OFFICE OF PROFESSIONAL AND SCIENTIFIC ASSOCIATES

February 7, 2011

Meeting of Consumer-Operated Oriented Planned

Program Advisory Board

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Chairman: Alan Feezor

P R O C E E D I N G S

CLERK: Co-Op Program Advisory Board, February 7, 2011.

MR. FEEZOR: Good morning, and welcome to the second meeting of the --

UNIDENTIFIED FEMALE: Sir, I am sorry. Let me go ahead transfer you over to the main call. Just one moment.

(Discussion off the record).

UNIDENTIFIED FEMALE: Your line is live?

MR. FEEZOR: We are fine. Good morning. I am Alan Feezor, and I have the pleasure of chairing the Consumer-Operated Oriented Planned Program Advisory Board. For those of you in the audience, and then we have heard some comments about, you can't trust a group that's dealing with co-ops and a group that calls a meeting on Super Bowl weekend; it's entirely un-American, and let me tell you the sacrifice made by a couple of our Board members was even in having the meeting, but there were a group of rowdies at a local bar last night close by -- and, Barbara, we did not talk any policies, so we are --

BARBARA: You didn’t? Are you kidding me?

MR. FEEZOR: -- but anyway, it was --

BARBARA: Football policy.

MR. FEEZOR: Football policy and second-guessing plays like we second-guess legislation. But anyway, for those folks from cheeseland, congratulations. And the group actually was pretty tolerant last night in terms of their winning. For those of you in the audience and are on the phone that maybe have not had a chance, there has been an awful lot of work, an awful lot of conversations on many of the elements that were presented in our first hearing, and yet, it’s fair to say that this meeting takes us about halfway through our process, so there is an awful lot of work that remains for those of us on this Board to do in the weeks ahead.

Also, at our meeting last month, we had some excellent testimony from the public, some comments. We have set aside at least an hour this afternoon to receive similarly, in the meantime, OSIO (ph) and HHS have put out requests for comments, and those are being -- at least some summaries of those have been shared

with those of us on the Board, and we are finding those to be particularly helpful and hope that they will continue to come in. And, if there are some issues that are raised today in the course of this Board’s discussions that there are some particular comments on, we would welcome that as well.

Just a reminder from my colleagues on this Panel that we do have about 45 days left before we are supposed to -- which means one full meeting, and probably an awful lot of conference calls, as we have had in the last two weeks to get our work done -- and we do have I think what will be some robust discussions today.

Let’s take a second, if you would, and pull up your agenda. We open up this morning with a panel of folks, who will deal with some of the more technical aspects of both solvency of application and process of plans getting licensed at the state, and of what makes for a good business plan for a start-up organization presented by the panel. We will then move into reports of our sub-working groups, starting with governance. We will take a break and then move into a sub-committee

report on finance that Donna will be bringing forth. And then -- it depends upon how the morning goes -- we may move one of those panels up a little bit before lunch, if we get through early. We will then also do the one on infrastructure, and then Barbara, who will be substituting for Margaret Stanley, will lead us in the discussion of criteria and process going forward. And then, in the afternoon, we will end up with the public session and Board discussion on where we go from here. Several of you have some pretty tight timelines to leave, so we are going to try to stay on time as much as possible, and if any of the subcommittees -- you are not obligated, by the way, to take your full 50 minutes, but I suspect we will be hitting pretty close to that given the discussions.

We are going to have the roll call in just a minute of the Board. For those of you who have not had a chance to read the -- I call it the summary minutes or minutes, and summary of -- the Executive Summary of the last meeting of this group, please do so between now and lunch, and the first order of business after lunch will be the consideration of the Minutes. So

that's sort of what lays ahead for us. Annie, would you like to call the roll for us?

ANNIE: Good morning. I will now call the roll for the Advisory Board. Herbert Buchanan?

MR. BUCHANAN: Here.

ANNIE: Dr. David Buch?

DR. BUCH: Here.

ANNIE: Dr. David Carlisle?

DR. CARLISLE: Here.

ANNIE: Dr. John Christianson?

DR. CHRISTIANSON: Here.

ANNIE: Rick Curtis?

(No audible response).

ANNIE: Alan Feezor?

MR. FEEZOR: Here.

ANNIE: Terry Gardiner?

MR. GARDINER: Here.

ANNIE: Professor Mark Hall?

PROF'R HALL: Here.

ANNIE: Patricia Haugen?

MS. HAUGEN: Here.

ANNIE: Donna Novak?

MS. NOVAK: Here.

ANNIE: William Oemichen?

MR. OEMICHEN: Here.

ANNIE: Dr. Michael Pramenko?

DR. PRAMENKO: Here.

ANNIE: Tim Size?

MR. SIZE: Here.

ANNIE: Margaret Stanley?

MS. STANLEY: On the phone.

ANNIE: Barbara Yondorf?

MS. YONDORF: Here.

MR. FEEZOR: Thank you. Just to again to turn over to our presenters, the same as we did the last time, ask that if you have a question turn your name tin up on the side, try to confine yourself to one question until your other colleagues have had a chance to ask theirs, and then we'll come back around and we'll try to make sure that everybody has an opportunity.

Our two panelists in our lead-off are Vivian Riefberg and Brian Webb. Ms. Refberg is Director of the Washington, D.C. Office of McKinsey and Company, a

co-leader of the firm’s health care practice. She has more than 20 years experience, in terms of working in the health care arena in private, public and non-profit sectors, and for those of you have had a chance to read her testimony ahead of time, you know we are in for, I think, some excellent advice and guidance on that. And, she will be followed by Brian Webb, who is -- and, Brian, I don’t know how you do it all -- but, is Manager of Health Care Policy and Legislation for the National Association for Insurance Commissioners. Brian participated in the discussions of the regulator panel last time, and is going to provide us, I think, some excellent information in terms of the state regulators’ perspectives of new entrance into the marketplace and requirements thereof. Vivian?

MS. RIEFBERG: Thank you very much for having me here this morning. As your Chair mentioned, my name is Vivian Riefberg, and I am a senior partner in the Washington office of McKenzie and Company. I do want to take a moment just to explain who we are and what we do do, and a little bit about what we don’t do, just to be clear.

McKenzie and Company is an independent and non-partisant management consulting firm, which serves public, private and social sector clients in the areas of strategy, organization and operations in more than 50 countries around the world. We do not engage in lobbying for its clients or itself. We are a management consulting firm.

I have been invited here today to present to you on the topic of what to look for in assessing business plans of organizations seeking to establish non-profit health cooperatives under the provisions of the Affordable Care Act. I will not be commenting directly on the legislation, or on the plans themselves, and will not be providing a perspective on agency approaches to the Act; rather, I will focuse on what makes a good business plan, and what I believe you should look for as you evaluate competing applications for federal support.

So, if we start there; what is involved in assessing a good business plan? Before beginning I think it's useful to consider what we mean exactly when we speak about evaluating a business plan and how this

pertains to your challenge. Quite frankly the first association most people tend to make about a business plan is not with the public sector, but with private sector investors and corporations assessing new businesses and start-ups for investment. And, assessments of this kind tend to focus on the evaluation of risk and the potential returns on invested capital, as well as the track record and quality of the management team. I think we believe that although the objectivees may be different; that is, the focus on earning a return on the cost of capital, is the focus in the private sector, and that this kind of assessment may be different in terms of the objectives undertaken by public funds, charitable groups or foundations that are interested in investing resources to achieve a certain social impact or policy goal. While there are differences in the objective function perhaps, the fundamentals of what to look for we believe are the same; that is, you are looking for investing in a talented management team that will skillfully develop their business model, and that will ensure the highest and best use of the funds you

provide against the objectives you seek, and will be in a postion to return those funds to you at the appropriate time. So the fundamentals, we would argue, are similar.

