcneil@cmanet.org).

Sincerely,

A handwritten signature in black ink, reading "James G. Hinsdale". The signature is written in a cursive, flowing style.

James G. Hinsdale, MD, FACS  
President, California Medical Association