



AMERICAN ACADEMY *of* ACTUARIES

March 4, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIO-9983-NC
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

**RE: Planning and Establishment of Consumer Operated and Oriented Plan Programs;
Request for Comments Regarding Provisions of Consumer Operated and Oriented Plan
Program**

To Whom It May Concern:

On behalf of the American Academy of Actuaries'¹ CO-OP Subgroup, I am pleased to respond to the Department of Health and Human Services (HHS) request for comments on the planning and establishment of consumer operated and oriented plan programs (CO-OPs). This letter includes specific responses to the solicitation of comments. But we begin with general comments related to CO-OP formation:

- Our comments are based on an assumption that the Affordable Care Act (ACA), and specifically Section 1322, will remain as they currently are written. If Section 1322 or other provisions of ACA are modified, our comments might need to be updated to reflect those changes.
- Section 1322 of ACA allows HHS the ability to establish the CO-OP program. The creation and financing of a new CO-OP with federal loans and/or grants requires that it first be a licensed entity within its state of operation. While each state's licensing process currently differs to some extent, these state processes typically require a captive sponsor to engage several professionals to navigate the application process successfully. For most states, actuaries, certified public accountants, and other professionals (e.g., attorneys) play a central role in developing an application proposal. As a licensed insurer, the CO-OP also will require a reserve certification signed by a qualified actuary.²

The licensing process requires extensive financial reporting filings, including an application, strategic business plan, articles of incorporation, bylaws, organizational chart, establishment

¹ The American Academy of Actuaries ("Academy") is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² A qualified actuary is an actuary who is a member of the American Academy of Actuaries, who is qualified to perform such work, and who meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States as promulgated by the American Academy of Actuaries.

of minimum capital, pro forma financials, actuarial feasibility study, financial statements of the organizers, sample policies, business agreements, reinsurance agreements, vendor contracts, among other requirements. As the process often can be lengthy and detailed, we encourage HHS to coordinate its review process with that of the approving state.

HHS should utilize the information prepared for the licensing state as appropriate. This will avoid significant duplication and keep the entry costs down.

- Section 1322(c)(4) of ACA requires that “*profits* inure to the benefit of members.” The term “*profits*” has various meanings across the insurance sector. For example, today there are various non-profit organizations, such as mutual and fraternal legal entities. These organizations are established for the benefit of their policyholders, yet they often retain premium surpluses. This surplus is held to protect policyholders against adverse claims that may arise. State insurance laws recognize the importance of this needed surplus by mandating that organizations retain a minimum surplus level that meets risk-based capital (RBC) requirements. Surplus also provides greater flexibility for the mutual or fraternal non-profit entity to serve new members.
- We recommend that HHS appropriately allow for surplus contributions to allow CO-OPs to serve the broadest possible group. One approach would be to allow a CO-OP to retain *profits* as surplus for a period of time to allow the CO-OP to grow and serve its policyholders. Such surplus growth, however, should be limited from creating excess surplus and significant subsidies for new members at the expense of existing members.
- Actuaries play a central role in the establishment and management of health program solvency, evaluating new programs, and developing premium rates and financial projections for most health insurers. Members of the Academy, as well as other relevant actuarial organizations, adhere to the Code of Professional Conduct and Actuarial Standards of Practice, and, therefore, should be designated to provide the needed actuarial assessment in the CO-OP development process.

Our response to specific questions included in the request for comments follow.

II. Solicitation of Comments

A. Section 1322 (a) of the Affordable Care Act (ACA)

6. What specific details should be required in feasibility studies, business plans, and marketing plans provided by prospective applicants before any loan or grant award is made? What should be included in the scope and content of these studies and plans? What level of detail should be required at the time of application?

There are challenges selling to individuals and small employers. Some of the challenges may be mitigated by ACA provisions (e.g., exchanges), but these buyers are highly price-sensitive and they know more about their health conditions than the insurer. It is important, therefore, to determine that an applicant can handle both the general business issues associated with any start-up and the unique challenges associated with insurance for small groups and individuals.

Our comments on this issue address the second element—how to avoid many of the unique problems typically experienced in these insurance markets. The business plan should demonstrate that the

management team understands why earlier programs may not have worked and describe their plans to address those issues. To avoid common problems experienced by start-ups, the management team should have a plan for the following:

- Obtaining highly competitive contracts with important local hospitals and physicians;
- Securing competitive contracts for pharmacy and services outside of the local community;
- Establishing controls for out-of-network payments;
- Obtaining a data source on local fee schedules or the population being served;
- Attracting and retaining customers (both healthy and unhealthy);
- Developing a strong working relationship with at least one set of local providers;
- Realizing economies of scale (possibly by buying with other CO-OPS);
- Building programs directly aimed at gaps/weaknesses which exist within larger competitors;
- Connecting to the exchanges (and other selected distribution channels);
- Communicating with state regulators.