With that in mind, there are three general questions we believe you would want to consider. The first and most basic is, what should be in the business plan, and I am going to outline 12 elements that we believe are appropriate in a business plan. Second, what are the features that you should look for as you compare competing proposals, and try to identify which have the greater likelihood for success. And finally, and in some ways most importantly, how can you evaluate the quality of the management teams, to anticipate how effective they will be in achieving the goals that are set out.

So let me start with the first of these, which are the 12 elements that we would want you to see in any business plan. The first is in fact a concise statement of the mission and objectives clearly describing the opportunity perceived in the market; how the co-op will differentiate itself relative to

competition; investment required; and the pathway to economic viability. The second is the product and services offered -- and there is more details in my testimony here, in what was written, but there is an outline of those things. The third is an overview of the management team and the proposed governance model. I note that you are planning to cover that later. You know, in many respects, we think this is one of the most important elements. A good management team here you should be looking for are people who have had significant experience in managing health plans or other similar insurance offerings; it should be people with deep knowledge of the state, the laws and the regulations, and the markets in which they are going to be operated; and it must include people with experience in the core business areas of the operation; whether it's medical management, network management, IT systems, plan administration, and quite frankly, people who can integrate all of those things. I think one of the observations in earlier testimony that came forard to this group was the possibility that people might use third-parties or outsource, or put together other

folks, who would provide some of these services. Well you do need, in the management team and in the plan, the outline of how that will all be put together; how that will be integrated. It won't surprise you to include analysis of the market and competitive landscape, a marketing and sales strategy, and the operational model as to how it will work.

The second think I think I would highlight on this list of 12, if the management team was the first, and there has been six other elements I have mentioned, the seventh would be the detailed plan for medical and network management. As you well know, the significant amount of the cost structure of any health insurance organization is around the medical costs, and how is it that they intend to work with providers -- and, when I use the word providers in my testimony, I am not just speaking of physicians and hospitals; I am speaking of the full array of providers; whether that is pharmaceutical products; whether that is nursing home capability; whether that is home health; it is, you know, the full array of providers -- what is the game plan and program for assuring that they will have a

complement of the medical services at an affordable cost that will turn into something attractive in the marketplace?

Let me continue on number eight. This is a detailed 90-day road map to get started, and then a clear one-year plan.

You'll see on number nine I mention a five-year plan. But, if I had to put a huge emphasis, it is first to make sure they know how they are going to start up, open the doors, run the enterprise in the first year. You can't get to the 5th year if you don't have the clarity. So, as you look at this, don't be surprised to see that as you get further out the details are less clear, but the clarity around that first year has to be there. And then, a solid five-year operating plan that includes a description of the product development timeline, the investment required, the critical milestones and roles, a compliance plan, a solid approach for how the organization will grow both it's membership and provider network, and a development plan for infrastructure and personnel.

Number 10 is a careful assessment of the risks

and opportunities with a full enterprise risk management plan and compliance approach, and in that, one of the things I would highlight is the good business plan should discuss the sensitivity of all projections, because often small changes in business assumptions can really impact what's going on. And, what you don't want to see is just -- and what I'll comment on in number 11 -- is the financial plan, but with no sensitivity analysis so that you can appreciate what those small changes might do to impact the viability of the enterprise, and I would just highlight that.

Number 11 is the detailed financial plan, and here it should describe a clear and reasonable forecast, both the capital and cash flow to start and grow the business; expected fix and variable costs; and projected revenues. It also should inlcude in this the clear model for paying back government loans and grants, and how and who would be the source of private financing. Again, if I had to highlight a third item, it is in fact: what is the other source of capital, and how does that capital come into the enterprise; and

what is the role of those who are providing that capital? What you don't want to do is face what has gone on in some other circumstances where the initial capital was available, but when people ran into tough times they failed, in some cases, and the government -- in past history it's been state governments, in some circumstances, that have been left holding the risks and quite frankly holding the bag on the financial situation. And finally, a clear set of performance measures. A good plan will include not just financial measures, but operational metrix that the team and Board would use to track the progress.

I'm not going to comment on some of the other elements that are in my testimony about, you know, clear and concise writing and those elements, but I do want to highlight something that I was asked to comment on in advance of this, which is; is there a way for you to kind of sequence and time things, and how do you think about that? And, one of the observations we have is that, given the limited time that you will have to get established and licensed, if they are in fact to compete on the exchanges beginning January 1, 2014, you

will likely want to look at all 12 elements before agreeing to extend any loans to any new co-ops. Under different circumstances, there might have been a more staged approach, but it's our observation that, if you really do expect the co-ops to open their doors for business in 2014, there will be very little time for the iterate of review process, particularly -- and Brian will comment on this later -- if they need funding to meet solvency requirements, you know, significantly earlier to open the door. While staging, we believe, can prove difficult, you might consider keeping a pool of funds for further development and expansion for these enterprises; so if they start off in a given set of markets in a state, and even though you have the state-wide aspiration for them, you might consider it that way. But, in general, it's our observation it's going to be tough to have the iterative process work as well.

I'll make a few more comments on how do you select the best plans, and then I'll turn it over to Brian. You know, how do you think about selecting the best of the new plans? Once you narrow the field to

the most promising plans based on the 12 elements I spoke of and the set of criteria that are already outlined in the Affordable Care Act around a consumer focus and integrated care, and there are some things articulated there, we think that you need to then recognize there is no perfect answer, but there are steps you can take to test the plans and the teams behind them. We believe the most important of these is to establish a committee of folks, ideally including start-up professionals, who can meet with the management teams and test their thinking in person. If you look at what venture capital firms do, or other parties who invest in start-ups, most meet multiple times with management prior to making an investment decision. And, in effect, you see the plan, but good management teams are effective at incorporating the feedback that they get from funders, the new thinking that goes with that, and their final plans tend to evolve out of meetings with those parties. And this also gives folks a chance, and the funders, that is you or the folks you will designate through your guidance here, but it gives folks an indication of the team's

ability to sell themselves and their business to other investors, who will have to partner with them; how they work with providers and consumers in the years ahead.

So, with that, we would say, you know, make sure that you recognize that your definitions of success are really not that different from those in the private sector; that, second, you invest in the best management teams; and that their choice to manage a co-op should be an indication that they believe there is a genuine opportunity; and finally, recognize that the best plans are often those who are able to anticipate, and then deal with unforeseen challenges as they move forward.

Thank you. I hope I didn't run over too much.

MR. FEEZOR: Thank you, Vivian. And we are going to hold questions until Brian -- I think there is some interactive dialogue here that will be quite good.

MR. WEBB: Well, thank you. I appreciate this opportunity to come and speak to you today. Again, I am Brian Webb with the NAIC. And, before I start, I just want to highlight the fact that what I am telling you today is generally what a company would need to do.

I always like to highlight the fact that states are all different, so there are always details to all of these that may be a little different, but we used to do this presentation a lot to Congress before they really started in earnest on this latest round. We do this Fundamentals of Health Insurance, and we start with the hypothesis that maybe one Monday you are maybe a little drowsy from maybe a Super Bowl party the night before, and you are hating your job; you say, you know, in a fit of insanity, I think I would like to start an insurance company, you know, just like that, you know? That sounds fun. What would you need to do? What's the process you have to go through? So here is what you've got to go through.

