DEPARTMENT OF Managed Health Care

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Testimony on CO-Ops for Advisory Committee Hearing on January 13, 2011

Introduction:

Mr. Chairman and Committee Members:

My name is Cindy Ehnes and I am the Director of the California Department of Managed Health Care (DMHC), responsible for regulating the 108 managed care plans that operate in California. The DMHC is the only stand-alone state agency in the nation with the responsibility for sole oversight of HMOs, touching the lives of nearly 21 million Californians.

Thank you for inviting me to attend this hearing to talk about the California health insurance marketplace in the context of the Patient Protection and Affordable Care Act (ACA) provisions that relate to establishment of new non-profit, member-run health insurance issuers. It is my understanding that the purpose of the consumer oriented and operated plan (CO-OP) program is to foster the creation of new non-profit health insurance issuers to offer qualified health plans in the individual and small group markets. Such support will take the form of start-up loans and grants to meet any solvency requirements. The law suggests that priority will be given to applicants that will offer qualified health plans on a statewide basis, utilize integrated care models, and that have significant private support.

The California Department of Managed Health Care supports the goal of increasing competition in the areas of cost, quality, and efficiency in the health insurance market. My testimony today will provide an overview of the regulatory context within which these new plans must operate. As well, I will provide an overview of the California individual and small group markets, identify potential interest in this new opportunity, and discuss regulatory requirements for the formation of CO-OPs under California law.

The California Health Insurance Marketplace:

The potential market opportunity for these new CO-OP plans in California is significant. According to the California Health Benefits Review Program, nearly two million Californians currently obtain coverage in the individual market, and another 3.3 million obtain coverage from small employers. The UC Berkeley Center for Labor Research and Education estimates that 8.3 million Californians will be eligible for individual or small group coverage in the post-reform marketplace exchange, with or without subsidies. Of those, 2.8 million will be eligible for subsidized coverage either through their employers (who will benefit from the small business tax credit) or due to their income levels.

Unlike states where one or two carriers dominate, California is a large and diverse state that benefits from robust competition and a legacy of innovation in the financing and delivery of

health care. The DMHC currently regulates 55 full service health plans that offer comprehensive coverage. In addition, another 53 specialized health plans provide coverage for vision, dental, chiropractic, and behavioral health care. Both Kaiser Permanente and Blue Shield originated in California, and a number of large national plans participate in the California health insurance market, including for-profit Aetna, Anthem Blue Cross (WellPoint), Cigna, Health Net, and PacifiCare (United Health Group). In addition, Kaiser Permanente, Blue Shield of California, and Western Health Advantage operate as non-profit plans. New CO-OP plans in California must be able to compete successfully against these well established competitors.

The full service plans range in size and complexity -- very large health plans competing in the commercial sector, government plans created primarily to serve the Medi-Cal population, and plans that primarily focus on the Medicare Advantage market. While commercial plans have consolidated and merged over the last two decades; new health plans providing coverage for public program recipients were formed in response to public policies that encouraged managed care.

In California, two separate entities are vested with regulatory jurisdiction over health coverage. HMO and many PPO products must be regulated by the DMHC. Health plans subject to DMHC jurisdiction cover approximately 21 million Californians, while roughly 2.5 million PPO enrollees are in products in which the carriers have elected the jurisdiction of the California Department of Insurance (CDI). Carriers have increasingly chosen to offer consumers in the individual market coverage under CDI-regulated PPO products because of lower premiums, achieved by lower legal standards for benefits and through high cost shifting provisions. In contrast, in the small group market, 2.4 million enrollees receive coverage under DMHC-regulated plans, versus 935,000 through the CDI.

California has the nation's highest proportion of consumers covered under HMOs, with roughly 14 million enrollees in the delegated model. Under this model, health plans delegate responsibility for patient care to providers who contract to take on the financial risk of that care. Under California law, organizations that take on this risk are referred to as "risk-bearing organizations" (RBOs). California introduced regulations for overseeing the solvency of RBOs, such as medical groups, independent practice associations, and medical foundations, to ensure market stability and patient access to care as a result of numerous medical group bankruptcies.