New organizations may be able to take advantage of innovations, such as Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), alternative networks, or other payment reform initiatives. Competing insurers, however, also may be using these programs as well. In any case, the pace of change may make it difficult to determine in advance which programs will provide a useful option for buyers.

In addition, many provisions in other sections of ACA will have a significant impact on programs that can be offered to individuals and small employers. The timing and implementation for these various provisions within each state should be tracked to evaluate the effect on enrollment, risk, and financial results for proposed CO-OPs.

Statewide programs in larger states are difficult to develop. So it will be important for CO-OPs to be allowed to focus on smaller geographic areas.

In its Oct. 4, 2010 letter to HHS responding to a request for comments on exchanges, the Academy's Exchanges Work Group included the following information that would be appropriate to include in the Stage 1 loan request and the Stage 2 grant and loan request.³ We have provided a few additional comments, as well.

For Stage 1 loans, CO-OP feasibility study applicants would submit an abbreviated business plan for their CO-OP to the appropriate federal authority that includes their proposed:

- a. *Names of board members;*
- b. *Disclosure of start-up capital and its source(s);*
- c. *Target market, including any unique aspects of the individuals or groups to be targeted;*
- d. *Target geographic regions;*
- e. *Provider network;*
- f. *Statement of intent to participate in the local exchange;*

³ American Academy of Actuaries' Exchanges Work Group letter to HHS on exchanges (Oct. 4, 2010): <http://www.actuary.org/issues/pdf/AAA%20Exchanges%20RFI%20response%20100410.pdf>.

- g. *Disclosure of outsourced activities and potential partners, including a “flow of funds” diagram;*
- h. *Identification of any unique aspects of the plan offerings that will benefit members and serve to make the market more competitive;*
- i. *Estimated total cost of the feasibility study along with the share funded by the CO-OP founders/investors.*

Stage 1 applications should provide enough detail and references that the reviewing organization can evaluate the management of the applicant CO-OP to ensure it has the expertise, qualifications, and background to operate a CO-OP in this challenging product market. As we understand the process, detail on the pro-forma, for example, would not be expected until the Stage 2 application.

Based on the variety of organizations providing testimony to the CO-OP Advisory Board, it is reasonable to anticipate that there will be numerous and diverse applicants. If HHS would like to see CO-OPs provide significant innovation in the health insurance marketplace, it may be valuable to encourage interested organizations outside the health insurance industry to apply, as long as they can retain the appropriate expertise. These organizations may benefit from the two-stage loan and grant process to fully develop, and hire or lease the expertise necessary for creating the needed business plan at the depth required for success.

For Stage 2 loans and grants, CO-OPs selected for additional investment or loans then would develop and file an in-depth business plan with their state of domicile with significantly more detail, including but not necessarily limited to:

- a. *All the items listed for Stage 1 loans above.*
- b. *Pro forma financial statements, including sufficient detail to confirm that the financial plans are viable while funding adequate surplus and meeting all requirements with respect to medical loss ratio and still repaying any federal monies as required. To the extent that the plan relies on federal loans or grants, such reliance should be fully described.*
- c. *A brief statement from each board member discussing his or her background and reason for being a board member, including any actual, perceived, or potential conflicts of interest.*
- d. *All other information required by the state of domicile for licensing a health plan/health insurer.*

The state then would determine whether the CO-OP should be awarded a license and be allowed to sell health insurance in its state and others. As the law states, we envision that CO-OPs will have to abide by all of the regulations applicable to insurers in any state, unless there is a good reason for exempting them from certain regulations.

These regulations include having a sufficient provider network, offering of qualified health plans, filing of rates and formulas (with the associated actuarial certifications), minimum loss ratio requirements, risk-based capital requirements, statutory financial reporting, etc.

We envision that the federal government will provide additional loan and grant monies (up to a predetermined limit) as a CO-OP works with the state and becomes fully operational.

As noted in our general comments, the licensing process within a state is often extensive including an application, strategic business plan, articles of incorporation, bylaws, organizational chart, the establishment of minimum capital, pro forma financials, actuarial feasibility study, financial

statements of the organizers, sample policies, business agreements, reinsurance agreements, vendor contracts, among other requirements. As the process often can be lengthy and detailed, we encourage HHS to coordinate its review process with that of the approving state, especially during the Stage 2 grant and loan process.