You need to get a Certificate of Authority. That's your license to actually sell insurance. You need to meet the solvency requirements. You've got to get some cash together. You need to get an approved form; that's the contract, so you will be going out, and the products you will be selling, and you've got to get your rates approved; simple as that. Well, where do you go? Well, this is where you go? Basically the

NAIC working with the states have tried to make it as easy as possible for people to get all the information they need to start a company, and you go here. You go to the Uniform Certificate of Authority Application. Now again I warn you, when you see the word *uniform*, it's a uniform application. The requirements vary from state to state, but it is a uniform application, and basically there is a website you can go to and it will give you all of the things you need to do to get a Certificate of Authority, to do all your financials, to do everything you need to do to start your company. It's in one place. Click on any state you want. It will give you everything you need to know, and all the forms you need, et cetera, et cetera, et cetera. So it is a one-stop shop to go and get started. Every state participates. As I said, there is always some additional information that's required by the states, but generally it is a uniform application. So, to get this application, you have to first of all decide which state you are going to start in, and that will be your primary state. Now, for these co-ops, we are kind of assuming they will be in one state. We are not really

looking at them starting in five or six states at once. So they'll find a primary state. They will start there; and then later, there is that opportunity to go into other states as a foreign or alien -- different states call them different things -- insurer, or get an expansion. So basically you are going to go in, you are going to pick a state and say this is my primary state, this is where I want to sell. You are going to get this in and you are going to -- submission -- usually the submission itself is approved within about two weeks. That's the process of just saying, is all the information in; have you filed everything; do I have everything I need? Then, once it's determined that everything is there, usually, believe it or not, it takes usually about 90 days. So I know everybody is thinking about time here. Typically, it's not that bad; about half that, about 45 days, if you are moving from state to another. So if there is an existing company that has kind of gone from one state, is expanding into another -- you know, don't know how your rules are going to work -- but it's a little quicker for those.

Now, what do you have to have in this application? You are going to just say, this is our line of business; this is what we are going to do. We are going to do an HMO in the individual market. We are going to do a PPO in this. So, I mean, you have to say what line of business you are going into. Pretty straight-forward. You can get the definitions of what those man in the various states and put that in. You also need to get your name approved. You say, what's the big deal there? Well, they don't want you too close to somebody else; they don't want you using your name in an inappropriate way, too closely matching; so you have to have your name approved, and you have to have that in there. You also have to have biographical affidavits for everybody who is going to be involved in this company; the Board of Directors, the financial operator, everybody who is involved, you have to have their biographical affidavits. Why? Well, we need to know who these people are. There are people, believe it or not, out there selling fraudulent insurance, who have been brought up on charges, or are maybe not the best people in the world; we've got to know who they

are. Who is going to be operating this? And they will do a full background check on every single person involved.

Then, you need to have your plan of operation, which Vivian kind of went through. You have to say how you are going to operate; where you are going to operate; how you are going to move forward; what's your 90-day plan; what's your one-year plan; what's your five-year plan; how you are going to expand; who you are going to contract with; what is your network going to be; basically, how are you going to operate? You've got to fill out all that information, and then you have to, of course, provide all of your financial information; where you are getting your money; are you meeting the minimum requirements; and, we'll get a little more into that here. First of all, you have to show that you are meeting your capital and surplus requirements, and we did provide a chart, a rather lengthy, hefty chart. It hasn't been updated since 2009, but pretty much these haven't changed much. But, when it comes to capital and surplus, if you are a start-up company, you are trying to meet these targets.

If you see a line on there that says health; that's your target. As a start-up company, you haven't had any seasoning, you haven't been around for five years, haven't been selling before in the last five years, there are usually a little higher requirements, but you don't have to meet RBC yet. It is a dollar amount. You've got to meet this. So, if you look on there, -- and let's just pick a state like Alaska -- they are on the front page -- your basic would be one million ($1,000,000) dollars; additional surplus for first authorize is an additional one million ($1,000,000) dollars; so we are talking two million ($2,000,000) dollars you have to have available to you. This cannot be a line of credit. It has to be cash or assets, capital on-hand that you have available to you to get started. Then, you need to show that you have your deposits. Again, that's an additional requirement. This is cash you have in the bank to provide any assistance to -- and this is always for the purposes of helping the consumer. These aren't deposits that you can do business operations with. These are deposits that you have on hand just in case something goes bad,

and then you can help out those consumers. You also need to list all of your holding companies; are you part of a larger entity? You have to provide information on them and their financial information. You also have to have your SEC or your consolidated GAP (ph) statements. So basically, are you meeting all the accounting principles, and is all this information correct about you, and your debt to equity rate. And, each state is going to look at that and just find out if that's within their comfort level.

Now, all of these financial things, basically what's happened over the years is, again, we have become more uniform. The NAIC has come up with guidelines and manuals for all the financial reviewers. We have come up with models that states use. While the numbers may differ, how they look at it and how they analyze it is pretty much the same from state to state. Now, if you want to go and expand, like I said, it's usually a little quicker, because there is a primary state that's already looked at it and has already approved it.

Now, as far as getting a little more into solvency regulations, which I know you guys are very interested in, first of all, as I said, the finances, you have your capital and surplus, your deposit. You have to have those in hand. Those are usually a number. You also have some factors, like seasoning. Most states, if you have not been in operation for five years, you have a higher standard. So like Alabama, let's take them; you have to have your capital of let's say one million ($1,000,000) dollars, and then your surplus has to be 100 percent of that, unless you are new, and then it's 150 percent; so often a higher level if you are brand new. Also, they will also usually have a maximum capital on one risk. So how much can I have invested? How much of my capital can be stocks in a certain stock, or how many can be in certain bonds? And usually that's capped at about 10 percent, so you've got to keep that in mind as well.

Now, here comes risk-based capital. In the second year -- they can't do this for the first year, because they don't what their risk is; they don't know all that -- but, in the second year, they have to keep

this in mind when they are putting in their initial application; do I have my initial money, but also, do I a plan moving forward to meet the risk-based capital standards that have been established by the NAIC and used by every state? And this is looking really much deeper into the risk of the company. So they will look at four basic things. They will look at their underwriting risk; what is the risk of their pool; who are these people bringing in; how much basically insurance risk are they going to be taking on from here, and looking going forward? Now, keep something in mind here, this can be very new and different for these 2014 companies. The risk pool is going to be very different; guarantee issue, especially going into the individual market, the guarantee issue, the way the rates are set, everything is going to be different in most states. Plus, you have things like re-insurance. You've got the risk corridors, and you have risk adjustment, also playing a factor in a lot of this, and frankly, we don't even know how we are going to handle all of that in our guidelines, and we are looking at that right now at the NAIC. Also going to look at

business risks: what's your operating costs; are you an efficiently run operation; what kind of contracts are you involved in; what are you contracting out; do you have contracts with providers, provider networks; how do those work; are they bearing some of the risks, like an HMO does, and how does all that work; what kind of guaranty funds are you involved in; do you pay into the state guaranty fund? Those kinds of things would also play into that.

Also, we look at your asset risk; not only your asset risk, but also the asset risk of any affiliates. So, if there are any downstream risks that you are responsible for, we look at that. We look at those companies. We look at those entities, to see what their risk is, and also looking at other risks, like your credit risk, your interest risk, your market risk, all those kinds of things. So, if you are piling a lot of your capital in the stock market, we will actually take a look and see what the stock market is doing. We have an organization called Securities Evaluation Organization, up in New York, and that's their job, is to look at this other risk, and they

determine whether the bonds you are putting your risk in are becoming more and more risky. If that happens, the insurance regulator will call that company and say, listen, you've got to change your mix, because your RBC is going down. So, even up front, you have to start thinking about this, and the states will be looking at this as they start-up.

Oversight -- they will be subject to audits and everything going forward. You also, as I said, you've got to get your rates and policies -- and again, we have set up a system called SERF (System for Electronic Rate and Form Filing), a one-stop shop. All participate. In fact, 24 states require it to be done this way; where you put in your policy -- they are looking on the policy to make sure you are meeting all your requirements for mandated benefits, mandated providers, disclosures, and all that kind of stuff, and then also of course looking at your rates. Now keep in mind the rate review is going to change some in a lot of states because of the federal law, plus the federal government is going to be involved in some states in the reviewing of rates. And that gets to that gets to

that second point there; file and use versus use and file.

