Testimony of
Sandy Praeger, Kansas Commissioner of Insurance and
Chair, NAIC Health Insurance and Managed Care Committee

before the

Consumer Operated and Oriented Plan (CO-OP) Advisory Board

January 13, 2011

My name is Sandy Praeger, and I am Commissioner of Insurance for the State of Kansas and Chair of the National Association of Insurance Commissioners' Health Insurance and Managed Care Committee. I appreciate the opportunity to appear before you today on behalf of the NAIC, which represents the nation's state insurance regulators, to talk about the new Consumer Operated and Oriented Plans that will be sold through Health Insurance Exchanges beginning in 2014. These plans may have the potential to provide consumers with a different model of coverage, one that has shown some promise in the limited areas where it has been tried to date. However, it is important that this Board recognize some of the unique challenges that CO-OP plans will face and the need to maintain a marketplace where all participants compete on a level playing field that protects consumers from abuse and insolvency. State regulators expect that CO-OP plans will be subject to all applicable state laws and regulations.

Challenges for CO-OP Plans

Nonprofit health insurance companies can face significant challenges in raising the capital needed to meet state solvency requirements, maintain a buffer against unexpectedly high claim costs, and expand their operations. While publicly traded insurers can simply go to the markets for additional funds, nonprofits must find other means of securing financing, which can be difficult. For this reason, many successful nonprofit insurers tend to maintain higher than average reserves. This difficulty may be compounded for CO-OP plans, which are required by PPACA to use any profits to lower premiums, improve benefits, or otherwise improve the quality of health care delivered to their members. It is unclear what limitations might be placed upon CO-OP plan reserves and whether such limitations might cause solvency concerns.

In addition to these challenges, which are unique to nonprofit plans, CO-OP plans will face the same formidable challenges that all new insurers face. The most daunting of these will be the difficulty of assembling a provider network and negotiating provider payment rates that allow them to be viable, all before they have amassed significant market share that will give them leverage in negotiations and make themselves attractive to providers. Furthermore, CO-OP plans will have to engage in substantial marketing activities to garner the name recognition necessary to attract the market share they will need to be successful over the long-term.

Need to Prevent Adverse Selection

Given these difficulties, it would be tempting to simply cut these plans some slack and reduce the regulatory standards that CO-OP plans must meet. I strongly caution against this course of action. These standards were put in place for a reason—to protect consumers. Furthermore, if there is one thing that insurance regulators have learned over the years, it is that insurers competing for the same purchasers must be required to play by the same rules. Failure to do so can lead to adverse selection, where carriers that operate under rules that are more advantageous to higher-risk policyholders attract those individuals, forcing them to raise premiums to account for higher claims costs, driving away the lower-risk policyholders that can get a better deal from carriers operating under different rules.

In any event, Congress was very clear in requiring that a CO-OP plan "meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health benefit plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b)."[1] This requirement is vitally important to preserve a level playing field for all and to ensure that CO-OP plans are neither unfairly disadvantaged nor held to a lower standard.

State Regulatory Framework

The cornerstone of insurance regulation is the requirement that all companies selling insurance within a state be properly licensed. Engaging in the business of insurance without a license is a criminal offense in most states, punishable by fine or up to 20 years in prison. A company's insurance license is what allows a regulator to undertake financial and market conduct examinations, audits, and to take regulatory action—everything from requiring corrective action to be taken to fines and revocation of the insurance license. Before approving an application for licensure, state regulators will review the company's business plan, the background of its key personnel and its finances. Typically, an insurer will obtain a primary license in its state of domicile, which undertakes this detailed review. If the company wishes to expand into additional states, it would then obtain a license to operate in those states as a "foreign" insurer. This entails a more expedited approval process, because the new state typically defers to many elements of the domiciliary state's review. However, states will often require that an foreign insurer satisfy a seasoning requirement by operating in the domicilary state for a number of years to demonstrate their ability to operate in accordance with all legal and regulatory requirements.

As a state regulator, one of my chief responsibilities is ensuring the solvency of the companies that operate in the Kansas insurance market. Insurers in Kansas are required to meet strict risk-based capital requirements that protect consumers by ensuring that the company maintains capital levels sufficient to pay claims that they are responsible for.

[1] P.L. 111-148 §1322(c)(5)

These capital levels are calculated for each company based upon the underwriting risk it has taken on by selling policies and upon the investment risk for the assets it holds. The finances of health maintenance organizations are regulated somewhat differently, because they share a portion of their risk with health care providers through capitation arrangements. HMOs are therefore required to meet net worth and depository requirements sufficient to ensure that they can provide promised health care services. Companies must file annual, quarterly, and supplemental financial reports that we use to monitor their financial condition and to coordinate financial regulation in every state where they operate.

It is absolutely critical for the protection of consumers from undercapitalized insurers that CO-OP plans be treated identically to other insurers or HMOs, depending upon how they are organized. If a CO-OP plan is organized as an insurer, it should meet the same risk-based capital standards as other insurers. If a CO-OP plan is organized as an HMO, it should be subject to the net worth and depository requirements required of other HMOs. Whatever new benefits might be offered to consumers by these plans will be for naught if they become insolvent and cannot pay claims or provide needed services to enrollees.

In addition to the critical protections afforded consumers by solvency regulation, there are a number of other important regulations in the area of consumer protections. HMOs and insurers offering products featuring provider networks must meet network adequacy requirements to ensure that a sufficient number of providers are available throughout the company's service area to provide timely services. As I already noted, assembling an adequate provider network with reimbursement levels that allow a new insurer to charge competitive premiums can be a substantial challenge. However, network adequacy requirements are core consumer protections and holding CO-OP plans to a lower standard would not be in the best interests of consumers, as doing so could lead to those with coverage being unable to access care and would create an unlevel playing field that would disrupt the insurance market.

CO-OP plans will also be subject to all state consumer protection laws, including state rating rules, which limit the variation in premiums attributed to certain rating factors, such as age and gender, and all new federal requirements included as part of PPACA. Finally, they will be required to abide by all state laws and regulations regarding marketing of insurance policies, including requirement in many states that all marketing materials be approved in advance by the state Department of Insurance.

In conclusion, I would like to thank the Board for inviting me to testify today. I look forward to any questions you might have and to working with all of you throughout the implementation process. Please do not hesitate to call on the NAIC or upon me if we can be of any assistance.