DRAFT REPORT AND PROPOSED RECOMMENDATIONS FOR CONSIDERATION BY THE ADVISORY BOARD

Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program

March 14, 2011

The Center for Consumer Information and Insurance Oversight (CCIIO)

Advisory Board Chair
Allen Feezor
Advisory Board Co-Chair
Barbara Yondorf

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Members of the CO-OP Advisory Board

Advisory Board Chair

Allen Feezor, MA. Mr. Feezor most recently served as the Deputy Secretary of the North Carolina Department of Health and Human Services. He currently coordinates the Department's efforts to implement health reform. He previously held positions as the Assistant Executive Officer, Health Benefit Services, of the California Public Employees' Retirement System and as Chief Deputy Commissioner for the North Carolina Department of Insurance.

Advisory Board Co-Chair

Barbara Yondorf, MPP. Ms. Yondorf is the President of Yondorf & Associates, a health policy consulting firm. She currently serves on the board of directors of the Colorado Consumer Health Initiative in Denver, CO. She previously held senior positions with the Colorado Division of Insurance, the National Conference of State Legislatures, and the Colorado Department of Health.

Members in Alphabetical Order

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David A. Carlyle, MD. Dr. Carlyle is a practicing family physician and Co-Medical Director of Homeward Hospice in Ames, IA. He is Chair of Iowa's Legislative Health Care Coverage

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Rick Curtis, MPP. Mr. Curtis has been the President of the Institute for Health Policy Solutions in Washington, DC since 1992. Previously, he was Director of Health Policy Studies for the National Governors Association, Executive Director of the National Academy for State Health Policy, and Director of the Department of Policy Development and Research at the Health Insurance Association of America.

Terry Gardiner. Mr. Gardiner is the National Policy Director of the Small Business Majority. As a commercial fisherman in Alaska, he helped to organize fishermen cooperatives and served five terms in Alaska's House of Representatives. He also served previously as the President of NorQuest Seafoods in Seattle, WA.

Mark Hall. Mr. Hall is one of the nation's leading scholars in the areas of health care law and policy and medical and bioethics. The author or editor of fifteen books, including **Making Medical Spending Decisions** (Oxford University Press), and **Health Care Law and Ethics** (Aspen), he is currently engaged in research in the areas of consumer-driven health care, doctor/patient trust, insurance regulation, and genetics. Mark also teaches in the MBA program at the Babcock School and is on the research faculty at Wake Forest's University's Medical School.

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Margaret Stanley, MA, MHA. Ms. Stanley, currently retired, previously served as the Executive Director of the Puget Sound Health Alliance in Seattle, WA. She also held positions as Health Benefits Administrator of the California Public Employees' Retirement System and Administrator of the Washington State Health Care Authority.

Overview

The Affordable Care Act (Section 1322) created the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of new consumer-governed nonprofit health plans to operate with a strong consumer focus. In addition to providing consumers more choices, greater control, and greater plan accountability, the CO-OP program also seeks to promote better models of care. To encourage the establishment of CO-OPs across the country, the statute provides $6 billion in loans to capitalize eligible prospective CO-OPs. The statute divides the loans into two types: start-up loans to be repaid in 5 years ("loans") and grants to enable CO-OPs to meet state insurance solvency/reserve requirements to be repaid in 15 years ("grants").

On June 23, 2010, the Comptroller General announced the appointment of a 15 member CO-OP Program Advisory Board to make recommendations to the Department of Health and Human Services ("the Department" or "the Secretary") on awarding loans and grants. The Board as a whole convened three times in 2011 (January 13, February 7, and March 14) to listen to expert panels and members of the public on how best to assure that sustainable CO-OPs are established. In addition, the Chair divided the Board into four subcommittees to address specific issues in greater detail and formulate proposed recommendations on the following topics: governance, finance, infrastructure, and process, criteria and compliance. The subcommittees presented interim recommendations for discussion at the February 7 meeting and final proposals for discussion at the March 14 meeting.

What emerged from these discussions is the conviction that the stated goal of the CO-OP provisions to foster the creation of these plans must provide the operational framework for the program. This means that the Department should develop flexible criteria that recognize the diversity of market conditions around the country and enable differing models of CO-OPs created and supported by different types of sponsors to develop. It also means that the availability of technical assistance at all stages of the process from loan application to licensure, to operation, will be important to the viability of individual CO-OPs and the success of the program.

The Advisory Board endorses four major principles for awarding loans and grants that inform all of the recommendations: (1) consumer operation, control, and focus must be the salient feature

of the CO-OP and must be sustained over time; (2) solvency and the financial stability of coverage must be vigilantly maintained and promoted; (3) CO-OPs should encourage greater care coordination, quality and efficiency to the extent feasible in local provider and plan markets, and (4) The program and first loans should be rolled out as expeditiously as possible (by the end of 2011) in order to provide CO-OPs the maximum opportunity to compete in the Health Benefit Exchanges in the first open enrollment period to enhance their ability to repay loans.

The report first will provide a summary of the recommendations. The details related to each recommendation are provided in the separate subcommittee reports attached at Appendix A. Appendices B and C will provide an explanation of the CO-OP provisions of the Affordable Care Act and describe in more detail the proceedings of the three Advisory Board meetings. Appendix D will address definitions used by the Board in making recommendations.

Summary of Recommendations

The recommendations presented below are organized according to the topics considered by the Advisory Board: governance, finance, infrastructure, and process, criteria and compliance. The Advisory Board formulated the scope of the recommendations to address issues relevant to both the unique mission of the CO-OPs and the creation of any new health insurance plan in the market anticipated after 2014.

Governance Recommendations

In considering the organization and structure of prospective CO-OPs, the Advisory Board heard extensive testimony on the role consumers should play in governing the CO-OP and the importance of sustaining consumer control over time. Testimony from experts and the public also underscored the need to have a wide range of expertise and technical resources available to board and management to achieve successful operations and the benefits of including providers in the organization of the CO-OP to assure adequate provider networks and improve the delivery of care.

The governance recommendations are designed to support diverse requirements for CO-OP success while ensuring that consumer control and focus remain. Accordingly, the Advisory Board provides guidance on the definition and role of CO-OP members, the composition of the Board of Directors (BOD) and the ethical standards to which they should adhere, the strategic alignments prospective CO-OPs could develop with providers, the definition of eligible organizations, and the constraints on contractual relationships and conversions to avoid weakening or eliminating consumer control.

Listed below are the recommendations adopted by the Advisory Board. The detail associated with each recommendation is in the governance subcommittee report at Appendix A.

1. A "Member" is defined as the individual insured life; a small employer would also qualify as a "member" provided s/he is insured through the CO-OP.

2. The governing body of a CO-OP is the board of directors (BOD). The BOD will be composed of Directors who meet state-of-the-art ethical, conflict-of-interest, and disclosure standards. There may be an initial formation BOD that will evolve into the

operational BOD. If this is the case, the applicant must describe the plan to transition to the operational BOD. The application should contain descriptions of the proposed BOD, both initial formation and operational, and describe how each is consistent with the goal of consumer governance. Prior to operation of the CO-OP, the initial BOD should include persons who will be eligible to purchase health insurance from the CO-OP to the extent possible. If there is a change in the governance structure of the CO-OP, the Department must be notified.

3. Every member of the operational BOD should be elected by the full voting membership of the CO-OP, and elections should occur within the first year of enrollment or at a designated membership level (e.g., 5,000), and should not be postponed beyond the second anniversary after beginning operations. There should be a preference for creation of a nominations committee to identify eligible director candidates to assure adequate expertise on the BOD, and choice among qualified candidates**.**

4. At least a clear majority of the voting seats on the operational BOD must be reserved for members, although the Advisory Board expresses a strong preference that such members constitute a larger proportion of the BOD. The remaining voting participation could come from designated groups or classes such as small employers, providers, or community and business leaders. Each director, regardless of class, has one vote. CO-OPs should put in place necessary protocols to assure that no particular interest group other than members exerts control or excessive influence in the governance of the CO-OP.

5. Directors who are not members of the CO-OP should be selected because they bring a specific set of expertise to the BOD (e.g., finance, actuarial, quality of care, market expertise, or human resources). Applications for loans/grants should describe the expertise being sought from non-member directors. This is consistent with testimony presented to the Advisory Board about the importance of providing for needed business and finance expertise on the BOD. If the applicant determines that non-member representatives would comprise a significant minority of the BOD, the applicant must demonstrate how the CO-OP will maintain strong consumer focus and control.

6. All applications for loans and grants under the CO-OP program must include a description of the following: the CO-OP's mission and how it intends to meet the goals of "consumer focused" and "consumer oriented;" the proposed BOD (both the initial formation and operational) selection and how its composition is consistent with member choice; and the BOD nomination and election process, its conflict of interest safeguards, and how it assures adequate expertise in governing the CO-OP.

7. To be eligible to apply for loans and grants under the CO-OP program, the applicant shall have legally formed the relevant nonprofit entity prior to completing the applications. A nonprofit cooperative under state law is an eligible entity. The entity will present to the Secretary evidence of such organization at the state level with the application for funding under the program.

8. Section 1322(c)(2)(A) of the Affordable Care Act states that any organization that was a health insurance issuer – or related entity or predecessor – on July 16, 2009, is ineligible for loans and grants under the CO-OP program. For purposes of determining applicant eligibility for the CO-OP program, a health insurance issuer is defined as an entity that is regulated by any state Department or Commission of Insurance and is licensed as an issuer by the state. Examples of entities that would not meet this definition include Taft Hartley plans, existing risk-bearing entities that provide health care coverage and are exempt from state insurance regulation(e.g. self funded plans), and nonprofit organizations that do not bear risk.

9. Certain predecessor organizations should be eligible for loans and grants. A nonprofit organization that was a health insurance issuer on July 16, 2009, and was (1) organized to provide partially subsidized health care coverage for the uninsured or the under-insured as reflected in its stated mission at the time of its organization and (2) has a small market share can apply for a loan or grant under the CO-OP program under certain conditions. These conditions include: the pre-existing organization has ceased to exist legally, none of the liabilities of the pre-existing entity are assumed by the new organization, and the new organization can present to the Secretary acceptable legal evidence that this has occurred. The former managers, directors, or affiliates of the pre-existing organization

cannot exert disproportionate influence on the new organization, and no members of the BOD of the pre-existing entity may serve on the BOD of the new entity. The new entity must be able to demonstrate to the Secretary that the entity's mission is consistent with the intent of the CO-OP program and that it conforms to the requirements of the statute and regulations. If the nonprofit organization is sponsored by another organization, the sponsoring organization must also be a nonprofit. This recommendation provides a mechanism for small nonprofit plans with consumer-oriented missions to restructure and possibly participate in the CO-OP program, thereby expanding access to CO-OPs and supporting the establishment of CO-OPs with greater stability and market impact.

10. A CO-OP can be formed by the participation of a variety of organizations including but not limited to nonprofit organizations, professional group practices, or business entities but the resulting CO-OP must be principally governed by its members. The formation team must assure that their involvement will not compromise the consumer focus or the operational control of the CO-OP by its members and that the goals of the statute are maintained.

11. A CO-OP may enter into a formation relationship with provider-based entities owned by or affiliated with state universities or other governmental instrumentalities, and such providers can participate in operations and management within the constraints previously set forth. Providers associated with health organizations affiliated with state and local authorities (e.g., state universities and local health authorities) may participate in CO-OP governance provided that they are not employees of a governmental entity or instrumentality and they do not constitute a majority of the formation or operational BOD. The CO-OP itself cannot be operated by a governmental unit since it is operated by a majority vote of its members as previously described. This allows providers associated with, but not employed by, government entities to participate in the health care delivery system of the CO-OP.

12. A CO-OP may contract with an existing issuer to provide Third Party Administrative (TPA) services. The contract with a TPA must assure that there is no undue influence by the TPA management on the CO-OP's management or operations. The contract must

meet business standards of arms length contracts and the approval of the BOD is required for the retention of a TPA and provider networks. BOD approval of other contracts that affect a significant proportion of plan operations is also recommended.