From the time loan or grant funds are initially paid out, until the time all loans have been repaid as required, regular status reporting should be in place to keep both the state of domicile and HHS informed of the CO-OP's progress. Items to be reported include expenditures versus budget as well as progress on various milestones such as network contracting, development of policy forms and rates, development of administrative capabilities, etc.

Contingency plans should be in place to address situations in which the co-op is failing to meet expectations or becomes insolvent.

The role of state guaranty funds with respect to insolvent CO-OPs needs to be clear, on a state-by-state basis.

8. What level of investment would be required by a qualified nonprofit issuer to develop sufficient health information technology systems necessary to operate a health plan in the health insurance Exchange market, including the use of electronic health records? Is there a minimum level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, enrollee characteristics, or other factors, and by how much? Are funding needs for this purpose different for any qualified nonprofit issuers that may already be in existence, and if so, in what way?

Start-up CO-OPs are likely to be relatively small, with a small share of the local market—at least in the initial years—if pricing is realistic. Even the largest health plans historically have not typically developed health information technology (HIT) for providers. We suggest, therefore, that CO-OPs should not be expected to develop HIT, but should demonstrate that they can link emerging technology with their local hospitals or physicians.

Question 10: What level of investment is needed to maintain appropriate fiduciary management and oversight, including setting actuarially sound premiums?

The initial investment contains three major segments:

- Capital required to set up the infrastructure necessary for implementation and administration of benefits (e.g., systems; policy forms; provider arrangements; financial reporting; product and premium development; marketing material and development of websites/agency relationships; etc. that will be employed to sell the products, contracting of vendors to support these functions, etc.);
- Capital required to subsidize any operational losses occurring until such time that the CO-OP has sufficient membership and premiums to fund claims and administrative expenses, including any interest payments on loans/grants; and
- The minimum RBC that meets the requirements of the state of domicile. Some states may have more rigorous RBC requirements for start-up entities than for ongoing companies.

The initial investment will be the present value of these three segments.⁴

Each prospective CO-OP should be required to demonstrate capital sufficient to fund these three segments as well as comply with the minimum loss ratio requirements for each market as required by ACA. This demonstration is provided in a financial pro forma and includes estimates of enrollment, premium levels, and expenses. A pro forma should be reviewed by a qualified health actuary and include comparisons to industry benchmarks for certain statistics, such as administrative costs per member at the end of a three-to-five year projection period.

Premiums need to be developed by qualified health actuaries who have full access to operational and expense information. It cannot be overstated how challenging it is to develop premiums for a new entity entering a new market at a time when underwriting, rating rules, and management approaches are changing (which will, by definition, disrupt the pre-reform markets). Any change can increase significantly the uncertainty associated with any type of rate setting. It will be critical for any pro formas and the corresponding rates to be reviewed by qualified regulatory health actuaries at HHS or at the state level to ensure reasonableness of assumptions, including scenarios reflecting moderately adverse conditions. Even in a stable environment (i.e., an environment in which the underwriting and rating rules have remained the same for a relatively long period of time), premium rates can be misstated due to the uncertainties associated with health care in general (e.g., changing technology, introduction of new drugs, changes in provider reimbursement levels, economic shifts, and changes in unemployment) and variability associated with the size of the specific insurance pool. Developing premium rates in the post-reform environment, when pre-reform experience may be of limited value because of all these changes, could be even more challenging. This is further complicated by the presence and interaction of some of the risk-abating provisions in ACA, such as temporary individual market reinsurance, risk corridors, risk adjusters, and the continuation of minimum loss ratios.

As noted in our general comments, members of the Academy, as well as other relevant actuarial organizations, adhere to a strict Code of Professional Conduct and Actuarial Standards of Practice. We recommend that any financial pro formas be developed or reviewed by qualified health actuaries who provide an actuarial memorandum discussing their development. We also recommend that any premium projections be developed by qualified health actuaries who provide an actuarial memorandum discussing their development.

Question 12: While “substantially all” of a qualified nonprofit issuer’s activities must be in the individual and small group markets, in what other markets or product lines, if any, would it be desirable for qualified nonprofit issuers to participate? For instance, could they participate in Medicaid or the Children’s Health Insurance Program (CHIP) and still satisfy the statutory criteria for being a qualified nonprofit issuer? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the small group market? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the individual market? To what extent would participation in other markets affect the viability of new qualified nonprofit issuers or their ability to satisfy the statutory criteria for being a qualified nonprofit issuer? What type of start-up costs are necessary and reasonable for establishing a qualifying CO-OP? What startup costs might be associated with establishing a private purchasing council?