Time is a big issue here. I think everybody agrees with that. We are going to get these guys up and running by 2014 in the Exchange. If they are at a use and file state, it takes less time, because really you are just filing your form and you are filing your rates, you are sending it to them, and you can start selling right away. No review process. Now the state, like Wisconsin, which is very good at this, they go back afterwards, and if they find out any of that is wrong, they will make them change it, or they'll make them give rebates. So there is always a review ability that every state is going to have, especially now that PAC (ph) is in place, but it still could be a use and file state.

If you are a file and use, usually you are talking about 60 to 90 days deemer (ph) on most of those; so, if the state hasn't taken any action within 60 to 90 days, it goes into effect. So you have to keep those timelines in mind as we are thinking about this, because these companies really, if they are going

to be selling products on the Exchange on January 1st, 2014, that means they need to be selling these things in October. Keep that in mind. They are going to be selling them in October, so they are effective January 1st, 2014. So we are backing up the clock here to make sure these guys are all meeting all these requirements.

So I will stop there and be happy to take any questions.

MR. FEEZOR: Thank you, Brian. And, again, folks around the table, if you will ask your one and hopefully single-part question, as opposed to the four-part questions that my colleague from North Carolina likes to ask, and let your other colleagues at least ask a question before we come back around to you. Tim, first up.

MR. SIZE: Thanks. Thanks for both presentations; really clear and I think right on, on the money. Brian, I am assuming a loan from this program, and we discussed this last time when you were here, can only be used, at best, to meet surplus requirements if there is some sort of subordination to the state having first claim?

MR. WEBB: Yes.

MR. SIZE: Could you talk about that a little bit?

MR. WEBB: Yes. And that's fine; you can start with a loan. You can't start with a line of credit, but you can start with loans, just keeping in mind that that then puts a liability on your books. So you will need to make -- say, you need to make two million ($2,000,000) dollars; if that's all in loans, you do have that cash on hand, but you would have to show going forward how you are going to pay that off and maintain your risk-based capital standard. So it's on as an asset, but it's also on as a liability going forward, and we would be looking at that.

MR. SIZE: So, presumably, the clearer -- the closer you got to that 15th year, that's going to be more and more of a challenge unless there is cash --

MR. WEBB: Correct.

MR. SIZE: -- being accumulated?

MR. WEBB: Right. So we would want to see up front that they have a plan; in their business plan, in their financial plan, how are they going to raise

enough capital, through premiums, through other avenues, to pay this back? That's what we would want to look for.

MR. FEEZOR: David Carlisle?

DR. CARLISLE: Thank you both for great presentations. You know the Act talks about fostering the creation of co-ops and encouraging the staffs for the co-ops, and the question I ask Vivian is, is there a tension between offering technical expertise and helping these prospective applicants to be able to do a good job versus the fact that, you know, the same institution has to go back and rate these applicants and determine whether they are viable, or do you save expertise for after they actually become officially selected and then help them in the process, or is there any role for technical expertise being offered by the, you know, OSIO (ph)?

MS. RIEFBERG: I think when we were -- when I made the comment about technical expertise, it was in anticipation that the states are largely governing these enterprises, not the federal government, largely because they operate under the state regulation for

these, for insurance companies. I think the thinking was that, at least up front, in terms of wanting to make sure they are economically and market-viable before you provided the funding, at least at that point it was thought that providing input was what was contemplated. I am not an attorney, and I am not probably in a good place to comment on the conflict elements of that, but from a business operating standpoint, it was in the spirit of, if you are the lending party for the funds and your obligation is to make sure that, on behalf of the taxpayers, that those funds are going to be returned, that you would in fact provide some guidance and input to ensure that what you are lending to meets your standards and needs, and it was only in that spirit. I can’t comment on the other part.

MR. FEEZOR: Dr. Mike?

DR. PRAMENKO: Thank you both for your testimony, and, Brian, I want to press you on something, --

MR. WEBB: Okay.

DR. PRAMENKO: -- because you mentioned the NAIC and the discussions you are having about risk adjustment.

DR. WEBB: Right.

DR. PRAMENKO: And, as co-ops are formed, we are not just forming these in vacuums; you know, there are other things that are new and different and are going to be different in every state in regards to how the exchanges function. Can you flesh out a little bit of some of the initial thoughts on risk adjustment and what that means as the exchange is formed, and how that could be different in one state versus another based on how vigorous that risk adjustment might be?

MR. WEBB: Yeah. We are looking at the possibility that there could be a variety of risk adjustment models used, all certified though; that there would be a standard set and maybe approved like three or four models. This is not a foreign concept. Medicaid, you know, MCOs, -- you know states are using various models, but we want to make sure it is a model that works for this particular individual, small group, large group market, works in this exchange, in this

private insurance market. But, there could be a couple of models that states could basically choose from. That's an idea that's out there. I can't say in any way that that's what we are going to do or anybody is going to do, but there is -- just to get to your question -- there is a possibility it could vary from state to state. That's a possibility. And what we are looking at in the NAIC is just -- our big question, how will that impact our risk-based capital calculations; how will it impact medical loss ratio calculations; how will it . . . you know this is going to be a new environment.

DR. PRAMENKO: Okay, a follow-up question, do you have any timeline on that?

MR. WEBB: I do not. Right now we are just advisors on that particular project.

DR. PRAMENKO: Because, as this gets moving and as the exchanges are set up, which are so important, it seems like, for states to have an idea on how to set up their exchanges, if there is good information from the NAIC on that, the sooner the better on that?

MR. WEBB: I know the folks at OSIO are working very diligently on that and we are having conversations, but we don't have a timeline.

MR. FEEZOR: Mark.

PROF'R HALL: First a quick comment. Brian, I think -- Mike, you were using the words risk adjustment, but you may have been thinking about the risk-based, the RBC formula; those are two separate issues.

DR. PRAMENKO: No. I was talking about risk adjustment.

PROF'R HALL: Risk adjustment, okay, as opposed to RBC. In any event, my question is to Vivian. I think you gave us great advice and I am trying to think about how to adapt that to a regulatory setting. So much of it is evaluating the people, as just kind of a subjective expert judgment about, does this seem like the right team here; meeting with those people; challenging their assumptions; seeing if they can adapt to changes in those assumptions; actually expecting the business plan to take a different shape during the course of these conversations. That's not

how the regulatory approach works. Your comments on how we might find a hybrid, in particular, I was interested in -- I thought I saw it in your written testimony -- having an expert team of evaluators that might make this assessment and somehow report back to the regulators about their judgment, as to the quality of the investment from an investment point of view?

MS. RIEFBERG: Yeah. I want to reiterate something in answering your question. We outlined, you know, 12 elements of the plan, and we would say that all plans, you know, should have these elements. Brian elaborated on the risk piece. I did not, in my spoken testimony, but in the written piece I would tell you that that's very, very important, what he is speaking of. It's after you have been through the -- you know, you have sort of got a finalist group, again, no idea what the demand for the funds will be, but presuming you have some choices, and I think -- I don't have in mind a particular model, I know that there are many standing advisory groups in the federal government on different topics, so groups get set up for providing advice to the FDA on product approvals; you know,

again, it’s advisory it’s advisory in nature, and I think there are some ways to use advisory input in a process that allows you to get some additional expertise. I did not contemplate a specific recommendation as to how that would work, but I think our belief was you are evaluating a start-up organization, and it would be good to have people who have some expertise in that available in some form. So, whether you can use some of the existing vehicles in the federal government to allow for that was, I would say, something in the back of our mind, at least.

MR. FEEZOR: Terry?

MR. GARDINER: For Brian, one of the items up there was SEC and consolidated GAP statements.

MR. WEBB: Right.

MR. GARDINER: If we are talking about a non-profit, under the ACA, that’s only established in one state, would they be subject to SEC?

