Comments on the Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program

Thank you. My name is Alan Mytty. I was the CEO of five different health plans during their start-up and initial operations phases. My responsibilities included obtaining the Certificate of Authority, regulatory compliance, building a management team, developing provider networks and so on.

Currently, I am Director of Payer Contracting at The Carle Foundation, an integrated health delivery system and health plan operating in Illinois. I am also the principal of Health Care Assets Management, a firm that provides managed care consulting and brokerage services.

My comments are in response to the Draft Report and Proposed Recommendations for Consideration by the Advisory Board. These comments are updated from the material I sent to Anne Bollinger on Friday. I sent this updated version yesterday, and have some copies with me.

These comments are based upon my many years of experience in health plans. Early in my career, I was the Executive Director of a very small health plan in Newton, Kansas that may hold the distinction of being the last HMO to use initial development grant monies under the Federal HMO Act.

I was also the CEO of start-up plans in Champaign, Illinois; Chicago; West Virginia; and The Bahamas. During my tenure in Champaign, IL, our organization converted from not-for-profit to for-profit, obtained the valuations and regulatory approval, and made the necessary contribution to a charitable trust. We also worked with the Department of Insurance to assume the membership of an insolvent health plan. In West Virginia, I was the CEO of Carelink Health Plans and served as the Chairman of the West Virginia HMO Guaranty Association.

I have seen health plans grow from zero members to become market leaders and serious competitors.

It is my hope that the CO-OPs will be successful competitors and will not suffer the same fate as so many of the original HMOs that started as not-for-profits and converted to for-profit entities. I think that metamorphosis fundamentally changed health insurance in the U.S. and I do not believe consumers or providers have benefitted. I also hope that CO-OPs will have the infrastructure, tight provider relationships and controls on medical expenses, so they have the staying power that many 'provider sponsored' plans of the 1980s and 1990s did not have.

When I was in graduate school, I helped develop the first consumer-focused health plan in Lincoln, Nebraska. Consumer-focused health plans are near and dear to my heart.

So here are my comments regarding the Draft Report and Proposed Recommendations for Consideration by the Advisory Board.

Summary of Recommendations

P 10 # 13 The first sentence deals with the conversion or sale. Maybe it's understood but could this be revised or re-stated so that it is clear that the Secretary's approval is required "for the life of the loan or grant, including the periods for paying back any loan or grant, plus 10 years."?

P. 10 # 13.b. Can the last sentence be amended so it reads as follows: "There should be substantial prohibitions on the ability of the BOD and management team to receive financial gain or participate in the governance/management of the converted entity, the successor organization or any organization purchasing the CO-OP"? A decision to convert or sell should not be swayed by the opportunity for management of a CO-OP to get a big pay raise when they get hired by the purchasing entity.

P. 10 # 13.c. The second sentence states, "The CO-OP should hold an investment equal to at least 25 percent of the voting shares of the for-profit successor in trust for the benefit of its members." My question is: Does this mean that in order for a sale or conversion to go through, the CO-OP will need to hold 25% of the shares in the successor or the entity purchasing the CO-OP? If so, it seems to me that this would have the effect of prohibiting the sale to the publicly traded managed care firms.

Finance Recommendations

P.11 First Paragraph of the Finance Recommendations. Could the Advisory Board consider adding after the last sentence the following "The Secretary will work with NAIC and appropriate state regulators so that strong hold-harmless language and the assumption of risk by qualified health care provider organizations can be considered in determining whether separate solvency and risk based capital requirements could be allowed for CO-OPs." I read the testimony from Mr. Brian Webb of NAIC and understand his concerns about solvency requirements for insurers and HMOs, but would hope that the CO-OP contracts with providers and the financial strength of substantial integrated delivery system providers could be considered. But if this suggestion would meet resistance from critics who might argue that CO-OPs have an unfair advantage, then it should be ignored.

P. 13 # 8. Will CO-OPs be allowed to make their provider networks and administrative services available to local employers, trusts, Taft-Hartley plans, etc. that wish to self-insure?

Other Finance Questions:

- Will there be Federal regulations specific to CO-OPs concerning pricing, underwriting, premium setting?
    - For example, will CO-OPs be required to use straight community rating?
    - Will there be other options for premium setting available?
- Will the financial strength of a provider network that seeks a capitated arrangement be considered?
    - If a small medical group or hospital wants a fully capitated arrangement, will that be allowed?
    - If not, what objective criteria will be used for determining the financial strength of providers that might want captitated contracts?
- Are there instances where state insurance rules regarding premiums and rate-setting would interfere with the CO-OP's ability to compete?

- Will there be rules regarding the minimum risk that the CO-OP and/or its provider network must assume?
    - What if a CO-OP shifts the vast majority of risk to a reinsurer?
    - Are there any rules anticipated regarding the regulatory/financial/organizational requirements of a reinsurer?

Infrastructure Recommendations

P 16 # 7 IT and Reporting. Caution is advised regarding reporting requirements imposed on CO-OPs that could be excessive when compared to other health plans. To be competitive I assume that HEDIS, NCQA and URAC requirements, compliance with HIPAA electronic eligibility and claims, Centers for Medicare and Medicaid Services reporting for Medicare Advantage plans, CAQH participation, and potentially other requirements and organizations need to be considered. A balance among the costs, value, transparency, competitive benefits, etc. needs to be reached so that CO-OPs can compete and show value while not being burdened with additional reporting and other infrastructure requirements that do not add to effective and efficient health care.

Criteria, Process, and Compliance Recommendations

P. 18 # 5. Is it assumed that "oversight" also includes authority by the Secretary to provide interim management for a CO-OP that is experiencing difficulties "where the Department has concluded discontinuing funding is not in the best interests of the CO-OP, its members, or the Department."

Conclusion

This paragraph addresses the challenges to market entry, but does not speak to sustainability or market viability. Before the last sentence, could the following be inserted: "To be viable and competitive, CO-OPS will need to realistically and diligently work to manage the use and costs of health care services while ensuring that high quality covered services are provided." I believe some statement about anticipating and managing costs while competing against other health insurance plans would appropriately emphasize a key challenge that CO-OPs will face.

Thank you.

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