⁴ The American Academy of Actuaries and the Society of Actuaries modeled possible capital needs under various scenarios. The paper can be found at: http://www.actuary.org/pdf/health/tech_coops_nov09.pdf.

Economies of scale are critical to the ongoing viability of any new start-up insuring entity. From this perspective, it would seem reasonable to allow the CO-OP the flexibility to enter multiple markets to achieve the critical mass of membership needed to be sustainable. Some markets, however, require unique skill sets that may not be readily transferable to other markets. A balance must be achieved between the resources required to support the various markets and the need to achieve greater membership.

One of the critical components required for any sustainable insuring entity is to negotiate provider contracts that enable the insurer to compete with leading carriers /HMOs in the market. The ability of an insuring entity to negotiate provider contracts usually is related to the number of members the insuring entity can deliver to the providers. Low-volume start-up programs typically have a more difficult time obtaining competitive contracts. Added volume can be achieved by insuring employees of large employers in the area. Insuring entities negotiate the same provider reimbursement levels for all their members. As a result, the entity's members in the individual and small group market enjoy the same provider discounts as its members in the large group market.

To date, insuring entities that focus only on the individual and small group insurance markets in a specific limited geographic area generally have not been able to enroll a sufficient number of members to reach the critical mass required to achieve long-term sustainability, although some have tried.

Administrative costs as a percentage of premium generally are higher for individual and small group plans than for large groups. ACA provides for lower minimum loss ratio requirements for the individual and small group markets than for the large group market. Enrolling large groups could help the CO-OP spread its overhead and capital costs over a larger membership. Constricting or limiting the markets of the CO-OP to individual and small group would introduce another barrier to long-term success.

The CO-OP, as part of its business plan, must develop and disclose its strategy for moving from its current condition to a fully functioning health plan. This strategic plan should describe the initial and ongoing capital required to fund the operational infrastructure for competing effectively in the marketplace and generating the required margin to repay start up loans/grants. The plan needs to identify the major assumptions regarding costs, such as officers' compensation, IT costs, compliance systems, and all fund flows outside the organization (including capital expense items).

As Section 1322 requires the CO-OP to use any profits to lower premiums, improve benefits, and improve quality of health care delivered to its members, it would be valuable for the CO-OP to incorporate reasonable controls on expense structures, including compensation (e.g., pay scales).

The CO-OP must identify the total capital required to fund all expenses until such time that there is sufficient premium volume to do so plus the capital for surplus requirements, as set by the state with jurisdiction. The start up should identify any other access to capital it will have in relation to its requested funding from the federal government.

The CO-OP needs to demonstrate that the officers/managers have sufficient experience in the insurance market to administer the plan and understand and manage its risk.

HHS loans and grants should not be subordinate to any other creditor. In addition, we recommend that HHS pre-approve any merger /acquisitions of CO-OPs. When a merger or acquisition occurs, HHS could request/require early repayment of loans and grants with respect to such activities.

Question 15: In evaluating applications for loans and grants, what actuarial and minimum plan enrollment criteria should be considered?

Recommended content for applications for Stage 1 is noted above in the answer to Question 6 above. The actuarial component of the application in Stage 1 includes identification of the source of actuarial support to be provided for the content in Stage 2 applications (e.g., resumes of the actuarial team that would be supporting the pro forma, premium rate development, and enterprise risk management program).

In Stage 2 loan and grant applications, as more detail is provided for the business plans, it would be valuable for the applicants to describe the assumptions used, as well as the potential range of assumptions and potential variation in results as the assumptions change. This information could be accompanied with an explanation of the risks surrounding each assumption. From this description, the reviewing organization (state and federal) potentially could determine the extent to which the applicant has researched and understands the health insurance market.

In addition, we recommend that, as part of the Stage 2 application, applicants include description of the risks inherent in a start-up plan and elements of risk management that would be appropriate for managing enterprise and insurance risk. Is there a plan, for example, to use excess loss or other reinsurance in order to manage risk? (It may be difficult to find reinsurance for a start-up CO-OP.) Does the CO-OP plan include transfer of risk to providers, and if so, how are providers planning to manage this additional risk transferred to them? Has the applicant considered the enterprise risk across the insurance spectrum? Does the applicant have a comprehensive plan to manage it?