MR. WEBB: We don’t believe so. It would be the GAP statements then.

MR. GARDINER: Okay, so --

MR. WEBB: It’s one or the other, as required

by the state.

MR. GARDINER: One or the other?

MR. WEBB: Mmm-hmm (in the affirmative).

MR. FEEZOR: Barbara?

MS. YONDORF: Thank you. Those were two such helpful presentations, both of you, very clear. And, sitting with my colleagues on a finance committee, I wish you had been there in the beginning, because it would have saved at least one conference call, so it was really useful.

Brian, we have been struggling with the following issue; the statutes in ACA (ph) require that all profits be returned to the members, and so we are a little concerned about that term profit, and as you have said before and the Commissioners have told us, that doesn't mean that you are at the minimum for RBCs; you are at the minimum for everything. And, you addressed some of that. You said the Commissioners are going to look at not just right now solvency, but into the future and plans for that; but we have got potentially OSIO in this mix and lots of different states. So let me share with you that what we are --

then get your response -- what we are thinking about is trying to define some minimum level of our own or target that's above the absolute minimum so that we don't have somehow someone saying you are at 201 percent of RBCs, so you need to start returning the profits. One of the things we have talked about is asking NAIC to help us with that, to give us some at least guidance, a statement, rather than our trying to figure that out. So is that possible? Are there any guidelines from states? You had talked about looking for red flags, I noticed in your testimony. Did they say we look for a red flag when you are at -- start getting nervous when you are at 500 percent of RBC? Is there anything you can tell us that helps us shape that critical issue?

MR. WEBB: The financial guys are nervous all the time, so -- 600, 700, they are very, very nervous all the time, especially on health. Health is different than most of the other insurance. It's very unstable, because constant claims make people nervous. This is something the NAIC has talked about in the past in the context of a lot of people think that some of

the non-profit insurance companies have way too much of an RBC, it's way too high. Some of the states have looked at that. The NAIC to this point has stayed out of that conversation, again, because there is a belief amongst many regulators that there is no such thing as too much, and it would be concerning to a lot of them if we did set an arbitrary and say anything above 400 or anything above 500 clearly is profit and therefore should be turned back. That would make people in many states nervous. I'll just say that. It's something we could talk to the states about. Certainly we are always willing to have conversations, and we'd love to talk to this board about that and see if there is some standard that states do use. Obviously there are non-profits in the states, and they are now meeting RBC requirements, and there are requirements on them as a non-profit on how they operate, so maybe there are some good standards out there that I am not aware of that they, you know, some of them do use.

MS. YORNDORF: A follow-up, because what I heard you say, and I understand that is sort of how much is too much RBC has been an issue for non-profits;

we are kind of looking at the other end of it. Is it possible that the Commissioners would make maybe a different sort of statement? We really get nervous. We are extremely concerned. We tend to call up the health company and say, what do you mean you are starting to get below a certain number? I mean, is it possible they could go on that end?

MR. WEBB: Yes. There are standards within our guidelines and our handbooks that -- you know the NAIC is running these numbers. We are running them quarterly, we are running them annually, and there are certain levels where we will tell the insurance regulator, you need to have a conversation with this company. So we can give you that information, as long as we are making it very clear that we are not saying this should be the maximum RBC that somebody should have, but we can get you some information on that.

MR. FEEZOR: David?

MR. BUCK: Thank you both for lending your expertise. Could you elaborate, Vivian, just a moment on what you meant by a focus on integrated care?

MS. RIEFBERG: In my written testimony I commented, but I didn't elaborate here today, that in addition to the 12 things you would be looking for, that the Affordable Care Act does highlight in it some considerations that they specifically -- the Act specifically contemplates for these plans. And, I think when I mentioned the integrated care, it was in the context of the Act itself, as we read through this, the list is based on a reading of the Act and our internal review, but there were five priorities mentioned that we saw. One was a clear and consistent consumer orientation, a plan to implement a robust governance model, and a focus on integrated care was the third one, and there were two additional. On the focus on the integrated care, we are really just taking from the Act itself, and I would never want to be someone who could exactly what was in the minds of those who were drafting this. I leave it to your good hands to try to interpret it. But, I think there has been an overall emphasis out of the Affordable Care Act around trying to put more pieces together, perhaps virtually not always with hard asset mergers, but to

get more pieces together working on behalf of the consumer. And so again, I am not -- I only picked it up in the context of what the Act said itself.

MR. FEEZOR: Donna?

MS. NOVAK: Real quick for Vivian, and then I want to get back to risk-based capital. That's also true when you say state-wide, you are just quoting what was the Act, rather than saying that's a recommendation of yours?

MS. RIEFBERG: Yes. Correct. So, here, it had said ability to serve entire state markets or larger markets, there was -- it seemed to be an encouragement in that direction, but I was not commenting on that.

MS. NOVAK: Recommending? Okay. Good.

MS. RIEFBERG: Thank you.

MS. NOVAK: That was the question I had from your written testimony.

Back to the risk-based capital; I want to clarify a little bit that we wouldn't really even want the level where regulators start getting nervous, because when we start talking about profits, we don't want to interpret that as your income is more than your

expenses, so that all has to go back. We want to bring in the idea that you have to build up something for a rainy day, but whatever level the secretary chooses, if in fact she decides to choose -- I don't know -- for that level, it would be a maximum; it would be, you can't have anything above that level. So you wouldn't want that at a nervous level. You would want that at a confidence amount above that, you know, we are getting level. So I just wanted to -- so is that something that the NAIC could attempt that --

MR. WEBB: That makes us more nervous, but -- because that brings us into these other conversations --

MS. NOVAK: I know.

MR. WEBB: -- but, we would happy to bat that about and maybe give you a few viewpoints.

MS. NOVAK: A few viewpoints at least would be helpful. That would be great.

MR FEEZOR: Bill?

MR. OEMICHEN: Thank you. My question for Vivian, just on a timing question; you said that all these elements should be completed at the time the

application is reviewed by HHS; are you saying 100 percent complete; are you saying substantially complete; because one of the things we have been looking at is can we do a phased process, a review of how the possibility of doing some initial grant of smaller amounts up front, and then go through an evolutionary process? It sounds like from your testimony, and I just want to make sure I understand you correctly; you are saying it should all be complete before you recommend HHS start looking at the application?

MS. RIEFBERG: I think there are always levels of detail and specificity that one can debate, and probably you all should debate. What I was doing was making two assumptions on why I was encouraging that these be quite complete applications at the start. One is the timetable of wanting to be ready for when the exchange is open. You know, here is a plan, and then this plan has to actually get implemented and completed and operationalized, and we are in February 2011 and the clock ticks; so I was contemplating what does it take operationally and managerially to get it going?

The second thing, I was assuming, perhaps wrongly, that the monies were either in the forms of loans to be paid back, or in the form of monies for -- either for, you know, the loans or the solvency requirements, and therefore these are monies that are either returned in a five-year period or in a 15-year period, and I did not assume there would be grants, if you will, that may never be returned, and so that was why I said you want to have something complete, because the contemplation is these monies are going to have to come back, and therefore you want to plan that, at a minimum, insures those monies are returned. So that was why I looked for the completeness of it; you know, do you have to have every single element of the sales and marketing effort detailed per -- you know, we could debate that, but I think overall I did intend for those reasons.

MR. OEMICHEN: Brian, sort of thinking out loud a little bit with you about the timelines that you looked at, particularly on rate approval and product approval; many of the departments are enhancing their rate review process. The federal government has put some grant monies into that, so there may be a little

more intensity there going in. What that does to the pipeline is another issue.

MR. WEBB: Right.