13. In addition to any approval required by state regulators, loan and grant agreement should specify that the Secretary's approval is required for a conversion or sale to a for-profit or non-consumer operated entity for the life of the loan or grant plus 10 years. The Advisory Board felt strongly that CO-Ops could provide needed new dynamics to the health care market place and hence should not be subsumed by other insurance issuers. Yet it was recognized that the question of conversion will arise. In the event of a potential conversion or sale, the Secretary should consider the effect of conversion on access to care, competition, quality of care, consumer accountability, and consistency with the overarching goals of the statute. A number of additional constraints on conversion, described more fully at Appendix A, should be imposed, including:

    a. The interest rate on the federal loans and grants should be reassessed to a market rate plus 5 percent, imposed from the day that the CO-OP drew down the original loan, and all loans and grants should be repaid in full at the higher interest rate before the conversion can occur.
    b. The CO-OP should retain an independent corporate valuation firm approved by the Secretary to set a "conversion price" to be paid to the CO-OP by any party or group of parties that will be the successor organization. There should be substantial prohibitions on the ability of the BOD and management team to receive financial gain or participate in the governance/management of the converted entity.
    c. The entire "conversion price" should be used allow pay for members' future coverage from the new successor entity, purchase coverage from other insurers, or pay directly for members' health care from any source. The CO-OP should hold an investment equal to at least 25 percent of the voting shares of the for-profit successor in trust for the benefit of its members.
    d. IRS Section 510 (c) (3) has conversion requirements that should have parallel requirements for 501 (C) (29) :

"Upon the termination, dissolution or final liquidation of the Corporation in any manner and for any reason, the Board of Directors shall first pay or provide for the payment of all liabilities of the Corporation; all remaining assets shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code (or the corresponding section of any future federal tax code), or shall be distributed to the federal government, or to state or local government, for a public purpose."

Finance Recommendations

During its meetings, the Advisory Board heard a great deal of testimony from both invited panelists and the public that addressed the financing challenges new qualified nonprofit health insurance issuers will face. Some of these challenges include achieving adequate membership, competing with current insurers, and contracting with a sufficient number of providers at competitive rates. The testimony also emphasized how important it is for CO-OPs to be able to meet and even exceed state solvency requirements in order to protect consumers, maintain sufficient capital reserves to fund growth, and provide for future financial stability.

The Advisory Board considered the provisions of the statute that require a CO-OP to repay both the loans and grants, prohibit a CO-OP from using federal funds for marketing, and require substantially all of the activities of the CO-OP to consist of the issuance of qualified health plans in the individual and small group market. It also weighed public testimony on the importance of the immediate distribution of development funding and the need for prospective CO-OPs to have planning funds to conduct feasibility studies to determine whether it will be possible to create successful new nonprofit health plans in their markets that will be ready to participate in the marketplace in 2014.

The Advisory Board evaluated what information would be needed by the Department from applicants to assure that the funds are used to the best effect and go to organizations that are likely to succeed, be financially stable, and have the ability to pay back the loans and grants.

Listed below are the Advisory Board recommendations on finance. The detail associated with each recommendation is in the finance subcommittee report at Appendix A.

1. Loans should be provided in two phases: a Stage 1 Start-Up Planning Loan (planning loan) and a Stage 2 Start-Up Development Loan (development loan). The application for the development loan will also serve as the application for the grant to meet solvency requirements. Applying for a planning loan is not required; an organization may submit an application for a development loan and grant without submitting an application for a planning loan.

2. In awarding planning loans, the Secretary should consider the extent to which the applicant has or will have resources available to support the start-up of the organization. Those resources can be in a variety of forms: financial, community support, or donated services and expertise.

3. In order to receive a planning loan, an organization should be required to submit: proof that it has formed a nonprofit organization under state law; a description of the individuals who are involved in creating the organization, the organization's mission, state insurance requirements, target market, proposed provider network, proposed products, anticipated funding and contributed resources or support; and a budget for the use of the loan, including the development of a business plan to be submitted with the application for an development loan and a preliminary timeline.

4. In order to receive a development loan, an organization will be required to submit, in addition to the requirements for a planning loan, a detailed business plan, which should demonstrate that it is ready to engage in start-up activities and reasons supporting its likely success. The business plan submitted by the CO-OP applicant should describe the anticipated capital needs over time. The organization should submit an operating plan which will identify the milestones that it will reach before additional funding is released. A team of experts should help the Department evaluate the applications. The types of experts that could be included are accountants, actuaries, and individuals with expertise in the following areas: developing provider networks, starting health plans, approving loans to business entities, and reviewing cooperative formation and governance documents.

The distribution of development loans and solvency grants should depend on a CO-OP reaching identified milestones in the funding agreement and demonstrating that it has met applicable state regulatory requirements.

5. The Department should maintain regular communication with the management team of a CO-OP. In conjunction with state insurance regulators, the Department should monitor the performance of a CO-OP on a variety of measures to assess operations in its development as well as COOP finances.

6. CO-OPs should be able to accumulate reserves in order to provide for enrollment growth, economic scale, future financial stability, and stable coverage for consumers. The Advisory Board felt that this is consistent with the statutory requirement to use profits to benefit members.

7. The purpose of grants under the CO-OP program is to assist CO-OP plans in meeting state solvency requirements. The Department should structure the grants so that the relevant state insurance regulator will recognize them as meeting state determined reserve requirements.

8. The statutory provision requiring that substantially all of the activities of the CO-OP consist of the issuance of qualified health plans in the individual and small group markets should be interpreted to mean that substantially all of the insurance contracts issued by the CO-OPs should be to individuals or small groups. Recognizing that it may be difficult for a CO-OP to achieve growth and maintain economies of scale or financial stability if it has to rely solely on the issuance of policies or contracts to individuals and small employers, the Advisory Board recommends that the Secretary exercise maximum flexibility in interpreting "substantially all" and give applicants a number of years to meet this threshold.

Infrastructure Recommendations

The purpose of the infrastructure recommendations is to identify the basic functions, systems, and processes required for a CO-OP to succeed. In addition, these recommendations provide guidance on the key elements needed in a CO-OP application. According to expert witnesses, success of a CO-OP depends on a number of factors, including: being able to participate in the first open enrollment in the Health Benefit Exchanges; improving the quality and efficiency of care provided; developing an adequate marketing strategy to maximize enrollment; and capitalizing on administrative and clinical information technology. In order to achieve even the most basic levels of success, a CO-OP will require a well developed infrastructure that is sustainable in a competitive market place.

The Advisory Board offers the following infrastructure recommendations to aid in shaping CO-OPs into entities that have the greatest likelihood of success. The detail associated with these recommendations can be found at Appendix A.

1. The definition of "marketing" should not preclude the use of loans and grants for activities related to community outreach and education. CO-OPs should be permitted to use other sources of funds for direct marketing purposes, including premium revenue. Because adequate enrollment is essential to the stability and durability of the CO-OP, applicants should submit as part of their applications marketing plans that describe their strategies for building enrollment over time.

2. The Advisory Board supported the preference set in the statute for COOPS that provide integrated care. Accordingly, it recommends that each applicant be required to describe the (integrated care) model that it will use and why this model is appropriate for the applicant's service area. Because the Advisory Board recognizes that "integrated care" can encompass a variety of approaches to coordinating care, it refers the public to the infrastructure subcommittee report at Appendix A for further clarification on the definitions and examples of this concept.

3. In awarding loans and grants, preference should also be given to an applicant that includes a strong local network and model of integrated care over an application that

includes a statewide network with little emphasis on care coordination. The Advisory Board felt that new nonprofit health plans with strong local networks integrating a broad range of services are more likely to be successful and achieve the goals of the statute than those that emphasize a relatively weaker statewide network. The evaluation of the potential CO-OP's ability to provide statewide coverage should take into account the size of the state, both geographic and in terms of population, as well as the patterns of health care delivery and the ability of the CO-OP to improve access to care.[1]

4. Applicants for loans and grants should be required to discuss whether or not they expect to be operational for the Health Benefit Exchanges' first open enrollment period. Participation during the initial enrollment period would permit the new plans to take maximum advantage of the opportunity to enter the market at a time when individuals will be provided with coverage for the first time and potential enrollees may be more open to joining new health plans. However, it may not be possible for some new organizations to be fully operational by the end of 2013. Applicants that are unable to enter the market in January 2014 should provide detailed strategies to assure success in local markets, in subsequent open enrollment or marketing periods.

5. Applicants should describe the expertise of their development and management teams, and the Secretary should consider the relative strength of each applicant's management team in awarding loans and grants. Expert panels testifying before the Advisory Board emphasized the importance to the success of a CO-OP of a management team with insurance as well as care management expertise.

6. Applicants need to provide evidence that they are in building the CO-OP's provider network and that providers have expressed a commitment to contract with the new insurer on meaningfully competitive terms. During this stage, applicants should identify consultants/experts in provider network development, have an understanding of the network requirements for state licensure and to be a qualified health plan under the

[1] The Agency for Health Care Research and Quality released a "Care Coordination Atlas" in December,, 2010. Please refer to this report at: http://www.ahrq.gov/qual/careatlas/careatlas.pdf for further guidance on care coordination.

statute, and identify strategic alignments with providers that may affect the CO-OP's risk and member access to care.

7. Applicants need a plan to show how they are going to rent, procure, or develop needed financial and information technology (IT) systems. This plan should describe a functioning IT system that administrative, financial claims, and care coordination functions. To the extent that applicants intend to use integrated care models, they could describe their plans over time to encourage the use of electronic medical records and other IT designed to enhance the quality of care.

8. Applicants should describe their provider and their consumer complaint and resolution processes, including a discussion of how complaints will be used to improve the operations of the CO-OP plan. In addition, applicants will need to present a plan to build capacity for customer and provider service.

9. To the extent that applicants intend to rely on third party administrators (TPAs) and other vendors to provide any of the plan infrastructure, applicants should provide a management and operational plan that describes how they will manage, supervise, and integrate the contractors and the services and infrastructure they provide. To the extent that applicants have identified specific contractors, the management and operational plan should include information on the officers of the company, their backgrounds, the experience of the company, references from other clients, and other information to demonstrate that the applicant has conducted or is conducting appropriate due diligence in choosing its vendor(s) and that its vendors will be able to operate effectively.

10. Applicants should describe their proposed systems of quality oversight and improvement, or a timetable for developing such system. The Advisory Board recognizes that a CO-OP should meet the requirements to be a qualified health plan under the statute, including the requirement to implement a quality improvement strategy.

Criteria, Process, and Compliance Recommendations

The Criteria Process, and Compliance recommendations below were developed by the Advisory Board to lay out a framework for the CO-OP program operations going forward, provide a logical timeline for interested parties planning to apply for CO-OP funds, and offer additional guidance on how to foster CO-OPs that will be successful. These recommendations identify specific criteria, measurements, and other evidence that the Department may want to consider requiring of applicants or that may help in triaging competing applicants from the same state, should the Secretary determine that the available funding is not adequate to support all the applicants in a state. In addition, the recommendations provide guidance on how to sustain funded CO-OPs and identify CO-OPs most seriously at risk of terminating operations or defaulting on loans.

The Advisory Board offers the following criteria, process and compliance recommendations. The detail associated with these recommendations can be found in the criteria, process, and compliance subcommittee report at Appendix A.

1. The Affordable Care Act requires the Secretary to give priority to applicants that intend to offer qualified health plans on a statewide basis, utilize integrated care models, and have significant private support. "Private support" should be defined to include: committed funding, committed in-kind support, letters of intent from key stakeholders (e.g., provider groups) to participate in the CO-OP or its formation, and letters of support from key community leaders. The Advisory Board has concluded that a strong application from a regional applicant with substantial support and the potential to become statewide would be more likely to succeed than a weaker statewide proposal.