These entities are not licensed, but are subject to provider solvency reporting requirements that include:

- Positive tangible net equity
- Positive working capital
- Minimum cash-to-claims ratio (minimum 0.75 requirement)
- 95 percent claims payment timeliness

These requirements are for RBOs that take *professional risk.* Should they decide they want to take on partial or global risk for institutional services, they must apply for a license as a health

care service plan. Three RBOs currently hold a limited license under DMHC regulation that permits them to assume greater financial risk without functioning as a full service health plan.

Opportunities for New Consumer Oriented and Operated Plans (CO-OPs):

Given California's rich history of innovation in the health care marketplace, there may be a variety of types of entities that would seek to capitalize on this new program opportunity to create new consumer oriented and operated health plans. However, as a result of the size and complexity of the California market, we think that it is not probable that a consumer oriented plan would seek licensure to operate on a statewide basis. Health care is local, and it is more likely that one or more interested parties may seek to establish regional health plans in California under this program.

Given the number of sophisticated existing RBOs in California and the interest that integrated systems have shown in forming new entities, existing provider organizations may want to use this program to establish new regional health plans. An example that may serve as a model is Western Health Advantage, a Sacramento area non-profit health plan that was formed about a dozen years ago by the UC Davis Health System, Mercy Healthcare (CHW), and NorthBay Healthcare.

In addition, California has a number of clinics led by forward-thinking innovative administrators in underserved communities. A number of these clinics are developing integrated models that may qualify as Accountable Care Organizations (ACOs). These groups might also seek to use this program to further expand upon their mission of delivering culturally competent care when lower income, uninsured individuals gain access to coverage under the Exchange.

The Role of Regulation:

The DMHC was statutorily created in 2000 as a stand-alone entity within the Business, Transportation and Housing Agency to regulate managed health care in the state, with a focus on protecting consumers and ensuring the financial viability of the managed care marketplace. The health plans under DMHC's jurisdiction include full-service managed care (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs) and Point of Service products.

DMHC licensees must demonstrate that they have adequate capacity to perform all of the essential administrative functions required of health plans (e.g. claims processing, network management, medical management). California also has extensive standards for timely access to care, including authorizations and referrals, claims payment, plan and provider dispute resolution, benefit design, disclosure of coverage and grievance rights, language assistance, and consumer and provider customer service. The primary focus is ensuring that consumers receive the right care at the right time, and assuring the solvency of the health plans and provider groups that pay for and provide services.

The application process for obtaining a license from the DMHC takes 6-12 months from the time of filing. The lead time is dependent on the ability of the applicant to timely respond to the requests for information and documentation needed to establish compliance. Applicants are expected to engage the assistance of persons knowledgeable about the regulatory compliance requirements, including, but not limited to, health care quality assurance and financial and legal expertise. The filing fee is based upon the actual cost of processing, but may not exceed $25,000.

Prior to granting licensure, applicants are required to provide the DMHC with a business plan, including the proposed area of operation, and financial statements and calculations of tangible net equity (TNE) along with financial projections, including assumptions for at least two years. In addition, plans have to post a restricted deposit in the amount of $300,000, and have a minimum TNE of $1 million. The solvency requirements for licensure under the DMHC's regulation, while challenging for some applicants, actually represent a lower barrier than the risk-based capital standards for licensure as an insurer under the CDI.

Under California statute, the DMHC Director has authority to waive certain requirements governing health plans under the DMHC's jurisdiction, and this could be used to address some barriers to the establishment of CO-OP plans. For example, the DMHC is studying how such authority might allow for the establishment of ACO pilots that incorporate shared professional and/or institutional risk in California.

However, during the 1990s, California witnessed a number of new health plan entrants into the market, and rapid expansions via mergers and acquisitions of physician groups willing to assume risk from health plans. California's approach to regulation of the managed care market evolved in response to widespread health plan and medical group closures and bankruptcies during the late 1990s. Stakeholders (regulators, plans, providers, and consumer groups) have collectively learned from these experiences, and as a result have developed an appropriate regulatory oversight of managed care that ensures robust consumer protections. Any flexibility in the requirements for licensure provided to new CO-OP plans must be balanced against the important role that solvency requirements and consumer protections play in ensuring a stable health insurance marketplace.

In conclusion, if the goal of the commission is to have established CO-OP plans licensed and offering coverage when the Exchanges open in 2014, then time is of the essence. California's licensing experience suggests that start-up funding for these entities should be made available by the end of this year, to allow sufficient time for their formation and establishment.