MR. OEMCHIN: Secondly, as you approach 2014, there may be a lot of folks who are going to put those metal products filed in the actuarial equivalency of 80 percent and so forth, so that may be a bit more truncated process, it would seem to me; and then the third possible element would be, in those states where hopefully the Exchanges will really delegate most of that plan review process to the existing regulator rather than be redundant, but there may be some Exchanges who have their own review process.

MR. WEBB: Right.

MR. OEMICHEN: So, I guess all that’s my way of saying there may be a little longer length of time, at least around that 2014 operational time; is that a fair statement?

MR. WEBB: More than now, but like I said, most have some kind of deemer, which sets an outside limit on that. Now, most states are doing it much quicker than the deemer period.

MR. OEMICHEN: Yeah.

MR. WEBB: But, yes, we are expecting some back-up.

MR. OEMICHEN: And, do most of the departments have a list of re-insurers that they do business with, or that are more accepted so that if I am running a co-up and part of my security package is having re-insurance, that I can go to the North Carolina Department there and say, well, here are a half dozen that we have done -- that companies are doing business with that we are familiar with?

MR. WEBB: That would be all part of public record. You can find that information, and they would be familiar with who does re-insurance in the state.

MR. FEEZOR: Rick?

MR. CURTIS: Just a very quick question. Also, in terms of timing and the ticket A (ph) of, you know, investors don't want to give money to an enterprise that isn't going to be approved, but you can't get your approval until you have your money;

MR. WEBB: Right.

MR. CURTIS: -- so I assume there is some way to put your paid in capital into some kind of escrow or something, where the money is sitting there, but if the approval somehow doesn't come through the money reverts to the grantor, or would you -- would the states not accept the full faith and credit of the United States Government on this?

MR. WEBB: Eh, it's too -- no (laughter). This is something that we can talk about. Basically, on all of this, you're, as a company, you are sitting down with your regulator and you are walking through this. Again, you have that first submission that they look at it -- it usually takes about two weeks -- to look at it and see if it's a full submission or not. That's when you start that conversation, and that's where you can say right there and then, okay, this is the situation. This is what we have. This is what we are looking at. I mean, you have to pay the filing fee, which, by the way, we gave you a list of those too -- you have to pay the fees, but that's a process. You are not committing to anything. You are not going through the full process yet, but this is a

conversation they would have to have with the state, and, in most cases, we have seen this before.

MR. CURTIS: The money being available, if approved?

MR. WEBB: The money, if the HMO -- the HMO Act, they gave some money out, and there were some timing issues there. Some of the Part D plans, there were some timing issues, because we had such a short period of time to get them up and running. We work with companies. I mean, our goal is to make sure they are going to be able to get up and running, to have the financing when they need it, and they have a good product on the table.

MR. CURTIS: Okay. So I am hearing that nobody is going to get tripped up on a catch-22 situation? You just -- you know, you figure out how to work through it reasonably?

MR. WEBB: Yes.

MR. CURTIS: Yeah.

MR. FEEZOR: Terry?

MR. GARDINER: Question for Vivian. My question to sort of, let's say, right after approval

and it sort of plays off of the idea that I like that you said, a committee of start-up experts is in there, you know, helping them iterate their business plan before the final approval from HHS, but now we are in the first 90 days in one year and, as far as I know, there is a pretty high failure rate of start-ups, private sector companies. I have never seen the data on failure rates of non-profits, so that's a critical stage. Do you, in your experience as management consultant, do you know of any mechanisms that HHS might contemplate that would enhance the success rate in that start-up phase?

MS. RIEFBERG: You are correct in the private sector world; the failure rate of companies starting up is very high. There are a variety of studies done over time, but suffice it to say that there is rarely a study that's been done that doesn't say the majority of them fail, a majority of companies fail. I don't know the statistics in the non-profit world either. In respect to, are there some things that you can put in place, you know, I think that if you look to what the private sector does, and you look in the plans, I think

there is a set of milestones in any enterprise as to what are we trying to achieve, by when, and in what way? And, I think there is the potential to put in place opportunities to look at whether milestones are being achieved. I have not really thought through whether you would provide any ongoing advisory support and how that would interact with the states and the state activity in terms of their interaction with plans and start-up plans. And so I, quite frankly, would have to think about that a little more, but I think conceptually, one of the reasons why you want that detailed one-year plan and the five-year view is what milestones are we hoping to achieve that are not just staying above the risk-based capital kinds of requirements, but are looking at operational and market-based milestones, not just financial. Because, people can be doing very poorly in terms of market impact and still be fine on the financial picture for some period of time.

MR. GARDINER: Right. No, I would agree with that, and that's, you know -- basically what we would offer is -- and the states would really want to work

with this board. So, as you are looking at entities, to the extent we can kind of do this at the same time, you know, we know that they are going to be putting in an application. We know what your standards are. You know what the state's standards are. This would kind of be working together, even though there is no guarantee at the end you are going to approve them and give the money, there is no -- you know, at least there would be some thought on our side that they have met all of the minimum requirements, and would be an entity that could be licensed in the state, if all this worked out. So, we offer that.

MR. BUCHANAN: Let me, maybe as a last question, although this one may prompt you, I'm going to let you folks step out of your current roles, and you get to be a part of this panel. And, my read of the legislation is that we are to make recommendations to the Secretary that tries to make sure -- not make sure -- that tries to provide reasonable assurance that there are some new competitive health insurers operating in the marketplace, and yet a very important subtext of the legislation is that we want these things

to bring about a different set of dynamics between consumer, between providers, between that. And so we are facing, I think, and you will probably see it in the committee discussions coming up, of a real tension between, okay, you've got somebody who is trying to start up, who is going to be competing with some pretty big and pretty professional entities, and yet we really wanted to do all these other things that are really kind of nice and that might save the world going forward. How do you reconcile those tensions?

MR. WEBB: Any ideas? (laughter). No, it --

MR. BUCHANAN: I mean, it's a little bit tongue and cheek, but I mean the reality is, that's the tension that -- stick around for a few minutes -- we will be grappling with, because we know -- there is so much that we know that the health care system needs to be changed, and it's almost irresistible not to grab these entities and say, you shall do it, when we haven't required Aetna, with all of its billions of dollars, to make those same changes. So, I mean . . .

MR. WEBB: Absolutely, and that's where this is difficult. All of these new things that they will

be required to do, do go into what we call business risk, and this will actually increase the amount of risk that this company is going to have, and that's going to put some more pressure on them to have more finances and to make sure these things work. You hope they do, but there is going to be a lot of pressure on these companies, and breaking into new markets is not going to be easy, especially when everybody else is trying to consolidate and everybody else is trying to keep everything together as these new entities come on-line and all these subsidies are out there, and things like that. It's going to be very difficult.

MS. RIEFBERG: I respect the tension you face.

MS. STANLEY: May I ask a question?

MR. FEEZOR: Any further questions (inaudible). Margaret?

UNIDENTIFIED PARTY: Margaret --

MS. STANLEY: Yes. I can barely hear you. I did have a question. Can you hear me?

MR. FEEZOR: Yes. Yes.

MS. STANLEY: Okay. Typically insurance companies will have a significant part of their

business in the large group market or the self-insured market, and if they are in the small group or individual market at all, they would perceive those markets to be much more volatile and subject to losses from year to year sometimes, and yet, we are requiring that these new entities focus only in small group and individual. I am wondering if our panelists have any suggestions on how we might structure or instruct these applicants to try to minimize the risks in these markets?

MR. WEBB: This is Brian. There are a couple things already in the law that will, we believe, help. One is the three years of re-insurance for the individual market only, and that's where they are taking money from large group individual TPAs and shifting it all down to the individual market. We think that would be of great help to these start-up companies, as well as all those in the individual market, who are having to take on this very volatile new risk coming on. For the individual small group, they also have the risk corridors in the first three years, which should help as they are setting rates to

provide some stability to them. So, from a financial standpoint there are some things that will help, but you have hit on a very valid concern that we all have, is that -- especially the individual market is going to change considerably from state to state. They all are. And, a whole bunch of risks that we don't know about. And these companies, we are asking them to take on this very unknown, and also to do it and keep rates down, and try to lower their profits. I mean it's going to be very difficult on these companies, that's a given, but there are some things at least there, and people are looking at it, and states are taking it very seriously as well, and may look for some other tools to try to try to level things out in those two markets as well.