2. Assuming all applicants from a single state meet the basic criteria for consideration for an award, the Secretary should consider the following additional factors in prioritizing awards should the Secretary determine that the available funding is not adequate to support all the applicants in a state: non-profit business start-up experience, insurance expertise, a completed feasibility study and a draft business plan, readiness to enroll individuals and small groups no later than when the relevant Health Benefit Exchange selects/qualifies health plans for participation, new or innovative reimbursement models,

emphasis on care coordination, quality of care improvement, and demonstrated commitment to the CO-OP governance goals and objectives.

3. The Department should make every effort to help a CO-OP succeed by providing, or arranging for needed technical and management support as well as additional funding. Additional funding should be given to protect an investment already made, with the requirement that there would be closer oversight and more frequent reporting to the Department.

4. The Department could consider discontinuing funding for CO-OPs if they continue not to meet key operational milestones, growth and funding targets or the terms of the contract with the Department. This includes: failure to meet business plan benchmarks, falling enrollment that jeopardizes sustainability, audits indicating serious and ongoing financial problems, failure to meet requirements for a qualified health plan, quality of care issues, or a demonstrated lack of consumer support. In addition, funding could be discontinued if a CO-OP fails to meet state regulator solvency requirements or enters court-ordered bankruptcy. Although the Advisory Board hopes all CO-OPs succeed, it is necessary to have provisions in place to prevent continued federal funding if a plan is failing.

5. As an integral part of Department oversight, The Department should establish a process similar to that of commercial bank lenders for overseeing the use of loans by clients experiencing operational/financial difficulty. The process would be utilized for a CO-OP that is not meeting terms and conditions of its loan and grant agreement, but where the Department has concluded discontinuing funding is not in the best interests of the CO-OP, its members, or the Department. The purpose of the process would be to provide stronger and more frequent review of the CO-OP performance to prevent failure and closure of the CO-OP.

6. Applicants should be required to demonstrate early on in application process the engagement with local and state insurance regulators and knowledge of licensing requirements to assure that CO-OPs are able to obtain licensure and commence operations.

7. The Department should approach national foundations about providing technical assistance (TA) directly to applicants and funding recipients. Assistance should be available at every stage of the process from completing applications and developing business plans to launching the CO-OP to supporting operations, possibly through a dedicated TA center.

8. The Advisory Board recognizes that the need to compete for plan membership means that it will be highly desirable for new CO-OP plans to be ready to enroll members during the first open enrollment period offered by Health Benefit Exchanges. The Advisory Board also recognizes the amount of work and length of time required for CO-OPs to be able to be open for business on this timetable. In order to provide funding for CO-OPs to be ready to accept enrollment in late 2013, the Department should issue draft regulations in Spring 2011. It should issue final regulations and the loan/grant solicitation in Summer 2011, with the capability to receive and review applications in Fall 2011. Because participation in the Health Benefit Exchange is essential to CO-OP viability and the ability to repay loans and grants, a CO-OP should be able to participate in its state's Exchange regardless of the Exchange model adopted in the state. This is consistent with the "deeming" provisions of Section 1301 of the statute.

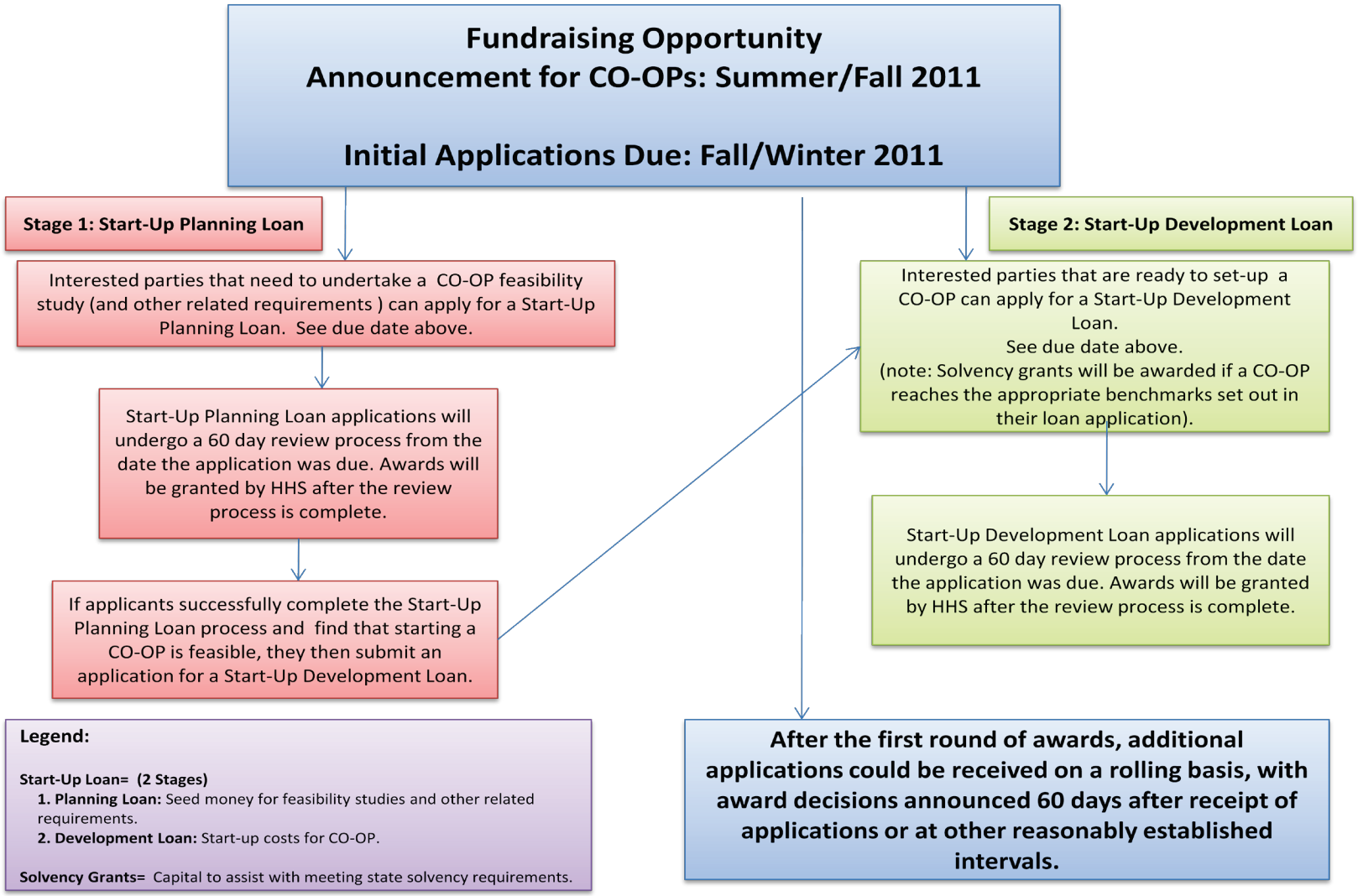
9. The loan repayment period should not begin until each CO-OP has achieved enrollment. It will be very difficult for CO-OP plans to begin repayment without first receiving enrollment revenues. Repayment must also be consistent with state solvency requirements.

To clarify these recommendations, the Advisory Board created the timeline and flowchart provided below.

Recommended Timeline for CO-OP Program

Appointment of Advisory Board.	June 2010
Publication of Request for Comments regarding CO-OP provisions of the Affordable Care Act in advance of future rulemaking and grant and loan solicitations.	Feb 2, 2011
Request for Comments period closes.	March 4, 2011
Advisory Board submits its recommendations in a report to the Secretary.	End of March 2011
Draft regulations on CO-OP program released.	Spring 2011
Final regulations released.	Summer 2011
Department begins receiving and reviewing initial applications.	Fall 2011
Department begins announcements of initial awards.	Late 2011/Early 2012
CO-OPs that intend to participate in Exchanges effective Jan. 14, 2014 are operational.	May 2013
CO-OPs that are ready to do so enroll first Exchange members.	Fall 2013
Statutory deadline for awarding loans and grants.	July 1, 2013
Statutory deadline for beginning distribution of loans and grants.	July 1, 2013
Advisory Board meets to review activities.	December 2012

Flow Chart for CO-OP Loan/Grant Process



Conclusion

As the recommendations reflect, prospective CO-OPs face substantial challenges in building new insurance plans that are governed by and responsive to consumers. Many of the challenges represent hurdles that must be crossed by any new health insurance entity, regardless of mission or structure. The need to move quickly to be operational multiplies the effort required.

Historically, the greatest barriers to market entry for new plans have been the need to reach adequate enrollment, the complexities of building appropriate provider networks, and the difficulties of raising sufficient capital to meet state solvency requirements. This program, combined with other elements of the Affordable Care Act including the ability to compete for enrollment in the Health Benefit Exchanges, significantly reduces those barriers by providing adequate start-up and solvency capital to give CO-OPs time to build enrollment and stability. These factors and the opportunity to participate in health coverage that promotes coordination of care should make CO-OP participation more attractive to providers. To succeed, CO-OPs must work energetically with their communities, experts, state regulators, and providers. If funds are distributed expeditiously, the goal of providing consumers across the country more choices, greater control, greater plan accountability, and better models of care can be realized.

Appendix A – Subcommittee Reports

Governance

Members: William Oemichen (Subcommittee Chair), Rick Curtis, Mark Hall,

1. Applicant shall have legally formed the relevant nonprofit entity or cooperative prior to completing the applications for CO-OP loan or grant funds and present evidence to this effect. *(Applicant is or has applied to be a nonprofit corporation)*

2. Member is defined as the individual insured life. *(A small employer would also qualify as a "member" provided s/he is insured through the CO-OP)*

3. A CO-OP can be formed by the participation of a variety of organizations including but not limited to nonprofit organizations, professional group practices, or business entities but the resulting CO-OP must be principally governed by its members. The formation team must assure that their involvement will not compromise the operational control of the CO-OP by its members and the consumer focus and the goals of the statute are maintained.

4. There can be multiple manifestations of private support for CO-OPs.

5. Prospective applicants must describe the CO-OP's mission and how it intends to meet the goals of "consumer focused" and "consumer oriented," providing specific examples of how it will achieve those goals.

6. The application should contain descriptions of proposed the board of directors, both initial formation and on-going operating boards, and describe how it is consistent with the statute.

CO-OP Board of Directors (BOD)

7. The BOD will be composed of Directors who meet state of the art ethical and conflict of interest standards.

8. There may be an "initial" Board that will evolve into the "operational" Board. If this is the case, the applicant must describe the plan to transition to the new operational Board.

9. Prior to operation of the CO-OP entity, the initial BOD should include persons who will be eligible to purchase health insurance from the CO-OP entity, to the extent possible.

10. BOD elections for the operational Board should be voted on by the full voting membership of the CO-OP and occur within the first year of enrollment or at a designated membership level (once the consumer membership has been determined). Failure to

reach the designated membership level should not result in the postponement of elections longer than the second anniversary after beginning operations.

11. At least a clear majority of the voting membership seats on the operational Board must be reserved for general members purchasing the insurance. There is a strong preference by the Advisory Board that consumer members constitute a proportion of the Board greater than a clear majority. To the extent that non member representatives would have a large minority share on the Board, the applicants would have to demonstrate how a strong consumer focus is maintained. The remaining voting participation could come from designated groups such as small employers, providers, or community and business leaders. Directors who are not members of the CO-OP should be selected because they bring a specific set of expertise to the Board, e.g. finance, actuarial, quality of care, market expertise, and human resources. Applications for loans/grants should describe the expertise being sought from non-member Directors. In general, no particular interest group represented by designated seats shall have control or excessive influence in the governance of the CO-OP. This may be accomplished through conflict of interest rules, structured Board composition, and/or by other mechanisms.