When the CO-OP starts operations through the state exchanges, there is expected to be pent-up demand as coverage extends to individuals who previously did not have coverage. With no past experience on which to base premium rates, how will the CO-OP develop adequate rates to cover historic experience and account for change in underlying cost patterns with a new exchange population? An exchange will include factors that allow for risk adjustment and transitional reinsurance, but it will be important, especially in the first year, for CO-OPs to develop appropriate rates to cover average expected costs. It is difficult to recover from underpricing. If an applicant plans to offer aggressive initial rates, the applicant should describe its plans to establish appropriate rates while recovering from the effects of underpricing. Applicants should describe in their Stage 1 applications how they expect to develop appropriate rates. In addition, to the extent possible, they should identify the qualified health actuary they expect to use to support the development of appropriate rates.

A CO-OP's plan should include adequate RBC. The CO-OPs must meet all state licensing requirements, which include adequate RBC for solvency purposes. In addition, as a start-up plan, the CO-OP will need to show in its application how it will add to capital to continue to meet capital requirements for growth in membership and medical cost inflation. If membership does not grow, capital requirements will increase because of medical cost trend. With additional capital needed to cover membership growth, however, the increasing capital needs could be difficult for start-up plans to meet. As part of the business and financing plans, as well as a feasibility study, the applicant should describe how it plans to meet these growth requirements while still meeting the requirement

in Section 1322 that any “profits” made by the organization be used to lower premiums, improve benefits, and improve the quality of health care delivered to its members.

As noted in our general comments, we recommend that HHS provide for appropriate surplus contributions to allow CO-OPs to serve the broadest possible group and allow the CO-OP to grow and serve its policyholders. Such surplus growth should be limited from creating excess surplus and significant cross-subsidization of new members at the expense of existing members. The applicant should include in its business plan how adequate RBC for solvency and growth is defined for its organization. In addition, the applicant should include a description of how it plans to repay HHS loans and grants.

What is the effect, if any, if providers are anticipated to bear risk?

The effect is to lower a CO-OP’s risk. A CO-OP will need less capital if it passes on risk to providers. The capital requirements likely will not change significantly if the risk passed on is small (e.g., capitating primary care providers). The capital requirements could be much lower, however, in a situation in which the CO-OP enters into a global capitation agreement in which the CO-OP takes X percent of premium (e.g., 20 percent) to perform administrative duties and passes the rest of the premium on to the providers of medical care. Current RBC levels defined by the National Association of Insurance Commissioners (NAIC) reflect these differences in provider risk levels.

At this time, solvency requirements in most states are focused on insurance companies. With such potential new programs as ACOs, PCMHs, and CO-OPs, however, providers may take more responsibility for management and accept more risk. The CO-OP governing body may want to be familiar with the state approach to provider risk. For instance, do state regulators review a provider’s ability to take risk, level of understanding of risk, and how it might address such risk?

Providers could have a substantial positive impact on the performance of the program through better health management, effective resource use, and many other techniques. In addition, administrative costs could be much lower. Providers could get into financial difficulty, however, if they enter into agreements that pay them less than their costs or assume a level of health care management they cannot achieve. For example, providers under global capitation from a CO-OP may face losses if the CO-OP prices its products low, relative to market competitors to increase its enrollment.

Some states require risk-taking providers to hold reserves and meet minimum capital requirements. These requirements can be quite different from the requirements for insurers. With the creation of ACOs and PCMHs, more states may require additional provider groups to hold reserves and/or capital to support any risk the provider group takes.

The CO-OP, state regulators, and the reviewing organization for grants and loans should address providers’ financial soundness and risk management abilities if a CO-OP plans to pass on risk.

How would such criteria affect the financial soundness of the qualified issuer?

The financial soundness of the qualified issuer (i.e., CO-OP) would improve as more risk is passed on to providers. The financial soundness and ability to manage risk of the provider, however, also must be considered. The CO-OP that passes on risk may be required to hold additional liabilities.

As the CO-OP is the contract issuer, it retains responsibility for all claims, even those claims for which the CO-OP initially may have transferred risk to a provider group by way of capitation. Existing solvency requirements require surplus for provider risk contracts, although at a lower level.

If a provider group goes out of business, a CO-OP remains financially liable for claims incurred by its members for covered services. This might result in the CO-OP having to reimburse providers at higher levels than assumed when the premiums were being developed, thereby increasing CO-OP expenses. This illustrates a need for CO-OPs to retain surplus to protect their members during adverse circumstances. We recommend that HHS recognize that such provider non-performance risk exists and permit CO-OPs to hold sufficient capital to protect their members.

We welcome the opportunity to discuss any of these items with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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American Academy of Actuaries