MS. STANLEY: Thank you.

MR. FEEZOR: Tim, you have the last question.

MR. SIZE: Oh? It's a good question, but I am not sure it's that good. Vivian, I totally, totally resonate with your emphasis on the importance of getting the right management team, and I am old enough to have been around in the early to mid-1980s when we

had a similar kind of land rush to create new, then what we called HMOs, and I know how difficult it was to get the right team, and how tempting it was to get any team. And, I guess if you just comment on that and what are options to just simply thinking you could hire someone? I guess I'm inviting some reflecting on strategic alliances for that core capacity. And, Brian, if you have thoughts as well?

MS. RIEFBERG: Look, there is no substitute at the end of the day for leadership that can lead an organization and help make it successful, and I don't think this is unique to private sector. This is a private sector, public sector and non-profit sector world. And you all come from different backgrounds and with different experiences, but I think what I am saying, you probably all have somewhere where that resonates.

I think there are ways to get some help through third-parties and contracting and technical support, but then the onus to have really good integrative skills becomes very, very important, and so that's one way to supplement things. But, I think the

law, as written today, does not contemplate a lot of flexibility beyond, you know, what I'll call contracting or other arrangements in terms of ventures with parties who have a lot of other skills that could be brought to the table. So I think you are going to have to look hard for the skills that are needed, and I think you have to be very mindful of your point, which is the search for capability does not turn into search for anything, but is in fact the capability that's required.

MR. WEBB: The only thing I would note is what we see with health insurance is it's a very local thing; each market is very different from the other. A lot of things states are looking for when they see there business plan is that they have somebody who understands the local marketplace, understands the providers, understands who they would contract with, understands the market that they are going into, and you know, just having some management team, you know, that doesn't really understand what they are trying to do. These kinds of co-ops have historically kind of come up organically in areas surrounding people in the

area, who basically are the marketplace or are the provider groups and things like that, and that's kind of what you are looking for here; you want people familiar with the area, who really have a mission in mind to go out and provide the best care for the best price in that area.

MR. FEEZOR: Thank you both very much for a great discussion, and also particularly for your written testimony, which went into more detail. We had asked our last month's meeting panelists -- that we planned to publish their names as potential experts that can be gotten to, and the only question, as I looked over you guys' testimony again is, you don't mind if we plagiarize some of your recommendations, do you?

(No audible response).

MR. FEEZOR: Thank you both very much.

MS. REIFBERG: Hopefully it's been helpful.

MR. FEEZOR: It has been indeed. Thank you. As we move to our first panelists, I am going to ask Bill to go assume the hot seat. Let me say what we hoped to do, what the due process was today, and this

would be my recommendation subject to some better ideas being put forward. As our sub-work groups present some concepts, and they will be probably grouped in those that they feel that they can make some -- or that they are in fact making recommendations about, would hope that our discussions, if in fact the body, the larger body agrees with that, that we might -- that is, we being the staff and the rest of us -- sort of put those in the category of probably a recommendation that we will make. In other words, as they make a recommendation, we will discuss. If there is a lack of consensus, then that's one thing, but if there is some general consensus on that, we would sort of put that in the category of that is -- it will go into at least the preliminary drafting of our recommendation. If the issues presented by the sub-groups are more problematic and need a more working, maybe a bit more information, we will sort of set that aside, and that will be, by the way, for that work group to take back and try to do in the first two weeks probably after this meeting to resolve that.

And then probably a third category, if, in the course of the discussions, there are some substantive questions that we haven't even thought of that fall in sort of that bucket of that work group, then that would be sort of the third category. So again, one that we will, if there seems to be general agreement, that we will sort of move over into the category of, yeah, we'll make our recommendations, at least at this stage, if it needs more work, and then totally new ones which we have not had. I would suggest that we not worry about word-smithing; that we get general concepts. The group has got tripped up a couple times, and for a good and valid point this morning, on the discussion between -- the difference between integrated care and coordinated care, and I think many of us think there are some significant differences there. And that one is not just a matter of word-smithing; that one may actually be something that we will set aside and actually have a couple of people try to work on it. If there is a question that seems to be sticking, the Chair is going to try to set this aside and say, can we work on that, so we don't slow down the larger process.

If there is something like, I think there ought to be a different term there, that's what I call word-smithing and we are not going to use the collective time of this group to do that; just simply say it can be worded better, and we'll be working on that in the health center.

The other thing is, if there are some issues that are particularly dear to your heart, it doesn't necessarily have to be in the one that you are in a work group on; that is, we move towards some drafting, either say I'd like to be put on that, or I'd like to see that. You can either say that here, or probably preferably make sure that one of our staff members, Annie or Barbara, say, geez, when the issue of a minimum financial capital or risk-based capital comes up, I'd like to participate in those discussions.

So that would be -- a couple of other things -- we are first making recommendations. We are making recommendations that the Secretary should follow in trying to carry out the legislation, and then there is always that dynamic between wanting to be prescriptive, and the work groups in the past week or two seem to

have come up with a couple ways of trying to deal with that. Maybe instead of being precise about it, it ought to be X, that it simply says it should be present; a nuance of difference, or that, in fact, if it's something that -- the difference between the old accreditation thing between shall and should; shall is that, yeah, it really be, these entities should have that; should would be that it's strongly encouraged, and in fact it might provide, which is sort of another category, of what would be a preference. I think, Mike, I think it was your group that talked about being some -- there was a strong preference for X or Y, or maybe that was the government's group. I'm getting all confused now. So I probably now have confused everybody, but is that -- generally, again, sort of trying to get, as we go through our topics, sort of three buckets: yeah, it will make the report, and with Barbara's help -- both Barbaras -- I will try to make sure that seems to be a principle that will make it over into the report; it needs more work; or if they are totally new questions that will need to be assigned, let's put those up, spend a couple of minutes

on them, but not burden -- try to debate that one anew here.

MR. OEMICHEN: Thank you, Mr. Chairman, and thanks for that introduction, because that's exactly how the Governance sub-committee has prepared our presentation. We have a relatively short PowerPoint, because we thought that would help illustrate the definitions we were dealing with, the questions, our recommendations, and I assume, Mr. Chair, we are thinking this is a -- is this an interactive presentation, where people can ask questions as we go through this hopefully, and . . .

MR. FEEZOR: With this group, I don't think we could avoid it, but . . .

MR. OEMICHEN: Yeah. I would agree. And just for a quick bit of levity, since the productivity of your average was constant worker today is absolutely zero, I hope your expectations from me are not much higher than that, and because I was in product safety I passed out cheese-heads for everybody. Hopefully you have them. They go out the -- yeah, exactly, Barbara -- they go at the head of your pen. These are not

edible, so don't attempt to eat these. And, my final comment is, I am proud to be one of the 111,000 owners of the Green Bay Packers, so with that all set aside -- community owned. Okay. Well, obviously I didn't get a whole lot of sleep last night.

We'll go right to the presentation on the charge to the Governance Committee, which is the next slide, and hopefully -- yeah -- and maybe that's just the best way to do it -- for all the groups was to review our testimony, the statute, all the examples of co-ops, and so Rick, Mark, Pat and I sat down. We had our first meeting on late Friday afternoon on January 13th. We had a continuation of the meeting last night through the first quarters of the Super Bowl, and these are the recommendations that we have come up with to date for all of you.