12. Each director, regardless of class, receives one vote.

13. Applicants must discuss how the proposed Board nomination process assures adequate expertise (e.g. finance, actuarial, quality of care, market expertise, and human resources) and consumer focus, while also ensuring that CO-OP members have a choice of Directors.

14. There should be a preference for creation of a nominations committee to nominate eligible director candidates for election by members to assure adequate expertise on the BOD, *and to the greatest extent possible, contested board elections.*

15. The Department must be notified if there is a change in governance from that provided in the original loan application.

CO-OP Conversion or Sale to For- Profit or Non-consumer operated entity

16. Specify in the loan/grant contract that the Secretary's approval is required for a conversion, sale, encumbrance, or disposition of all or substantially all assets, as well as any approval required at the state level, for the life of the loan or grant plus 10 years.

17. Standards for the Secretary's approval include evaluating the effect of conversion on access to care, competition, quality of care, consumer accountability, and consistency with the overarching goals of the statute.

18. Current and past Board members should be prohibited from participating in the converted entity post conversion or receiving any compensation in the form of salary, consulting

fees, ownership interest, and loans from any party at interest in the potential or actual transaction.

19. The interest rate on the federal loans and grants should be reassessed to a market rate plus five percent, imposed from the day that the CO-OP drew down the original loan and all loans and grants should be repaid in full at the higher interest rate before the conversion can occur.

20. An independent corporate valuation firm should be required to be retained by the CO-OP to set a "conversion price" to be paid by any party or group of parties that will be the successor organization to the CO-OP.

21. The entire "conversion price" should be used to provide a benefit to the members of the CO-OP at that time, on a pro-rata basis. Such a conversion benefit could be (as contemplated in the CO-OP section) used to provide future coverage by members in the new successor entity, or to purchase coverage from other insurers, or used to pay directly for health care from any source. Such a conversion price and/or benefit could be paid to a new non-profit corporation with the same members as the predecessor CO-OP.

22. The new non-profit should hold an investment equal to at least 25% of the voting shares of the for-profit successor in trust for the benefit of its members.

23. Require in the loan and grant agreement that the assets be used for the purpose for which the nonprofit has been formed, i.e. the purpose for which the CO-OP was formed, rather than for general public purposes and require approval of the state attorney general.

24. IRS Section 510 (c) (3) has conversion requirements that should have parallel requirements for 501 (C) (29) :

"Upon the termination, dissolution or final liquidation of the Corporation in any manner and for any reason, the Board of Directors shall first pay or provide for the payment of all liabilities of the Corporation; all remaining assets shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code (or the corresponding section of any future federal tax code), or shall be distributed to the federal government, or to state or local government, for a public purpose."

CO-OP Relationships with certain provider systems, third party administrators, and issuers:

25. Providers associated with health systems affiliated with state and local authorities (e.g. state universities, local health authorities, and community health centers) may participate in the CO-OP governance provided that they are not employees of a governmental entity or instrumentality and they do not constitute a majority of the development Board of Directors or operational Board of Directors.

26. A CO-OP may enter into a contractual relationship with provider-based entities owned by or affiliated with state universities or other governmental instrumentalities, and such providers can participate in operations and management.

27. The CO-OP itself cannot be operated by a governmental unit since it is operated by a majority vote of its members as previously described.

28. An existing CO-OP may contract with an existing issuer to provide Third Party Administrative (TPA) services provided that the contracts meet business standards of arms length contracts. Contracts with TPAs must assure that the contracts do not allow undue influence over the CO-OP's management and operations. BOD approval is required for the retention of third party administrators and provider networks. BOD approval of other contracts covering a significant proportion of plan operations is also recommended.

29. A nonprofit entity who was an issuer on 7/16/09 can establish a qualified nonprofit health insurance issuer eligible to apply for a loan or grant if the following conditions are met:

    a. The entity is a nonprofit organization or, if sponsored by another organization, that organization must also be nonprofit that has as its mission expanding coverage for the uninsured and the under-insured and was organized to provide health plans for these populations
    b. The entity accounts for a small share of the existing insurance market.
    c. The pre-existing organization will cease to exist anywhere as an entity, consistent with state law requirements, upon formation of the co-op and its cessation according to state law is verified by the affidavit of an attorney with knowledge of the underlying transaction.
    d. The CO-OP will assume none of the liabilities of the pre-existing entity; the existence of appropriate mechanisms for residual liabilities under state law is verified by the affidavit of an attorney with knowledge of the underlying transaction.
    e. There is no disproportionate influence exerted on the new organization by former managers, directors, or affiliates, and no members of the Board of Directors of the pre-existing entity may serve on the BOD of the CO-OP.
    f. The new entity is able to assure the Secretary that the entity's mission is consistent with the intent of the statute and that it otherwise conforms to the requirements of the statute and regulations.

Entities Not Covered By Statutory* Prohibition:
Health Insurance Issuer for purposes of this statute is defined as an entity that is regulated by any state Department or Commission of Insurance and is licensed as an issuer. Therefore, the following would not be considered issuers:

a. Taft Hartley Plans.
b. Existing health care coverage, risk-bearing entities exempt from state insurance regulation.
c. Nonprofit organizations that do not bear risk.

Statutory Language:

*** 1322 (E) Limitation on Participation. -** No representative of a federal , state, local government or political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

1322(c)(2)(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009.

Finance

Members: Donna Novak (Subcommittee Chair), Dr. Jon Christianson,

The Finance Subcommittee of the Consumer Operated and Oriented Plan (CO-OP) Advisory Board was asked to identify and provide guidance on key financial issues related to the awarding of loans and grants for the creation of new nonprofit health insurance issuers.

The Subcommittee's recommendations are related to: loan and grant application requirements; milestones for the release of loan and grant funds; expert reviewers of applications; meetings with CO-OP management; monitoring of CO-OP plans; financial reserves; grants to meet solvency requirements; and activities of the CO-OP plan in the individual and small group market.

A. Loan and Grant Application Requirements: Section 1322 of the Affordable Care Act provides for loans and grants to provide assistance to organizations proposing to become new nonprofit health insurance issuers. Loans are to provide assistance in meeting start-up costs. Grants are to provide assistance in meeting the solvency requirements of the State in which the organization will be licensed. Both loans and grants must be re-paid.

   It is the recommendation of the Advisory Board that loans be provided in at least two phases. The first phase, which is not required of applicants, would be a start-up planning loan ("planning loan"). The second phase would be a start-up development loan which would include the grant for solvency funds ("development loan").

   Below are the Advisory Board's recommendations on the information the Secretary should require from applicants for planning loans and development loans and grants.

   "CO-OP" as used in these recommendations refers to the nonprofit health insurance entities created under the Consumer Operated and Oriented Plan Section of the Affordable Care Act. These entities may include nonprofit cooperatives as formed under state cooperative law.

   <u>Planning Loans</u>

   The Advisory Board recommends that in awarding the planning loan, the Secretary take into consideration whether the applicant has or will have resources, either financial or in the form of community support and donated activities and expertise, available to support the start-up of the organization.

   1. In order to receive a loan for planning and the development of a business plan, an organization would have to submit the following:
      a. Proof that it has formed the relevant nonprofit business entity under state law

b. Description of the Development team
    i. Management – names and biographies
    ii. Advisors – names and biographies
    iii. Business partners
c. General plan
    i. Description of applicant mission
    ii. Description of insurance requirements with which the organization will need to comply
    iii. Description of Target market
        a. Geographic area
        b. Target market make-up, including unique aspects of the individuals or groups to be targeted
        c. High level description of the marketplace in which the applicant intends to operate including insurance competitors and likely availability of providers to partner with or contract with applicant including current relationships with those providers, if any.
    iv. Discussion of planned provider relationships
    v. Intended products (HMO, PPO, indemnity, etc.)
    vi. Anticipated non-Federal funding sources/contributed resources
    vii. Budget for the use of the planning loan including the development of the business plan and application for additional funds
        a. Budget items quantified with amount and timing
        b. Current funding sources available, if any, with funding level and timing
        c. Plan for developing feasibility analysis and preparing the business plan and application
        d. Identification of staff or consulting support for feasibility determination and business plan development

<u>Development loans and grants</u>

1. In order to be eligible to receive an development loan, an organization will have to submit the following:
    a. Evidence of coordination with the State department of insurance and plan to meet state and federal requirements including:
    b. Actively coordinating with insurance department
    c. Plan to meet insurance license requirements
    d. Plan for compliance infrastructure to meet standards for qualified health plans
    e. CO-OP governance and management
        i. (see Governance Subcommittee Recommendations)
    f. CO-OP business structure
    g. Departments and Divisions
    h. Initial management – names and resumes
    i. Business plan including:
        i. Statement of mission and objectives, including impact on market
        ii. Target market and enrollment projections

a. Geography
b. Type of membership – potential size of each and any unique characteristics
    i. Individual market
    ii. Small group market
    iii. Large group market
    iv. Medicaid
    v. CHIP
    vi. Medicare

j. Plan and timing to have "substantially all of the activities" of the organization consist of the issuance of qualified health plans in the individual and small group markets
k. Proposed marketing and sales plan
    i. (See Infrastructure Subcommittee Recommendations)
l. Proposed product and services designs; how these match up to needs of target market; including any characteristics unique to the marketplace
m. Operational model for CO-OP
    i. (See Infrastructure Subcommittee Recommendations)
n. Discussion of Provider network, provider commitments and medical and network engagement
    i. (See Infrastructure Subcommittee Recommendations)
o. Analysis of risk and opportunities and proposed risk management strategies and arrangements (such as reinsurance or provider risk sharing) market and competitive analysis including products and premiums charged by competitors in the market place
p. Financial and operational plans and projections
    i. 90 day detailed startup roadmap plan
    ii. First year plan – detailed
    iii. Five year plan or until target solvency requirement is met, if later
    iv. Pro forma financial statements with sensitivity testing for alternative enrollment scenarios and other changes in business assumptions
    v. Plan for timing of loan and grant repayment
q. Funding plan including:
    i. Timing of funding requirements until sustainable enrollment is reached including:
        a. Description of use of funding for each point in time where funding is anticipated
        b. Description of specific, measurable milestones to be reached before additional funding is received
        c. Amount of funding required at each milestone
    ii. Source of funding
        a. Potential and secured sources of funding for marketing (see Infrastructure Subcommittee recommendations)
        b. Amount of loan and grant funds needed at key points in funding requirement plan
        c. Amount of grant needed to fund surplus requirements

d. Description of known and anticipated sources of private support, financial or otherwise.
e. Contingency plan for unforeseen circumstances
f. Source and amounts of additional
g. Plan for other unforeseen circumstances

iii. A clear set of financial and operational performance measures that the management team and board will use to track CO-OP progress.

B. Milestones for the Release of Loan and Grant Funds: We recommend that the Secretary use the approved business plan and business plan milestones to determine the level and timing of loans and grants. Some examples would include:

a. Loan amounts as required in the business plan when:
   i. Application is approved for startup activities;
   ii. Deposit amounts for contracted services when the contract is signed and amount is required;
   iii. Per business plan for hiring staff and renting facilities as contracts are signed and staff hired;

b. Grant amounts when:
   i. Initial state deposits and solvency amounts as required;
   ii. Prior to first year-end (an subsequent as required by actual needs) to fund risk-based capital requirements based on CO-OP anticipated year-end financial statement;

C. Expert Reviewers of Applications: We recommend that the Department utilize a team of experts to evaluate the business plans of the CO-OPs. The types of experts that could be included on this team are actuaries, accountants, individuals with expertise in developing provider networks, individuals with expertise in starting health plans, individuals with investment experience with approving loans to business entities, and individuals with expertise in reviewing cooperative formation and governance documents

D. Meetings with management. The Advisory Board recommends that as part of its oversight of the CO-OP plans, the Department meet with the management team on a periodic basis even after the funding decisions have been made. As thought partners, the Department will be able to continue working with management to refine the business model and to help the CO-OP achieve its goals.

