Testimony Submitted to the Advisory Committee of the Consumer Operated and Oriented Plan Program

Thursday, January 13, 2011

Thank you for the opportunity to testify at today's hearing on Consumer Operated and Oriented Plans (CO-OPs). I am submitting this written testimony on behalf of Neighborhood Health Plan of Rhode Island. I have been asked as the CEO of a small, community-based health plan to share my perspective on the key elements of success, particularly items essential to successful management, and the challenges associated with setting up a new plan. I have also included recommendations for the CO-OP Program to consider as they develop the loan and grant requirements for the new program.

Key Elements of Success in Setting up a New Health Plan

1. Building Adequate Reserve Levels

The issue: The most significant expense a new health plan has to account for is meeting minimum reserve standards set by state regulators, typically informed by the National Association of Insurance Commissioners (NAIC). Reserves are used to cover liability beyond amounts factored into premium levels. NAIC recommended reserve levels are influenced by a profile of risk factors including the organization's asset risk, credit risk, underwriting risk, and other relevant risks.

In the early years, Neighborhood's reserve obligations were met by: 1) initial capital provided by the founding community health centers of Neighborhood, 2) initial capital provided by Neighborhood Health Plan of Massachusetts (as part of an administrative services agreement), and 3) legislation allowing a non-profit, majority Medicaid health plan (a plan like Neighborhood) to meet an unusually low minimum reserve requirement. The legislation provided Neighborhood with the time necessary to build up reserve levels and to begin to meet the NAIC standards required of other health insurers. After six years of financial losses, Neighborhood was able to secure a low-interest subsidiary loan from a local foundation. The subsidiary loan was important because it was an infusion of cash and, given its subsidiary structure, could be counted towards reserve requirements. The loan along with actuarially sound rates finally helped Neighborhood begin to accumulate adequate reserves.

Challenges: Given Neighborhood's nonprofit status it was difficult to secure capital to support the accumulation of reserves. Building adequate reserve levels will also be an issue for the new CO-OP plans. It will be challenging for many new plans to be profitable enough to meet reserve requirements and payback start-up and solvency loans and grants.

Recommendations:

- The CO-OP Program needs to require the new entity to submit a plan for accessing capital as a way to pay back any grant funding used towards reserve requirements
- To alleviate the pressure to pay back the reserve grant, the CO-OP Program should consider starting the repayment clock based on the health plan meeting certain critical thresholds such as the initiation of enrollment

2. Establishing the Health Plan's Infrastructure

The issue: In this era of large, national insurance companies, a start-up health plan can be considerably disadvantaged due to its lack of market recognition and credibility with health care providers and state regulators, including those overseeing insurance and the Exchange. To build its reputation quickly, the CO-OP will need to partner with entities capable of administering the many functions of an insurance company. The CO-OP will also need to put in place an experienced senior leadership team to lead the start-up of the organization. The CO-OP will need to demonstrate competencies in key health insurance functions including:

- **Information Systems** – licensing, subscription or usage of claims platforms, reporting systems, web portals, EDI portals, enrollment applications, interface maintenance, application hosting and support
- **Member Acquisition and Enrollment** – front end marketing, sales, data entry and imagining of enrollment materials, premium billing, and eligibility checking
- **Claims Administration** – entering claims data into the health plans payment system, paying claims for the right members to the right providers for the appropriate covered services, answering questions about claims status from members and providers, and coordination of benefits
- **Customer Service** – answering member calls regarding benefits, provider network and member correspondence (e.g., issuing ID cards, member handbook)
- **Provider Service** – identifying, credentialing and contracting with providers across the continuum: medical, behavioral health, ancillary (home health, durable medical equipment), pharmacies, nursing homes, rehabilitation and acute care hospitals; additionally, functions such as contract configuration, customer service, correspondence, and reporting will need to be supported
- **Pharmacy Management** – establishing a pharmacy benefit (formulary) and rules, pharmacist support, identifying poly-drug interactions, fraud and abuse programs, and mail-order
- **Medical Management** – utilization management, care management, disease management, and medical Policy/Clinical Guideline Development
- **Compliance Support** – ensuring all state and national regulatory requirements are met
- **Knowledge Services** – underwriting analysis, financial reporting, and Planning
- **Policy Maintenance** – overseeing benefits configuration, changes to benefits

When Neighborhood started, it relied on an administrative services contract with Neighborhood Health Plan of Massachusetts to provide the key health insurance infrastructure and experienced staff. Under the contract, Neighborhood Health Plan of MA (NHP) provided: IS infrastructure, claims payment platform, network development/contracting, and utilization management processes that were ready to launch when the health plan opened its doors. For Neighborhood of Rhode Island, working with NHP brought a shared mission for what a health plan can provide a community. The CO-OP plans should also consider if a similar non-profit, community-based health plan could benefit them in building their new organization.

