STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

Testimony of Washington State Insurance Commissioner Mike Kreidler
Consumer-Operated and Oriented Plans (CO-OP) Advisory Board Public Hearing
Office of Consumer Information and Insurance Oversight
January 13, 2011

Members of the CO-OP Advisory Board,

Thank you for the opportunity to be a part of this public hearing. I am Mike Kreidler, Washington State Insurance Commissioner. I'd like to begin by giving you some background on cooperatives in our state, and then detail the process that companies go through to be admitted to offer healthcare insurance in Washington state.

History

The history of the cooperative in Washington State began in 1947 with the organization of Group Health Cooperative of Puget Sound. During the 1940's, 60 percent of the U.S. population was uninsured. It was this huge unmet health care need that brought a few dozen labor unionists, farmer grange leaders, and consumer activists together to establish Group Health Cooperative of Puget Sound. Their objective was to create a new healthcare system with the following:

- Prepaid medical coverage that was affordable and equitable;
- A group practice where family physicians and specialists coordinated care and shared knowledge, and;
- An organization governed by members that would give consumers a say in the decisions affecting their care.

These ideas were considered radical at the time, and were met with much controversy. The King County Medical Society refused to accredit Group Health doctors, so the physicians couldn't purchase malpractice insurance anywhere in the United States. It was also difficult to recruit new physicians and the King County Medical Society and private physicians slandered Group Health. In 1951, the Washington State Supreme Court ordered the King County Medical Society to end discriminatory practices against Group Health and its staff.

Today, Group Health has evolved into a nationally-acclaimed organization with more than 950 physicians in GH medical centers, and many more contracted medical staff who work in the community.

Regulatory Environment

Washington offers a business-friendly environment and is a fair and reasonable insurance regulator. We welcome insurance companies to apply for admission to our state. The first step in the admission process is to determine if the entity can meet the financial and corporate governance requirements to apply for a solicitation permit. A critical requirement in the formation of a health carrier is that it must have a minimum net worth of $3 million, PLUS additional sufficient capital for the expenses involved in the start-up of a health carrier. These usually include significant attorney and consulting fees, acquisition of real estate, equipment, qualified staff, etc. Also mandatory for future success is the recruitment of senior management staff with the professional skills to run a health carrier. The board of directors needs to be composed of a sufficient number of knowledgeable, independent, active members with the professional qualifications to properly fulfill its governance and oversight responsibilities. Some health carriers have attempted to fill these roles with doctors. Others have hired health care managers whose primary background is sales. Our previous experience has shown that these approaches have generally not been effective. Successful health carriers are led by senior managers with extensive health care insurance experience.

A solicitation permit is required for any person(s) forming or proposing to form a health carrier in this state. It must be approved and issued by the Washington State Office of the Insurance Commissioner prior to advertising or soliciting or receiving any funds. Application requirements for a solicitation permit include filing the following proposed documents: articles of incorporation, bylaws, insurance contract, advertising, and form of escrow agreement. These items need to be drafted prior to applying for the solicitation permit. Selection of incorporators is another process that must be completed prior to the submission of the solicitation permit, as the incorporators must meet statutory requirements, and biographical affidavits need to be provided for them as part of the solicitation permit application. As the creation of a non-profit corporation or any business structure can be complex, it is recommended that a trusted legal and financial advisor be contacted. It is also recommended that those involved with the formation of the health carrier work closely with the Company Supervision Division of the Insurance Commissioner's Office to confirm that all of the necessary statutory application and formation requirements are being met.

The application requirements for the solicitation permit include:

- Name, type, and purpose of health carrier or corporation to be formed;
- Names, addresses, fingerprints, biographical affidavits and third party investigative reports for each person associated in the formation of the proposed health carrier;
- Full disclosure of the terms of all understandings and agreements among persons associated to the proposed health carrier;
- The plan according to which solicitations are to be made;

- Copies of the proposed articles of incorporation;
- Copies of the proposed bylaws;
- A copy of any security proposed to be issued (must include notice required by Washington Constitution Article XII, Section 11);
- A copy of any insurance contract(s) proposed to be offered;
- A copy of any prospectus, advertising, or literature proposed to be used;
- A copy of a proposed form of any escrow agreement required;
- Deposit of all applicable fees (application, criminal background checks, filing of articles of incorporation with the Insurance Commissioner's Office and the Secretary of State and for the solicitation permit).

Once all items are received for the solicitation permit and the application is complete, Company Supervision Division staff conducts an in-depth review and analysis.

After the solicitation permit is approved and issued by the Insurance Commissioner's Office, it is permissible to create a Washington non-profit corporation through the Corporations Division Office of the Washington Secretary of State. A non-profit corporation is any organization that does not attempt to make a profit and is not a public body. Non-profit organizations are formed by incorporating in the state in which they expect to do business. The act of incorporating creates a legal entity, enabling the organization to be treated as a corporation under law and to enter into business dealings, form contracts, and own property as any other individual or for-profit corporation may do. Registering a non-profit corporation with the Washington Secretary of State involves filing the articles of incorporation, initial directors and incorporators, among other requirements.