E. Monitoring of CO-OPs: The Advisory Board recommends that once a CO-OP is operational, the Department monitor its performance in various ways, to determine whether additional grant funds will be required. These could include the following:
   a. Review state financial examinations and solicit input from state regulators
   b. Monitor provider complaints regarding prompt payment
   c. Monitor consumer complaints
   d. Compare actual experience to the business plan on the following:
      i. Enrollment
      ii. Premium revenue
      iii. Medical costs

iv. Utilization
v. Net Income

F. Financial Reserves: Section 1322(c)(4) requires that a CO-OP's profits be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members. The Advisory Board recognizes that there may be a perceived tension between this requirement and the need of the new CO-OP plan to generate net income to fund growth and replace capital. It is the conclusion of the Advisory Board that the accumulation of reserves to provide for future financial stability and the ability of the CO-OP to grow is consistent with the use of profits to benefit members.

G. Grants to meet Solvency Requirements: We recommend that the Secretary structure grants in conjunction with state requirements so that they can be used to meet risk-based capital requirements. Since the loans and grants under the CO-OP program have to be re-paid, it will be necessary for each CO-OP to discuss the appropriate mechanisms for meeting reserve requirements with its insurance regulator and describe those mechanisms in its application.

H. Activities in the Individual and Small Group Markets: Section 1322(c)(1) of the Affordable Care Act requires that, in order to be a qualified nonprofit health insurance issuer, "substantially all of the activities" of the CO-OP must consist of the "issuance of qualified health plans in the individual and small group markets in each state in which it is licensed to issue such plans."

a. The Advisory Board interprets the "issuance of qualified health plans in the individual and small group markets" to mean issuing qualified policies or contracts to individuals and small groups.
b. Substantially all" has been interpreted to have a wide range of meanings depending on different situations and cases. Recognizing that it may be difficult for a CO-OP to achieve and maintain financial stability if it has to rely too heavily on the issuance of policies or contracts to individuals and small employers, the Advisory Board recommends that the Department exercise maximum flexibility in interpreting substantially all and give applicants a number of years to meet the "substantially all" test.
c. CO-OPs will need a firm base on which to build their business. In the initial years of operation, CO-OPs should be allowed to issue policies to, contract with, or administer a self-insured plan for, groups of more than 50 or 100, building their business to a point where they can meet the "substantially all" requirement of issuing policies to individuals and small groups. For example, a CO-OP may want to offer coverage to the providers in its integrated care network. The "substantially all" requirement should be looked at as something to be achieved over several years.
d. "Activities." The law states that substantially all of the activities of the CO-OP shall consist of the issuance of qualified health plans in the individual and small group markets. The advisory group interprets "activities" to refer to issuance or

contracting activities. Therefore if, for example, the substantially all test is defined as 65%, then a CO-OP would meet this test if 65% of the policies it issued were to individuals or small groups and the balance were issued to other purchasers.

Infrastructure

Members: Dr. Michael Pramenko (Subcommittee Chair), Dr. David S. Buck, Herbert C. Buchanan, Dr. David A. Carlyle, & Tim Size

1. The Advisory Board recognizes that the new CO-OP plan will be offered through the new health insurance Exchanges in 2014 and that this will provide a vehicle for consumers to be informed about the availability of the plan. The Board also recognizes that the Health Benefit Exchanges will have navigator functions to conduct outreach.
    a. The prohibition of the use of federal funds for marketing purposes does not prevent the CO-OP from using other sources of funds, including premium revenue for marketing.
    b. It is the recommendation of the Advisory Board that the definition of "marketing" for which federal funds cannot be used permit activities related to community outreach and education.
    c. Because adequate enrollment is essential to the stability and durability of the CO-OP, applicants should submit marketing plans that describe their strategy for building enrollment over time.
2. The statute indicates that, while not required in awarding loans and grants, priority in grant awards should be given to applicants who have private support, rely on integrated models of care and can operate on a statewide basis.
    a. The Advisory Board recognizes that integrated models of care can encompass a variety of approaches to coordinating care taking into account local provider markets.
    b. To receive priority in loan/grant awards, the Advisory Board recommends that applicants be required to describe the integrated care model that they will use and why it is appropriate for their service area. Integrated care will look different from community to community. The following definitions of Integrated may provide further clarification of this concept:
        i. Integrated Care can be defined as an approach to care that is exhibited throughout the CO-OP's operations and includes a **payment** process that incentivizes a system of care coordination to provide safe and clinically based **quality** health care (including preventive care) in the most **efficient** and **evidence-based** manner (which should include elimination of medical mistakes and avoidance of unnecessary consultations, services, emergency visits, and hospital admissions or readmissions). Such care coordination should be (1) comprehensive (including a chronic disease model incorporating, for example, behavioral health or diabetes care within a medical home), (2) patient-centered, (3) continuous in nature and (4) involve the patient (and family) in his/her care and health maintenance. It could require a **coordinator** (probably a primary care provider) and be coupled with health promotion and patient education. Team-based care should be developed to the fullest extent possible. Due to issues related to start-up, capacity limitations, geographic limitations on available provider resources, and patient choice, integrated care would not have to be mandatory for all members of the CO-OP and may require adaptations of the above-discussed models. Applicants who wish to receive priority on

this basis should present a plan to make the proposed model as widely applicable as possible to all members regardless of age, gender, ethnicity or socio-economic status. For example, for the purposes of this application, a detailed description of payment for patient-centered medical homes or use of Accountable Care Organizations as defined by CMS regulations would be one way to meet the criteria of Integrated Care.

ii. World Health Organization (WHO) definition: "Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."

iii. Other definitions of integrated care (taken from published articles, briefs) include: the seamless and coordinated provision of health care services, from the perspective of the patient and family, across the entire care continuum, irrespective of institutional and departmental boundaries; an approach characterized by a high degree of collaboration and communication among health professionals that involves sharing among team members of information related to patient care and the development of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient; and treatment-delivery models in which physicians work together to coordinate their patients' care.

3. It is the conclusion of the Advisory Board that new nonprofit health plans that have developed strong local networks integrating a broad range of services are more likely to be successful than those that emphasize developing a relatively weaker statewide network. For this reason, the Advisory Board recommends that in awarding loans and grants, priority be given to a strong application that includes a strong local network and a model of integrated care versus a weaker application that includes a statewide network. The evaluation of the potential CO-OP's ability to provide statewide coverage should take into account the size of the state, both geographically and in terms of population, as well as the patterns of health care delivery.

4. The Advisory Board recognizes that it is very desirable for new CO-OP plans to be operational in time for open enrollment in the Health Benefit Exchanges that will probably occur in late 2013.
    a. This would permit the new plans to take maximum advantage of the opportunity to enter the market at a time when individuals will be provided with coverage for the first time, and potential enrollees may be more open to joining new health plans.
    b. However, it may not be possible for some new organizations to be fully operational by the end of 2013. Some organizations may need additional time to develop and will need to wait to enter the market until the CO-OP is better organized and has developed a more comprehensive set of provider relationships.

c. The Advisory Board recommends that applicants for loans and grants be required to discuss whether or not they expect to be operational for the exchange's first open enrollment period and the rationale behind their decision.

5. The Advisory Board has heard a great deal of testimony from invited experts regarding the importance of a management staff that is experienced in insurance for the success of a CO-OP.
    a. The Advisory Board strongly recommends that applicants describe the expertise of their development and management team and that the Secretary take this into account when awarding loans and grants.

6. Applicants need to provide evidence that they have taken initial steps to "rent" established networks or have had preliminary discussions with a range of providers and that providers have expressed willingness to contract with a new insurer. Applicants should address the following:
    a. Identified consultants/experts in provider network development
    b. Applicants' understanding of the network requirements for state licensure and to be a qualified health plan.
    c. To the extent possible in their service area, any strategic alignments with providers that may affect the CO-OP's risk and member access to care that has been developed or is planned or anticipated.

7. Applicants need a plan to show how they are going to rent/procure/develop their IT system.
    a. This involves a description of their development of or contracting for a functioning IT system that includes both administrative and care coordination functions.
    b. To the extent that applicants intend to use integrated care models, they could describe their plan over time to encourage/maximize the use of electronic medical records and other IT designed to enhance the quality of care

8. Applicants should describe their system for a provider and consumer-focused complaint and resolution process. This should include a discussion of how complaints will be used to improve the operations of the CO-OP plan.

9. Applicants will need to present a plan to build capacity for customer and provider service.

10. To the extent applicants intend to rely on third party administrators (TPAs) and other vendors to provide any of the plan infrastructure, applicants should provide a management and operational plan on how they will manage, supervise and integrate the contractors and the services and infrastructure they provide. This should include information regarding the officers of the company, their backgrounds, the experience of the company, a list of other clients of the company, references from other clients, and other information to demonstrate that the applicant has conducted appropriate due diligence in choosing its vendor(s) and that its vendors will be able to operate effectively.

11. The applicant should describe its proposed system of quality oversight and improvement. The Advisory Board recognizes that a CO-OP plan should meet the requirements to be a qualified health plan under the statute, including a requirement to implement a quality improvement strategy.

Criteria, Planning and Compliance

Members: Barbara Yondorf (Subcommittee Chair), Allen Feezor, & Margaret Stanley

1. How should application reviewers evaluate multiple applications from a single state?
   [Note: PPACA allows for multiple CO-OP awards in a single state. The points raised here are to be applied where two applicants in a single state would have overlapping target populations and thus are unlikely to both be viable or where there are insufficient funds to make more than one award in a state.]

    a. Affordable Care Act states that the Department shall give priority to applicants that:
        i. Offer qualified health plans on a statewide basis,
        ii. Utilize integrated care models, and
        iii. Have significant private support.
    b. "Private support" should be defined to include,:
        i. Committed funding,
        ii. Committed in-kind support,
        iii. Letters of intent from key stakeholders (e.g., provider groups) to participate in the CO-OP or its formation
        iv. Letters of support from key community leaders.
    c. A strong application from a regional applicant with the potential to go statewide should be given priority over a weaker statewide proposal.
    d. Assuming all applicants from a single state meet the basic criteria for consideration for an award, the following factors, in addition to those listed above, should be given greatest weight:
        i. Non-profit business start-up experience;
        ii. Insurance expertise;
        iii. How far along in the process the applicant is (e.g., already has completed a feasibility study and has a draft business plan);
        iv. Greatest likelihood of being ready to enroll individuals and small groups no later than when state exchange selects/qualifies health plans for participation;
        v. New or innovative reimbursement, care coordination, quality of care improvement that the CO-OP may be undertaking that has a chance to change current market or stakeholder dynamics; and
        vi. Demonstrated commitment to the CO-OP governance goals and objectives.
2. After the first round of awards, additional applications could be received on a rolling basis, with award decisions announced 60 days after receipt of applications or at other reasonably established intervals.
3. Under what circumstances could the Department discontinue funding of a funded CO-OP?
    a. The Department should make every effort to help a CO-OP succeed by, for instance, providing technical/management support where needed and providing additional funding—along with closer oversight by, and more frequent reporting to, the Department—to protect the investment already made.

b. The circumstances under which the Department could discontinue funding of a funded CO-OP include:
    i. Failure to meet substantial conditions for any stage in the funding process or the terms of the contract with the Department.
    ii. Failure to meet state regulator solvency requirements or court ordered bankruptcy.
    iii. Ongoing irremediable problems in the following areas (not a comprehensive list):
        1. Failure to meet business plan benchmarks;
        2. Falling enrollment that jeopardizes sustainability;
        3. Substantial increases in, and continuing high levels of, consumer complaints
        4. Audits indicating serious and ongoing financial problems;
        5. Failure to meet the requirements for a qualified health plan
    iv. Quality of Care Issues
    v. Inability to maintain adequate provider capacity/network
    vi. Demonstrated lack of consumer control/support
c. The Advisory Committee recommends that the Department establish a process similar to that of commercial bank lenders for commercial loans to clients who may be experiencing financial or operational difficulties. The "special credit" process would be utilized for a CO-OP that is not meeting terms and conditions of its loan and grant agreement and where the Department has concluded discontinuing funding is not in the best interests of the CO-OP and the Department. The purpose of the process would be to provide stronger and more frequent review of the CO-OP performance to prevent a failure and closure of the CO-OP.