The infrastructure needed to launch and run a health plan is considerable and CO-OP plans will need to find business partners (most readily in the form of vendors) to buy turn-key solutions to

perform key insurance functions. The CO-OP will need to understand its business needs enough to purchase these services and to identify reputable vendors who will reflect the CO-OP in their community.

Challenges: As a nonprofit start-up company, a CO-OP may have difficulty attracting and paying for experienced management. Initially, they will need to rely on consultants and vendors to help them put the infrastructure and staff in place to launch a successful organization.

Recommendation:

- The CO-OP Program will need assurances from the new health plans of:
  - an experienced Senior Leadership Team (Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Financial Officer);
  - demonstrated infrastructure in place;
  - adequate cash flow; and
  - key policies and procedures formulated
- The CO-OP Program should have the authority to help new plans with infrastructure assistance payment and technical resources

3. Developing Market Affinity

The issue: The new CO-OP will need to compete for participants in the Exchange alongside experienced, large, well-funded national companies. How the CO-OP distinguishes itself in the marketplace will be critical to its survival. The CO-OP plan will need ready access to a potential membership pool to meet initial enrollment commitments. The initial membership pool may come from connections made by the new CO-OP plan with providers and advocates.

For Neighborhood, we gained an initial membership base through our affinity with the state's Community Health Centers (CHCs). The CHCs founded Neighborhood and served as a critical channel for their Medicaid patients to join the health plan. The CHC affinity allowed the plan to build-up membership in a short period of time.

In addition to the CHCs, Neighborhood received strong support from the advocacy community (e.g., organizations concerned about children, low-income families and individuals, children with special health care needs, disabled adults as well as provider groups). We developed credibility with advocates because we demonstrated we were true to the mission of providing access to high quality health care. Over the years, Neighborhood has rarely strayed from its mission as demonstrated by: 1) advocating for members and consumers even when it did not benefit the plan directly, 2) significant improvements in access and quality of care, 3) high levels of Customer Service (Neighborhood's Customer Service is consistently ranked one of the best among all Medicaid plans), and 4) listening to our members input through Advisory Committees and our Member Ombudsman. These actions have helped to solidify our credibility with advocates and providers and have contributed to our current 69 percent Medicaid managed care market share.

Challenges: Ensuring an adequate membership base to successfully launch the new CO-OP health plan and quickly begin to generate sufficient enrollment.

Recommendation:

- The CO-OP Program should require an extensive market analysis of potential consumers and those likely to enroll in the CO-OP plan; the analysis needs to include a thorough description of expected competition under the Exchange and the CO-OP's plan for attracting members
- The potential CO-OP plan needs to describe how it will be distinguished from the competition
- Consistent with its mission as a CO-OP, the new plan needs to provide a robust plan to be a member-centered organization; this can includes ways to seek member input and involve members on key organizational committees
- The potential CO-OP plan needs to demonstrate an understanding of the provider market place and have in place commitments from providers to join the CO-OP's network

4. Creating High Quality Health Plans

The issue: Requiring CO-OP plans to develop an infrastructure to meet quality standards is essential to ensure members receive access to high quality care and services. A plan committed to high quality for its members is also able to distinguish itself in the market and gain credibility with advocates and providers.

For Neighborhood, the state HMO licensing regulations required NCQA accreditation. As a new plan this was a formidable task requiring an investment of resources – new staff had to be hired, consultants retained and fees paid to NCQA - to meet the standards and conduct the measurement required of accreditation. The state recognized the work associated with accreditation and allowed Neighborhood additional time to prepare. Our first accreditation survey took place four years after we starting enrolling members. Because accreditation was a commitment from the beginning, Neighborhood had no choice but to organize around quality and I believe we are a better plan as a result.

We grew with an embedded respect for, and understanding of, quality health care. We learned the value of measuring performance, analyzing data, and acting on results to make sure our members were receiving access to the right services at the right time.

Challenges: Preparing and paying for accreditation is a substantial task for a new health plan. As a result it takes a strong organizational commitment to ensure staff are adequately engaged in the process to prepare for accreditation.

Recommendation:

- Neighborhood endorses the use of NCQA accreditation standards in the development of the CO-OP plans; the CO-OP Program should require a comprehensive Quality Management Plan from each potential CO-OP plan
- New CO-OP plans need additional time to meet accreditation/quality standards given the considerable infrastructure and membership base that needs to be in place to make accreditation practical and meaningful
- The CO-OP Program should have the authority to assist new plans with meeting accreditation standards through payment and technical resources