Consumer Operated and Oriented Health Plans Advisory Board

Testimony of John M. Bertko, FSA, MAAA

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Good morning. My name is John Bertko and I am the retired chief actuary of Humana Inc., a Visiting Scholar at the Brookings Institution and a Senior Fellow at the LMI Center for Health Reform. I have had experience with health insurance rate-setting, establishing new innovative lines of business, solvency requirements for health insurers, and relations with state Departments of Insurance. In addition, while a consultant, I worked for several consumer governed health plans across the country and for several provider-run community health plans.

The creation of Consumer Operated and Oriented Plan (CO-OP) program under ACA to foster the creation of non-profit, member-run health insurance companies is one of the law's major provisions to provide greater health insurance value to consumers and to increase competition in the health insurance industry. At the same time, we should recognize that development of new CO-OP insurance plans will take time and should proceed with care in order to provide consumers with products that have adequate premiums guaranteeing solvency while bringing innovation and new options to the market.[1] Many states might benefit from having

[1] See the attached technical paper from the American Academy of Actuaries, "Federal Health Care Reform 2009: Start-up Capital Costs for Health Care CO-OPs and a Public Plan" for a description of solvency issues.

increased competition in their Individual and Small Employer insurance markets that are currently dominated by only a few large insurers.

Necessary Size for Successful CO-OP Plans

There are potentially two membership size thresholds that should be considered for CO-OP success. First, a CO-OP plan needs to have sufficient membership to be financially and operationally stable. From my experience, this size level is reached at around 25,000 members. At this level, a CO-OP plan can afford professional managers, the infrastructure to support evolving product designs and utilization management and a distribution network. Many of the infrastructure components at this level may be "rented" rather than purchased or developed internally.

A second level of success might be measured as when the CO-OP begins having an impact on the overall state or regional insurance market. In my opinion, this level is reached with an approximately 5% share of the private insurance market, which may be around 250,000 members in a medium-sized state and around 50,000 members in a small state. While well short of the marketshare of the biggest plans (at 50% or more), a 5% marketshare can mean that buyers take the CO-OP plan seriously, that employers recognize it as a real and stable alternative to bigger insurers and that the CO-OP can negotiate successfully with providers.

Neither of these levels needs to be reached immediately. With the financial support in ACA, a CO-OP with a good business plan might be able to “ramp up” to the economically viable level over, say, a three year period. By taking a frugal approach to start-up costs, a new CO-OP may be able to reach the economically viable level by the end of the three-year period with a good marketing and outreach campaign, especially with the advent of Exchanges in 2014. However, the CO-OP plan must also be completely prepared to open its doors on January 1, 2014 to not miss the 2014 “land rush” for newly insured membership.

As a comparison to this growth path, High Deductible Health Plans with accounts like HSAs have gone from virtually no marketshare in 2000 to a reported 12-15% in a recent 2010 analyst report.

Success Factors for a New CO-OP Plan

I am going to suggest a number of factors that will likely contribute to the success of new CO-OP plans. These include:

- Use of professional health insurance management – to avoid some of the usual problems with start-up health insurance operations
- Maintaining a focus on low administrative costs – Because a CO-OP will be a new entrant and not need to worry about established distribution channels or other ways of doing business, it can focus on using the lowest cost

administration, such as only doing business through the Exchange and avoiding high distribution costs, using Electronic Fund Transfer (EFT) and Internet mailing of enrollment and billing materials and use of reasonable executive compensation.

- Development of community support – for provider contracting, employer offerings of the CO-OP products, and consumer trust in their own health plan.
- Realistic pricing of insurance premiums, including a migration towards premiums with a solvency contribution factor after the initial period of ACA-supplied start-up funds
- Use of risk adjustment across all Exchange markets to lower the risk of the CO-OPs' attracting a higher-risk group of new enrollees. Risk adjustment would potentially offset this issue by assessing low risk plans and making payments to high risk plans.
- Use of the transitional reinsurance program in ACA from 2014 through 2016 to reduce the risk of pent-up demand for health services from the first newly insured members who no longer are subject to underwriting denial.
- "Renting" infrastructure services to maintain a low administrative cost structure, such as:
    - Claims adjudication
    - Network contracting
    - Utilization management
    - Billing and enrollment systems
    - Accounting and legal services

    - Rate filing and other actuarial services
    - IT support and data analysis support

- Use of appropriate and innovative products – such as use of local Accountable Care Organizations, tight networks and Value-Based Insurance Design products. A new CO-OP plan can be much more innovative than a traditional insurer.
- Last, the Consumer Board governing the CO-OP must be realistic and business-like. It must see that success involves serving the community through financial stability and consumer-friendly practices while establishing and maintaining solvency.

Thank you for inviting me to address the Advisory Board and I look forward to your questions.