4. Should applicants be required to demonstrate engagement with local and state insurance regulators and knowledge of licensing requirements? What types of activities should be used as metrics of engagement with insurance regulators?
    a. Yes, this type of engagement should be demonstrated.
    b. For planning loans, examples of metrics include:
        i. Names, dates and summary of meeting(s), conversations with state insurance regulators,
        ii. Submission of list of relevant statutory and regulatory citations for licensure,
        iii. Names and bios of expert(s) in filing for a health insurance license with whom the applicant has been in contact and may/has contracted with.
    c. For development loans: submission of insurance license application by a date indicated in business plan as milestone for release of additional funds.
    d. For grant award: State licensure according to timeline in business plan.
5. Can the Department talk to foundations about supporting planning grants, providing technical assistance? What are the elements of technical assistance that could be provided to grantees?
    a. The Department should approach national foundations about providing technical assistance directly to applicants and grantees.

b. Assistance should be available at every stage of the process: putting together an application and qualifying for a planning loan, qualifying for a development loan, assistance, launching the CO-OP, ongoing operations.
c. Encourage the Department to create a TA center to support development and early operations of CO-OPs.
d. Examples of technical assistance could include providing advice and counseling on:[2]
    i. Establishing a private purchasing council involving multiple CO-OPs in a region or across the country;
    ii. Developing nonprofit health insurance company business plans;
    iii. Nonprofit board governance/training/ongoing education;
    iv. Building, contracting with, and maintaining integrated care networks;
    v. Maximizing consumer engagement and making optimal use of successful cooperative models.

6. Can CO-OP costs associated with forming Purchasing Councils be an element of the loan?
    a. Yes, the cost of Purchasing Councils can be an element of the loan.
7. The Advisory Board recognizes that the need to compete for plan membership means that it will be highly desirable for new CO-OP plans to be ready to enroll members during the first open enrollment period offered by Exchanges. The Advisory Board also recognizes the amount of work and length of time required for CO-OPs to be able to be open for business on this timetable. In order to provide funding for CO-OPs to be ready to accept enrollment in late 2013, the Advisory Board recommends that the Department issue draft regulations in Spring 2011. The Department should issue final regulations and the loan/grant solicitation in Summer 2011, with the capability to receive and review applications in Fall 2011. Because participation in the Health Benefit Exchange is essential to CO-OP viability and the ability to repay loans and grants, a CO-OP should be able to participate in its state's Exchange regardless of the Exchange model adopted in the state. This is consistent with the "deeming" provisions of Section 1301 of the statute.
    a. Loan repayment timing:
        i. It would be very difficult for CO-OP plans to begin payback without first achieving enrollment. Therefore the loan repayment period should not begin until enrollment has been achieved.
            1. Repayment must be consistent with state solvency requirements.

[2] The list includes the types of activities foundations might fund. For other critical activities (e.g., pricing the product, working with insurance agents, building IT systems), CO-OPs will need to hire consultants or staff, or look to a private purchasing council to assist in getting expert input.

Appendix B - Summary of Section 1322

Section 1322 of the Affordable Care Act requires the Department to establish a program to be known as the Consumer Operated and Oriented Plan (CO-OP) program. The purpose of the program is to foster the creation of consumer-governed qualified nonprofit health insurance issuers that will offer qualified health plans in the individual and small group markets. The qualified nonprofit entities will operate with a strong consumer focus, and any premium revenue that exceeds plan costs will be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members.

Pursuant to this section, the Department will make loans to such nonprofit entities to fund start-up costs and award grants to such non-profit entities to assist in meeting State solvency requirements. Loans must be re-paid within 5 years and grants must be repaid within 15 years, taking into account State solvency requirements. These awards are to be made no later than July 1, 2013. Priority for these loans and grants will be given to applicants that offer qualified health plans on a statewide basis, use an integrated care model, and have significant private support. If no health insurance issuer applies within a State, funds may go to award grants to encourage the establishment of a qualified issuer within the State or the expansion of another qualified nonprofit issuer from another State. Loan and grant funds may not be used for marketing or for carrying on propaganda, or otherwise attempting to influence legislation.

In order to qualify to receive loans and grants, an organization may not have been a health insurance issuer on July 16, 2009. It must be organized under state law as a member corporation and substantially all of its activities must consist of the issuance of qualified health plans in the individual and small group market. An organization that is sponsored by a State or local government, or any political subdivision or instrumentality thereof, is not eligible. The governance of the CO-OP must be subject to a majority vote of its members and its governing documents must protect against insurance industry involvement. The organization must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members. Representatives of State and local government and the insurance industry may not serve on the Board of Directors of the CO-OP. The CO-OP must comply with all the requirements that other issuers are required to meet in any State where they operate, including licensure.

Appendix C - Summary of Advisory Board Meetings

Meeting One: January 13, 2011

Consumer Operated and Oriented Plan (CO-OP) Program
Advisory Board
January 13, 2011
Agenda

1. Convening of meeting and roll call **8:00AM (EST)**

2. Introduction of members of the Advisory Board **8:05AM**

3. Welcoming remarks by Jay Angoff, Director, Office of Consumer Information and Insurance Oversight **8:20AM**

4. Overview of Section 1322 of the Affordable Care Act **8:25AM**

5. Consumer Operated and Oriented Plans: Concept and Feasibility **8:30AM- 9:30AM**

    - Sara Collins, Vice President for Affordable Health Insurance, Commonwealth Fund
    - Paul Hazen, President & CEO, National Cooperative Business Association
    - John Bertko, Senior Fellow at the LMI Center for Health Reform, Adjunct Staff at RAND, Visiting Scholar at the Brookings Institution, Visiting Scholar at the Center for Health Policy at Stanford and the retired Chief Actuary of Humana
    - Jay Ripps, Chief Health Actuary, Department of Insurance, State of California

6. The Role of the Consumer in Consumer Operated and Oriented Plans (CO-OPs) **9:30AM- 10:15AM**

    d. Elizabeth Abbott, Director of Administrative Advocacy , Health Access California
    e. Sabrina Corlette, Research Professor, Health Policy Institute, Georgetown University

B R E A K – 15 minutes

7. Starting-up New Nonprofit Health Plans **10:30AM- 11:30AM**

    b. Cindy Palmer, CEO, Colorado Choice Health Plans, San Luis Valley, Colorado
    c. Mark Reynolds, CEO, Neighborhood Health Plan of Rhode Island
    d. Mary Dewane, former CEO, CalOptima
    e. Amit Bouri, Director of Strategy and Development, Global Impact Investment Network

8. Elements of Success: Perspectives of Member-Run Nonprofit Health Plans **11:30AM- 12:30PM**

    b. Peter Farrow, CEO and General Manager, Group Health Cooperative of Eau Claire, Wisconsin
    c. Andrea M. Walsh, Executive Vice President and Chief Marketing Officer, HealthPartners of Minneapolis
    d. Diana Birkett Rakow, Executive Director of Public Policy, Group Health Cooperative

L U N C H – 1 hour 15 minutes

9. New Nonprofit Health Insurers: Perspectives from State Regulators **1:45PM- 2:30PM**

    - Sandy Praeger, Commissioner of Insurance, State of Kansas
    - Cindy Ehnes, Director, Department of Managed Health Care, State of California
    - Mike Kreidler, Commissioner of Insurance, State of Washington

B R E A K – 15 minutes

10. Questions and comments from the audience **2:45PM- 3:45PM**

11. Committee discussion **3:45PM- 5:00PM**

The Office of Consumer Information and Insurance Oversight (OCIIO)
Consumer Operated and Oriented Plan (CO-OP) Program
Advisory Board

Minutes of the Meeting
January 13, 2011

Meeting Convened at 8:00am

Committee members in attendance:

Buchanan	**Herb**
Buck	**David**
Carlyle	**David**
Christianson	**Jon- by phone**
Curtis	**Rick**
Feezor	**Allen- Chair**
Gardiner	**Terry**
Hall	**Mark**
Haugen	**Patricia**
Novak	**Donna**
Oemichen	**William**
Pramenko	**Michael J.**
Size	**Tim**
Stanley	**Margaret- by phone**
Yondorf	**Barbara- Vice Chair**

The purpose of this meeting was to assist and advise the DHHS Secretary and Congress, through the Office of Consumer Information and Insurance Oversight (OCIIO), on the Department's strategy to foster the creation of qualified nonprofit health insurance issuers. The Committee convened to discuss specific ways to advise the DHHS Secretary and Congress concerning the award of grants and loans related to Section 1322 of the Affordable Care Act. During the meeting, the Committee received input from five (5) panels that provided recommendations

regarding the grant and loan award strategy. The summary points below provide highlights of the main points discussed during and after each presentation.

Panelist Recommendations

Consumer Operated and Oriented Plans: Concept and Feasibility

Panelists discussed the importance of risk capital derived from investors and from a portion of the net income retained from operations. In the case of co-ops, initial risk capital will be provided by grants to be repaid within 15 years. Successful co-ops will grow in terms of membership, so risk capital will have to grow as well. It was argued that retained net income should be the primary way to raise risk capital. One concern is that in Sec. 1322, it states that any profits made by co-ops are to be given back to its members, suggesting that any net income should be used immediately for the benefit of the members. Key recommendations: (1) Loan and grant recipients should incorporate a policy in which premium rates are set with intention of generating net income; (2) A portion of net income should be set aside to either meet risk capital or to lower premiums, improve care, or go back to the members; (3) Co-ops should have to meet rigorous fiscal solvency requirements; and (4) High level of regulatory oversight should be in place to prevent problems.

The Role of the Consumer in Consumer Operated and Oriented Plans (CO-OPs)

Co-ops' governance must be dominated by consumers. Co-ops run the danger of either succeeding or failing. If they fail, this isn't good for anyone. If they succeed, they become target of opportunity for larger insurance companies to buy them out. Key recommendations: (1) Co-ops should have same requirements that apply to others, e.g., licensing, network adequacy, claims processing, cultural and linguistic access to care, reserve restrictions, and other financial and auditing requirements; (2) Co-ops must have a sustained program of oversight, including database monitoring, assessments, tracking of consumer and provider complaints, consumer numbers, etc.; (3) Consumer reps should represent the majority of the governing board; (4) Expertise from consumer reps should be drawn from a wide range of credentials; (5) There should be transparent written bylaws, including clear conflict of interest rules, in selection of board members; (6) There should be transparent, clear procedures in place; and (7) There should be insurance experts managing the plan.

Starting-up New Nonprofit Health Plans

Several of the panelists discussed the need for start-ups to anticipate higher front-end costs; have strong IT support; form a board with diverse skill sets and strong financial backgrounds; focus on staffing and a realistic timeline; rent infrastructure, particularly at the beginning; have a diverse set of investors, including impact investors; and design these businesses so that they have stable and consistent cash flows.

Elements of Success: Perspectives of Member-Run Nonprofit Health Plans

Some of the pathways that lead to success include having a mission focus and consumer governance; knowing your market; integrating care and coverage to assure absolute alignment of consumer interest; test, innovate, and redesign care delivery; keep administrative costs low; and assure appropriate financial reserves.

Key recommendations: (1) Co-op should be comprised of value driven partnerships with providers within community; (2) Co-ops should approach health care coverage for members across their lifespan; (3) Co-ops should be held to same standards as other health insurance plans to assure a level playing field, e.g., they should be accredited by National Committee on Quality Assurance; and (4) New co-ops should benefit from past and present experiences. Many co-ops throughout the country already exist; use these as examples of success.

