FirstCarolinaCare
INSURANCE COMPANY

A PROPOSAL TO ENSURE SUCCESS OF CONSUMER OPERATED AND ORIENTED PLANS

EXECUTIVE SUMMARY: The Department of Health and Human Services ("HHS") could increase the likelihood of success of the Consumer Operated and Oriented Plan ("COOP") Program established under section 1322 of the Affordable Care Act by issuing rules that could enable existing small, nonprofit, consumer-oriented health insurers to fall within the definition of "qualified nonprofit health insurance issuer".

BACKGROUND: FirstCarolinaCare Insurance Company ("FirstCarolinaCare") is a unique managed care organization that is community-focused in all aspects of its operations. Established in 2000, it is a nonprofit, taxable member organization. Its sole member is FirstHealth of the Carolinas, Inc., a community board-governed 501(c)(3) hospital system with a mission to make health services accessible to everyone in its rural service area of south central North Carolina.

FirstCarolinaCare has approximately 17,000 members, chiefly in small employer groups in a seven county service area. In line with its parent organization's community oriented mission, FirstCarolinaCare's long term goal is to reduce the increase in the number of uninsured in the community. It also helps improve the health of the community through work-site health screenings and education.

Perhaps FirstCarolinaCare's most innovative program is FirstPlan, an affordable small group benefit product. Among other incentives, FirstPlan offers low wage enrollees a monthly cash subsidy to offset employee premium contributions. The subsidy is funded by FirstHealth of the Carolinas, which has contributed approximately $2 million in community benefit through FirstPlan. Of particular note is that fact that FirstCarolinaCare limits its target profitability from operations to from 1 to 1.5 percent. In 2005, FirstCarolinaCare exceeded this target and returned a pro-rata share of its profits to its clients.

PROPOSAL: FirstCarolinaCare embodies all of the characteristics of a qualified nonprofit health insurance issuer as set forth in section 1322 of the ACA, except for the fact that it has been in existence for ten years and has a proven record of making health coverage more accessible. In order to expedite the availability of nonprofit options in the insurance exchanges, HHS and the Advisory Board should consider drafting the applicable regulations so that willing companies like FirstCarolinaCare could restructure to meet the requirements of section 1322. The definitions of "affiliate" or "successor" could provide some flexibility in that regard.

A program based solely on start-ups may prove to be difficult to operationalize and slow to impact the market. There are significant barriers to entry for any start-up health insurer, including the cost of simply submitting an application, typically involving legal and consulting fees from $500,000 to over $1 million. Compliance with other state licensure requirements, such as network adequacy, may be a barrier to entry in many states. The length of time to complete the application and approval process will have a negative impact on the program. In North Carolina, for example, a start-up insurance

company application could undergo up to 12 to 18 months of review prior to approval by the Department of Insurance.

Once the licensure hurdle is overcome, another obstacle to viability is the financial risk posed by adverse selection. In a guaranteed issue environment, unhealthy people will have a greater incentive to buy coverage on the exchanges than healthy people while the tax penalty remains comparatively low. The exchanges may attract high risk enrollees with proportionally higher medical costs. This scenario suggests that a start-up under the COOP Program could operate at a loss for a significant period of time, resulting in instability. If entities established under the COOP Program cannot establish a good balance of actuarial risk within the critical early years of operation, they will not be sustainable, threatening the availability of the option. A company with an existing base of members and a history of sound financial stewardship would be better positioned to absorb and manage underwriting risk.

Other trends support the argument for building on the existing base of nonprofit plans. According to some industry insiders, the health insurance industry is heading for increased market concentration. Twelve health plans cover two-thirds of the enrollment in the U.S. commercial health insurance market. Analysts foresee that health reform is likely to push at least 100 independent plans with 200,000 members or less out of the business "as the plans are increasingly unable to invest in the infrastructure and technology to effectively manage care."[1] Congress and HHS should be concerned about that scenario, and should find a way for the COOP Program to take advantage of independent nonprofits and to help them survive and thrive in the post-reform environment.

There are a number of regional managed care organizations like FirstCarolinaCare. A report issued by HealthLeaders Interstudy using 2006 data listed over 100 small (less than 300,000 enrollment) nonprofit managed care organizations in 33 states.[2] Like FirstCarolinaCare, many of those organizations already are pursuing and accomplishing the aims of section 1322.

If existing plans could be included in the program, the funds available under section 1322 could be used immediately to expand coverage and build capacity to improve care management and cost-effectiveness. The return on investment of section 1322 funds would be much higher than if they were disbursed only to capitalize start-ups that may or may not be viable. Taxpayer funds would be used more efficiently, leading to long term savings.

The viability of the COOP Program and the exchanges would be enhanced if a way could be found to exploit the operational and management expertise of the small, consumer-focused nonprofit plans already working in their communities to improve access to care and health status. The prohibition in section 1322 on participation of existing insurers is a significant legal hurdle, to be sure, but the risk of failure of the program and excessive market concentration should not be ignored. If HHS would exercise its rulemaking authority to permit the participation of organizations like FirstCarolinaCare that meet all the requirements of section 1322 and do not exceed a certain membership threshold, e.g. less than 300,000, then the COOP Program will have a better chance of expanding coverage options in the market.

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[1] Alex Nussbaum, Wellpoint's Kleinman Sees Health Insurer "Oligopoly", Bloomberg Business Week. Retrieved June 25, 2010 from http://www.businessweek.com/news/2010-06-24/wellpoint-s-kleinman-sees-health-insurer-oligopoly-.html.
[2] Health Leaders/Interstudy. The Competitive Edge:Managed Care Directory. August 2006.

FirstCarolinaCare management would welcome the opportunity to provide the Advisory Board and HHS staff with more information about its programs and philosophy and to answer any questions about the concerns expressed above. For more information, please contact Rose Young at 910-715-8114 or ryoung@firstcarolinacare.com.