<u>Formation of a CO-OP</u>

Once the cooperative has been incorporated, the entity may apply for admission as either a health maintenance organization (HMO) or a health care service contractor (HCSC). The primary difference between the two structures is that an HCSC offers more flexibility at a similar cost than an HMO. The HCSC is often referred to as a *preferred provider organization* (PPO), which is network-based, but has the flexibility to offer point of service (POS) plans that allow the use of out-of-network providers. HCSCs may also offer a number of options in accessing care. An HMO usually is more restrictive and traditional in that the consumer is required to receive comprehensive health care through the HMO's network. The HMO doctors may be employees, who usually do not practice outside of the HMO, or contractors who may also contract with other health carriers. Again, it is recommended that a legal adviser be

consulted during the formation of an HCSC or HMO to determine which structure would be a better fit for the entity involved.

The documents required for application for an HCSC and an HMO are similar. Some of the filing requirements for admission of an HCSC or HMO include:

- Name, address, type of organization, area of operation
- Types of health care services provided
- Articles of incorporation, by-laws
- Plan of operation
- Financial projections
- Financial statements
- Establishment of provider network
- Creation of funded reserve

Rates and Forms

Rates and forms can be filed after the Certificate of Registration and National Association of Insurance Commissioners (NAIC) number is received.

As part of the process to receive a Certificate of Registration and NAIC number, a health carrier must demonstrate it has an adequate network to provide comprehensive health care services to enrolled participants. One of the challenges of this process is that the carrier must demonstrate it has an adequate network of providers to receive its certificate, but cannot receive approval of the necessary forms to contract a network until the Certificate of Registration is received. This issue can be overcome if there is a coordinated effort between the new entity, and the Company Supervision and Rates and Forms divisions within the Office of the Insurance Commissioner during the registration process.

A health carrier must file and receive prior approval for sample contract forms it will use to contract with providers and facilities. Once approved, the carrier may begin the contracting process. If material changes occur to template contracts during the negotiation process, they must be filed 15 working days prior to use. It is critical that a new carrier understand what constitutes a "material change" to its sample provider contract forms. Some changes will always be considered material, such as a deletion or addition of a term. Others, such as payment rates or amounts, need not be filed, as carriers are not required to submit contract provisions governing payment rates.

These filing requirements include the entire chain of contracts between the carrier and its providers. Carriers that use a third party leasing arrangement are still responsible for the

content of the leasing entities agreements. In this scenario, leasing arrangements with third parties and downstream providers, and facility contracts must be filed for prior approval with the Insurance Commissioner's Office.

All rate and form filings must be submitted using the System for Electronic Rate and Form Filing (SERFF). A new filer to the SERFF system must contact the system administrator through the NAIC SERFF marketing team to initiate the purchase and setup of the SERFF system. The NAIC SERFF team regularly conducts industry staff training for the proper use of its filing system. If a carrier has already established itself as a SERFF user in one of the other 23 states, its staff will need limited training to learn Washington state-specific filing requirements. General filing instructions, checklists and submission requirements for Washington state also offer guidance when using the SERFF operating system.

History has shown that one of the most effective ways to overcome rate and form filing hurdles is for the carrier to arrange for a face-to-face meeting with the rates and forms staff during the licensure process and prior to submitting rate or form filings. It has been demonstrated that questions and concerns raised during this meeting make the initial filing process easier.

Contributors to success

The ultimate success of a cooperative health carrier may be dependent on a number of key elements. Foremost, a new carrier must be able to offer a distinct, unique advantage from other health carriers. This model may involve empowering members with a true sense of ownership through voting rights for all, involvement in the selection of the board of directors, etc. Because of the many changes in health care since the 1940's including cost, technology and distribution, the original Group Health pure democracy model may not provide a distinctive edge favoring success. Perhaps the modern credit union governance model could provide both a distinctive edge and structure to support cooperative success for a new carrier just entering the market. Other factors that may lead to success include:

1. Senior management with extensive experience in leading a healthcare insurance company.
2. Demonstrated organizational intent and ability to assure that comprehensive health care services will be provided in a manner to assure both their availability and accessibility.
3. A financially-responsible organization that can be expected to meet its obligations to its enrolled participants.
4. Procedures for offering health care services and offering or terminating contracts with enrolled participants that are reasonable and equitable in comparison with prevailing health carrier subscription practices and enrollment procedures.

Thank you again for the opportunity to offer my perspective on consumer-operated and oriented plans. I would be pleased to answer any questions that the members may have.

For further information:

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