New Nonprofit Health Insurers: Perspectives from State Regulators

Existing environment is not going to be easy to deal with. It would be tempting to relax regulations for co-ops; however, this doesn't protect the people. State regulators expect co-op plans to comply with all standards across the board. Assembling an adequate provider network can be a challenge; however, network adequacy requirements are in the best interest of consumers. Co-ops should talk to regulators early and get started as soon as possible. Most regulators will encourage this and will bend over backwards to be of assistance.

For future meetings, members of the Advisory Board were asked to divide their tasks into three (3) areas needed to effectively evaluate co-ops applying for grants/loans:

I. GOVERNANCE and LOOKING AT APPLICANTS

- Evaluate commitment level
- Assess ways to promote consumer support and consumer engagement and involvement
- Assess Leadership within community
- Evaluate Experience/Expertise
- Assess Community support

II. FINANCIAL AND BUSINESS PLAN

- Evaluate amount and type of capital that entity has and would be presenting; or entity's access to capital.
- Evaluate co-op's marketing plan, sustainability plan, pricing and product model
- Analyze risk management

- Analyze marketing and/or partnering issues

III. INFRASTRUCTURE

- Evaluate information technology systems (e.g., claims, accounting)
- Assess provider networks, e.g., vision of integrated or coordinated care
- Assess administrative structure
- Assess quality control and complaint resolution structures
- Evaluate regulatory relations, risk management, regulatory compliance
- Evaluate technical assistance, i.e., How do we keep failure rate down? We can suggest technical assistance and joint applications, for example.

Next meeting was scheduled for Monday, February 7th, 2011.

Meeting was adjourned at 5:00pm.

Public Testimony
January 13 Meeting

Council of Smaller Enterprises (COSE), Cleveland, Ohio

- A CO-OP must be able to operate on a dividend model. A surplus could be used to provide members with a credit towards their insurance premium. Only individuals who were members in the year in which the surplus was achieved would receive the credit.
- Question: Can profits be utilized for items such as wellness programs, health insurance education and perhaps other human resources programs?
- It is important to provide safeguards to prevent existing insurance companies from creating subsidiaries or entering into dominating relationships for the purposes of forming "fictitious" CO-OPs. However, the CO-OP must be able to contract with insurance carriers and other existing operations for back office functions.
- It is important to include safeguards that prevent providers from becoming CO-OPs in an environment that would foster a monopoly. If providers create CO-OPs it could increase provider power and lead to an environment with high health care costs and lower quality of care standards. In awarding loans and grants, the CO-OP program should test markets for competition to assure that no one provider or insurance company has the ability to dominate and control the pricing structure in a region.
- Request clarification on the marketing practices that are acceptable using federal funds
- Is it possible to require members to participate in wellness programs?
- Can CO-OP provide coverage outside of the Exchange?
- Request IRS to expedite requests for 501(c)(29) status.
- Recommend mechanism for preliminary funding to determine whether a CO-OP is a viable option.
- Require states to recognize grants not as loans, but as meeting reserve requirements.
- Repayment terms need to be as favorable as possible since it will be difficult for new insurers to repay the loans in face of competition from established carriers with considerable reserves.

Culinary Health Fund on behalf of HEREIU (Hotel Employees and Restaurant Employees International Union) Welfare Fund, Las Vegas, Nevada

- ERISA Self Funded Plans should be able to both form a CO-OP and participate as a self funded plan in the health insurance exchanges.
- Regulations should address the important role that the large employer market plays in supporting the start up of a sustainable entity which serves the individual and small employer market
- Regulations should allow for the creation of a parallel entity (to an unlicensed ERISA plan) under state statute which meets the requirements of the CO-OPs.
- Plans with a care delivery component should be given priority for grants.
- Regulations should not allow states to offer CO-OP support to models that match a not for profit with an existing for profit.

- There needs to be a mechanism for creating a state-licensed entity quickly (in Nevada)
- Superior plan management and a strong consumer voice will be required to sustain the plan long term
- Consumer boards must have a combination of patient advocates and plan management to keep the organization stable and pursue a long-term business plan
- Create CO-OPs by natural regions, not per state. Allow time for expansion.

Health Services Consulting, New Mexico

- Assist groups with technical assistance to conduct the population based and fiscal analysis to create a viable, sustainable member-driven CO-OP.

Consumers' Health Association of North Carolina, Lendy Pridgen, President,

- What can we do to access funds soon?

South Carolina Small Business Chamber of Commerce, Columbia, South Carolina

- A planning grant is necessary for our organization to have the resources to commission a feasibility study. This must be a grant; it cannot be a loan. The funds must be available in 2011 in order to allow the time necessary to conduct the feasibility study.

Roger Neece, Washington DC metropolitan area

- Funding for technical assistance must be available prior to September 2011 and cannot be in the form of loans

First CarolinaCare Insurance Company, North Carolina

- Permit organizations that are small, nonprofit consumer-oriented health insurers with membership under 300,000 and that embody the characteristics of a qualified nonprofit health insurance issuer to restructure to meet the requirements to be a CO-OP. The definitions of affiliate or successor should provide flexibility to accomplish this.

Freelancers' Union, New York, New York

- Social covenants should be built into the CO-OP program
- There needs to be a revolving loan fund

Western Growers on behalf of the National Council of Agricultural Employers, Vienna, Virginia

- Entities eligible to establish CO-OPs or convert into CO-OPs should include group health plans
- How does a subsidiary exchange relate to a CO-OP? Can an agricultural CO-OP be part of a subsidiary exchange?

Small Business Association of Michigan, Lansing, Michigan

- Can an organization limit the CO-OP to small business owners, their employees and direct family members, as opposed to making the cooperative available on the Exchange?
- Could a CO-OP offer a dividend if the claims experience is positive?
- Rule-making process needs to assure that existing health care or insurance organizations do not reinvent themselves to gain even more market share or market power.

Montana Health Cooperative

- A CO-OP must be able to be a health services corporation under Montana law; a mutual benefit corporation must pay premium tax.
- CO-OPs need a safe harbor from state "any willing provider" legislation

The Council of Insurance Agents & Brokers

- The prohibition against "insurance industry involvement and interference" should not be interpreted so broadly as to preclude CO-OPs from utilizing the assistance and expertise of independent insurance agents and brokers

Mark E. Rust, Esq., Barnes & Thornburg LLP, Chicago, Illinois

- Seek the advice of the National Organization of Life and Health Insurance Guarantee Association and work closely with the National Association of Insurance Commissioners to recommend a model approach to upfront reserves and the purchase of re-insurance so that the federal government has a standard on which it can risk capital, and founders of those CO-OPs, like our provider clients, understand what capital they will need ultimately to qualify to do business under state law.

The Evergreen Project, Baltimore, Maryland

- Regulations need to address multiple layers of funding dynamics to develop: (i) a definition for "profit" that allows appropriate risk based returns for capital invested, and (ii) rules regarding access to and use of the authorized reserve funds.

- Regulations should explicitly permit outside investment so long as it furthers the mission of the CO-OP venture.
- The process and timing for accessing the federal funding should be flexible.
- Permit CO-OPs to obtain outside capital, earn or receive profits as long as the revenue is reinvested in the CO-OP and allow investors a market standard return.
- The regulations should permit other legal structures that are not purely "non-profit" in nature.
- Permit a CO-OP a prominent position on health exchange websites
- Provide free or low cost reinsurance with guarantees provided by governmental entities
- Permit voucher acceptance of Medicaid patients at our clinics in order to allow us to care for entire families when one or two family members are on Medicaid. Require certain organizations to participate (hospitals, specialist centers) and provide their best rate to cooperatives in order to offset the inequity in pricing power that is currently available only to large insurers

Association for Community Affiliated Plans (ACAP), Washington, DC

- CO-OPs or existing Medicaid health plans operating in states that do not require NCQA or URAC accreditation should be allowed a grace period until 2017 during which they can work toward the necessary accreditation.

Workers' Cooperative National Association, Texas

- In order for CO-OPs to be more competitive, one association should handle the claims for all CO-OPs.
- There shouldn't be 40-50 CO-OPs with different principles

Sleep Apnea Association

- Sleep apnea should be recognized as a chronic condition and a disease management model should be used to treat sleep apnea

National Cooperative Business Association, Washington, DC

- The idea of retained earnings would not be contrary to CO-OP principles to build-up reserves.

Meeting Two: February 7, 2011

A G E N D A
CO-OP Program Advisory Board
February 7, 2011

8:30am EST Convening of Board and Introductions

8:40 – 9:40 Panel on technical development issues for prospective applicants

i. Insurance regulation overview – Brian Webb Manager, Health Policy and Legislation**.** NAIC
ii. Business plan development and adequacy – Vivian Riefberg, Principal. McKinsey & Company

9:45- 10:35 Report and discussion: subcommittee on governance

BREAK (15 minutes)

11:00- 11:50 Report and discussion: subcommittee on finance

LUNCH (45 minutes)

12:45- 1:35 Report and discussion: subcommittee on infrastructure

1:45- 2:15 Report and discussion: subcommittee on criteria and process

BREAK (15 minutes)

2:30- 3:30 Public Comment

3:30- 4:30 Board discussion

The Office of Consumer Information and Insurance Oversight (OCIIO)
Consumer Operated and Oriented Plan (CO-OP) Program
Advisory Board

Minutes of the Meeting
February 7, 2011
(To be approved at March 14 meeting)

Meeting Convened at 8:30am

Committee members in attendance:

Buchanan	**Herb**
Buck	**David**
Carlyle	**David**
Christianson	**Jon-**
Curtis	**Rick**
Feezor	**Allen- Chair**
Gardiner	**Terry**
Hall	**Mark**
Haugen	**Patricia**
Novak	**Donna**
Oemichen	**William**
Pramenko	**Michael J.**
Size	**Tim**
Stanley	**Margaret- by phone**
Yondorf	**Barbara- Vice Chair**

The purpose of this meeting was to assist and advise the DHHS Secretary and Congress, through the Office of Consumer Information and Insurance Oversight (OCIIO), on the Department's strategy to foster the creation of qualified nonprofit health insurance issuers. During the meeting, the Advisory Board received input from presenters who provided information and recommendations on insurance regulation and business plan development. In addition, three subcommittees reported back on their work addressing governance, finance, and infrastructure. The following summary highlights the main points of the presentations and subcommittee reports.

Business Plan Development

The first presenter explained the elements of a good business plan and outlined what to look for in evaluating competing applications for Federal support. The ideal is a talented management team that will develop a business model incorporating the best use of the funds and positioning the business to return the investment. Among the elements of a strong business plan are: a concise description of objectives; an overview of the proposed governance model; a management team with deep knowledge of and experience in core areas; a detailed plan for working with the full array of providers; detailed roadmaps for initial operations; a careful assessment of risks and opportunities; a detailed financial plan; and, a clear set of performance measures. The best plans are those that can anticipate and address unforeseen challenges. The panelist advised setting aside funds for further development and expansion.

Insurance Regulation Overview

This presentation began with a review of the requirements for starting an insurance company. All states participate in the Uniform Certificate of Authority Application, though some have additional requirements. Start-ups are required to have more cash or asset capital than are expansion operations. Where there is a parent or holding company, information on that entity is necessary as well. Solvency regulation protects policyholders against the risk that insurers will not be able to meet their financial obligations. The entity must have a surplus of 100 percent for new businesses, and 150 percent for expansions. States look at the underwriting risk, business risk, reinsurance, networks, contracting, credit risk, interest risk, market risk, and other elements. Audits are a key to ensuring compliance.

Discussion following the two presentations led to clarification of several points. In the private sector, lenders often provide technical assistance in order to help assure that their funds are returned. Although there is no surplus of expert evaluators, it would be valuable to find a way to provide additional expertise. Medicaid and similar programs may have risk adjustment models that could be used with the co-op program. The point at which a nonprofit insurance company must return profits to the members was debated; "rainy day funds" and expansion funding are allowed. The substantial investment by investors is another consideration, for which development grants are a possible solution.

Subcommittee on Governance

The charge to the Subcommittee on Governance was to review testimony, the statute, examples of co-ops in other disciplines, and innovative capital friendly designs, while also providing guidance on the issues raised. The Subcommittee made the following recommendations:

- Applicant shall have formed the relevant nonprofit entity prior to completing the applications for CO-OP loan or grant funds, and present evidence to this effect.
- Member is defined as the individual insured life.
- The Board of Directors (BOD) shall be composed of members who meet ethical and conflict of interest standards and disclosure requirements.
- The applying entity must be a nonprofit or, to carry out the purpose of the statutes:
    - Entity could own any legal subsidiary with controlling interest and proceeds to the parent;
    - Parent company of an applicant cannot be a for-profit entity;
    - Partnerships or joint ventures will be allowed so long as appropriate benefits accrue to the CO-OP members.

Remaining questions and unresolved issues were also detailed.

Subcommittee on Finance

The first charge to the Subcommittee on Finance was to identify and provide guidance on key issues raised to date: needed capital formation; forms of capital; solvency requirements and measurement; feasibility; and, business plan. The Subcommittee made the following recommendations:

- Loan application process should be done in stages.
- Stage 1 would provide funds for development of a full-blown business plan.
- Stage 2 would provide start-up funds to be phased-in based on the benchmarks in the approved business plan.

The Subcommittee was still discussing its second charge, to define factors to consider in approving applications for loans and grants. The Subcommittee also presented issues for discussion by the full Advisory Board:

- The statement "Substantially all of the activities of which must consist of the issuance of qualified health plans in the individual and small group markets."
    - Latitude of CO-OP plans to participate in large group market and public programs.
    - Ability to rely on enrollment from large employers in early stages and meet requirement over time.

Discussion of these issues centered on the degree to which the plans could change the health insurance market, how that might be accomplished, the role of the CO-OPs and large groups, criteria for the distribution of funds, and the percentage likely intended by the phrase "substantially all".

Subcommittee on Infrastructure

The charge to the Subcommittee on Infrastructure was to identify the basic functions, systems, processes inherent in successful CO-OPs and insurance issuers, and provide the full Board with an annotated listing of key/critical elements that should be present in any CO-OP application. The Subcommittee proposed the following recommendations:

- Marketing should not be defined to include outreach and community education efforts.
- Rather than assuming a particular model of integrated care, ask the applicant to describe the integrated care or care coordination model they will use and why it is appropriate for their area.
- Coordinated care is more important than statewide operation, which is very difficult. Some plans may be able to become statewide over time and should describe a plan for doing so.
- Experienced management with expertise in health insurance and finance is essential. Difficulty in recruiting experienced management to a new start-up organization might necessitate a reliance on consultants and vendors.
- In the area of provider networks, applicants need to provide:
    - Evidence that they have had preliminary discussions with a range of providers and that providers have expressed an openness to contracting with a new insurer
    - Evidence of an understanding of the provider contracting process
    - Where they will get the expertise to develop a network
- In the area of IT, applicants need to provide:
    - Appreciation of the importance of a functioning IT system and the difficulty of acquiring and operating one
    - Identification of consultants to assist with the choice of an IT system
    - Identification of vendors of IT system who will have capability of implementing by 2014

Public Comment

The Advisory Board held a public comment period. Speakers discussed the potential role of self-funded Employee Retirement Income Security Act (ERISA) plans; the difficulties and barriers potential CO-OPs may face in starting operations; ways in which existing CO-OPs might participate under ACA; board structure and involvement by individual employees and small

employers; CO-OPs outside the insurance arena as a potential model and resource; and, the use of revenue in a nonprofit, as well as the role of providers on the CO-OP board (See public comments below).

Conclusions and Next Steps

The Advisory Board agreed on a timeline for continuing work in order to discuss a draft report at the next meeting, March 14. The Board proposed two rounds of Requests for Applications for the Phase 1 development grants, as some groups are ready to respond and others require more time. DHHS anticipates that the applications will be peer-reviewed. Those who receive the Phase 1 grants will be eligible to then apply for Phase 2 grants.

Additional issues to be considered by the Board and DHHS staff include the mechanics of reviews, circumstances under which DHHS might discontinue funding a CO-OP, whether applicants should be required to meet Federal exchange requirements, the details of providing technical assistance, whether CO-OPs will be included in the exchanges, loan repayment, how best to deal with profits, and finding a way to deal with existing nonprofits.

Next meeting was scheduled for Monday, March 14th 2011.

Meeting was adjourned at 4:30pm.

Public Testimony
February 7 Meeting

Bobbette Bond, Culinary Health Fund, Las Vegas, Nevada

- The Advisory Board should consider a model that contemplates a path for ERISA plans to join in with the CO-OPs to provide many of the skills and much of the expertise they will need.

Roger Neece, ESOP Advisors, Inc.

- Marketing should not be defined as member outreach, member communications, product communication, or member development.
- Prospective CO-OPs will need funds before March, 2012.
- Applicants should be awarded $15 million for start-up.
- There need to be stages for loans and grants: an initial stage that is prior to the release of funds from HHS, then three stages of HHS loans and grants. The final stage is for grants – the organization must be licensed or nearly licensed to receive a grant.
- States will require $1 million to $10 million for guaranty funds. These should come from grants, not loans.
- It is difficult to find sources of matching funds – it would better to require these in stage 2 and consider in-kind contributions as matching funds.
- There is a concern about legal liability for the loan – taking a large loan from the Federal government is not prudent.
- The expectations from McKinsey & Company (testimony of Vivien Riefburg) for what would need to be included in a business plan are too high.

Emily Katz, CareOregon

- Define health insurance issuer to exclude safety net health plans as defined in Section 9010 of the Affordable Care Act.
- A regional approach is preferable to a statewide approach in Oregon.

Jerry Burgess, HealthCare21 Business Coalition of Tennessee, Knoxville, Tennessee

- Regulations should allow CO-OPs the flexibility to serve larger employers and multiemployer/shared risk arrangements.
- Regulations should allow a CO-OP to define its own initial market so it can be successful and ultimately serve other markets.
- Providers and Accountable Care Organizations (ACOs) should not sponsor or govern CO-OPs – too much integration on the provider side can lead to monopolistic behavior.

- Require consumers to be 2/3 to ¾ of CO-OP Board members to prevent providers from dominating the Board.
- CO-OP applicants should demonstrate either experience in or ability to bring together experienced partners in all the major health insurance/health plan functions.
- Grants for reserves should be forgiven over time if the funding is used to directly lower premiums.
- CO-OPs that contract with provider networks that report and demonstrate improvement in National Quality Forum performance measures should be favored.
- A CO-OP federation should be formed and funded from the beginning for the purpose of sharing 'best practices' and collaboration across state lines, and to help serve employers with employees in multiple states.
- Small employers should get the majority of seats on the Board.

Mark E. Rust, Esq., Barnes & Thornburg LLP, Chicago, Illinois

- Do no harm when defining a member.
- Provider expertise on initial board is essential and it is important to allow an orderly process to the operational Board that will allow for this provider expertise to be retained.

United Food and Commercial Workers International Union, Washington, DC

- Include the Voluntary Employees' Beneficiary Association (VEBA) structure as the model for a qualified nonprofit health issuer.
- Give labor organizations with demonstrated expertise special consideration in the awarding of loans and grants to form qualified non-profit health plans under the CO-OP program.

Meeting Three: March 14, 2011

Federal Advisory Board on CO-OPs

March 14, 2011

Agenda

8:30 -8:35am	Roll call and approval of the Minutes
8:35 - 8:45am	Welcome by Steve Larsen, Director of the Center for Consumer Information and Insurance Oversight
8:45 – 10:00am	Public comment
10:00 – 10:15am	Break
10:15 – 12:00pm	Presentation of Subcommittee Recommendations (10 minute presentation and 15 minutes of Q&A for each Subcommittee) 1. Governance 2. Finance 3. Infrastructure 4. Criteria Process & Compliance
12:00 – 1:15pm	Lunch
1:15 – 3:00pm	Discussion of final recommendations
3:00 – 3:15pm	Break
3:15 – 4:00pm	Summary of recommendations
4:00pm	Adjournment

Appendix D - Definitions Used by the Board in Making Recommendations

1. CO-OP

A CO-OP refers to the nonprofit health insurance entities created under the Affordable Care Act, Section 1322, Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers. The CO-OP is a qualified nonprofit health insurance issuer that is organized under state law as a nonprofit entity and for whom substantially all of the activities of the plan consist of the issuance of qualified health plans in the individual and small group markets in the state in which it is licensed. These qualified nonprofit entities will operate with consumer governance.

2. Profit

Premium revenue that exceeds plan operating costs will be used to establish adequate insurance reserves, promote growth of the entity, lower member premiums, improve covered benefits, or for other programs intended to improve the quality of health care delivered to its members.

3. Loan and Grant

Section 1322 of the Affordable Care Act provides for loans and grants to provide assistance to organizations proposing to become new nonprofit health insurance issuers. Loans are to provide assistance in meeting start-up costs. Grants are to provide assistance in meeting the solvency requirements of the State in which the organization will be licensed. Both loans and grants must be re-paid. Start-up loans must be repaid in 5 years and solvency grants must be repaid in 15 years. The Advisory Board recommends the following loan structure:

a. Definition of a "Planning Loan": It is the recommendation of the Advisory Board that "Startup Loans" loans be provided in at least two stages. The first stage, which is not required, would be a Planning loan. The Planning loan would provide eligible applicants seed money for feasibility studies and other related requirements. This is not a required step of the loan application process. If interested parties do not need a Planning loan they can apply directly for a Development Loan.

b. Definition of a "Development Loan": The second stage of a "Startup Loan" would be a Development loan. A Development Loan would provide start-up costs for a CO-OP plan as defined by an approved business plan.

c. Definition of a "Solvency Grant": A solvency grant is capital given to a CO-OP plan to assist with meeting state solvency requirements. As stated above, both loans and grants must be re-paid.

4. Integrated Care

The Advisory Board recognizes that integrated models of care can encompass a variety of approaches to coordinating care taking into account local provider markets.

Definitions include:

i. Integrated Care can be defined as an approach to care that is exhibited throughout the CO-OP's operations and includes a **payment** process that incentivizes a system of care coordination to provide safe and clinically based **quality** health care (including preventive care) in the most **efficient** and **evidence-based** manner (which should include elimination of medical mistakes and avoidance of unnecessary consultations, services, emergency visits, and hospital admissions or readmissions). Such care coordination should be (1) comprehensive (including a chronic disease model incorporating, for example, behavioral health or diabetes care within a medical home), (2) patient-centered, (3) continuous in nature and (4)involve the patient (and family) in his/her care and health maintenance. It could require a **coordinator** (probably a primary care provider) and be coupled with health promotion and patient education. Team-based care should be developed to the fullest extent possible. Due to issues related to start-up, capacity limitations, geographic limitations on available provider resources, and patient choice, integrated care would not have to be mandatory for all members of the CO-OP and may require adaptations of the above-discussed models. Applicants who wish to receive priority on this basis should present a plan to make the proposed model as widely applicable as possible to all members regardless of age, gender, ethnicity or socio-economic status. For example, for the purposes of this application, a detailed description of payment for patient-centered medical homes or use of Accountable Care Organizations as defined by CMS regulations would be one way to meet the criteria of Integrated Care.

ii. World Health Organization (WHO) definition: "Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."

iii. Other definitions of integrated care (taken from published articles, briefs) include: the seamless and coordinated provision of health care services, from the perspective of the patient and family, across the entire care continuum, irrespective of institutional and departmental boundaries; an approach characterized by a high degree of collaboration and communication among health professionals that involves sharing among team members of information related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient; and treatment-delivery models in which physicians work together to coordinate their patients' care.