The first is on the qualifying non-profit entity, and I am going to go through this relatively quickly, because the other little side comment I'll make, and I made this to the group last night, as someone of Germanic heritage, there is always a time clock going in my head, and I can't possibly go

overtime. So we are going to go through this pretty rapidly, but again, stop me if you have any questions. But, our first application is -- or our first recommendation is the applicant shall form the relative non-profit entity prior to completing the application for the co-op loan or grant funds and present evidence to this effect. What does this mean? Basically we are looking at, do they have to form the entity up front, or is it okay for them to say, we are looking at forming a non-profit entity, and if we get the grant, then we'll go forward under state law and form that entity. And, what the consensus of the working group or the subcommittee was that we think HHS really has to have this evidence up front to properly evaluate the application. The rationales are indicated there.

Number one, it helps indicate the seriousness of the intention. They have already pro-actively gone forward under state law and filed as some type of non-profit corporate entity.

Number two we felt, and this was based a little bit on the discussion from the last meeting, but we think it's important that the individuals who have

come together, whether it's organically or however, are protected from liability, and you need to do that through some type of corporate formation; whether it's an LLC or some other -- a co-op under state law or whatever. And so that was number two.

And then number three, we really felt, as part of the rationale, that the loan and grants have to be granted or loaned to some type of entity; so you really need to have that entity in place. So our recommendation once again is that the corporation documents have to be provided with the application for it to be considered by HHS.

The next page is the charge to the committee; what does it mean to be a consumer or member, consumer-focused, consumer-oriented, and start trying to flesh out some of those definitions within the statute? We really felt the key one was who is the member? And there were lots of different possibilities talked about in the concept of a non-profit entity; whether it's a co-op that's recognized under state law or otherwise, of who is this member in the end that keeps being referred to in the statute. And, our proposed

recommendation to the Advisory Board is the member is defined as the individual insured life. So that person who is actually -- and this is somewhat of a -- well, it's quite familiar to those who have organized cooperatives -- in the co-op world, the person who is the voting member of the co-op is that person who bought the products or services from that cooperative, or, in the case of a worker or somebody who is working for that cooperative and providing labor services, but in this case, we felt that it's the person who is actually receiving the insurance. This is to be distinguished from, let's say we have a small employer group that's part of the cooperative or the non-profit entity, while they are purchasing the insurance on behalf of their own employees, that the voting member in the end is going to be their employees, who are the covered insured lives.

And, I'll look to my committee members, if there is anything else any time during this that they want to ask questions about that, feel free to ask.

MR. CURTIS: Just one clarification?

MR. OEMICHEN: Yeah, Rick.

MR. CURTIS: The small employer, if they are insured, is also as an individual.

MR. OEMICHEN: Right. That's right, the small employer is also. Right. Okay. Yeah. Sorry if I didn't make that clear. Remember, I am half away.

Okay, conflict of interest.

MS. YONDORF: Can I ask you a question?

MR. OEMICHEN: Yes.

MS. YONDORF: Brian Webb is the UR, so that's really good on your kind of thing. I am sorry. I would just --

MR. OEMICHEN: Well, I'd like to be Brian.

MS. YONDORF: You are so efficient that I didn't get a chance to ask a question about the applicant shall inform the relevant non-profit entity? Can I just note, I am part of a group that's forming a non-profit entity, and it's taking the IRS forever to give us --

MR. OEMICHEN: Right.

MS. YONDORF: Is it okay if we say an applicant shall apply for the relevant non-profit

entity prior to completing the application? I just say that because --

MR. OEMICHEN: Yeah, let me clarify. We had a lengthy discussion on that last night. What we are talking about is form the non-profit under state law. We are not talking about completing the IRS tax application, because that could be different. In this case, this is a 501 -- potentially a 501(c)(29), and the process hasn't been fully evolved there. We don't know exactly how long it will take, so we are just saying that they are formed under state law and provide evidence to that. It's hopefully the intention of the applicant to go forward and complete whatever non-profit documents they have to file with the IRS to qualify for that, but we are not saying that in this recommendation. We could clarify that a little bit further.

Conflict of interest -- that too was a pretty significant area of interest by the members of the sub-committee, and we felt that all through the process that there should be best practices that are created in disclosure, conflict of interest, safeguards, all

basically attuned to the fact that we have to make sure that these entities and how they operate stay true within the meaning of the statute. And, I think the Chair and other individuals who said, we don't want to load up these entities with all sorts of requirements and then say go out into the market and compete in that marketplace, which is going to be a very competitive marketplace, but we are saying in this case though that within the Board, for example, that there really needs to be a transparency so everyone understands what it is that they are discussing and making decisions on. And so we haven't gone through and fully fleshed out what all of those best practices are. We intend, through the workings of the subcommittee, to flesh that out some more, but we are just saying that this has to be a pretty strong area emphasis within the application when the application comes to HHS, that there has to be clear evidence that these best practices and safeguards are actually in place. And the concern here is basically when they are working with -- they, being the entities, are working with surrogates and others, there was strong concern by members of the working group, for

example, that to the extent that brokers and agents are involved, other insurance companies, that any potential conflicts are disclosed, so that can be evaluated by HHS when they are reviewing the grant applications, and basically all to the extent to, once again, comply with the statute and ensure no improper industry involvement, insurance industry involvement.

So I understand that this isn't as complete as we would like it to be, but we felt that it was very important to say that this needs to be part of it. Any questions on this before I move along, because I am cruising through this pretty rapidly on purpose?

MR. FEEZOR: Jon?

MR. CHRISTIANSON: Yeah. It would help me understand what the Committee was thinking, if you could give me an example of an improper insurance activity and a proper insurance activity?

MR. OEMICHEN: Well, one of the issues that we discussed last night, for example, was, if you have a co-op, and I won't get into quibbling on what is or what isn't a co-op, but if you have a co-op under this law and it's formed by an insurance broker, for

example, and that insurance broker is deciding who is going to be on that initial board and play a pretty significant role in deciding who was going to be on that operational board, that that may be seen as some improper involvement. So, how do you get to that disclosure so that everybody is involved in that, including HHS, as they are reviewing the grant, can fully understand the relationships that people have to ensure whether or not there are any improper relationships. And so -- and that was just one example of if -- pardon?

UNIDENTIFIED SPEAKER: . . . side of that then of what would be a proper . . .

MR. OEMICHEN: A proper one is if you are looking at a whole bunch of individuals who are going to be consumers, and they are the people who start up that entity, and then they ended up being on the operational board, but they don’t have any prior insurance or any existing insurance involvement, then they are not going to have much to disclose about that.

UNIDENTIFIED SPEAKER: A proper insurance industry imports would be?

MR. OEMICHEN: Oh, improper industry?

UNIDENTIFIED SPEAKER: You did the improper analysis; (inaudible).

MR. OEMICHEN: Yeah. Well, we are going to -- yeah, and I'll get more to that as we go along further in the recommendations, because we will get into relationships with other types of entities. Yeah. Okay. I will keep going.

Board of Directors -- And, this was to -- you see the charge there?

MR. FEEZOR: Bill?

MR. OEMICHEN: Yes?

MR. FEEZOR: Donna has had her (inaudible).

MR. OEMICHEN: Oh, I am sorry, Donna.

MS. NOVAK: That's okay. My question really was -- or comment or confusion was around the member thing, but maybe we could discuss that later? I don't know if you want to stop and do it now? I am just kind of surprised by it and I am thinking through the employer. I know if the employer is insured they would be a member, but the role of an employer?

UNIDENTIFIED SPEAKER #2: There is also (inaudible) that might be (inaudible).

MR. OEMICHEN: Right.

UNIDENTIFIED SPEAKER #2: (inaudible).

MS. NOVAK: Yeah, that's --

MR. OEMICHEN: Right, as we keep going on.

MS. NOVAK: Okay.

MR. OEMICHEN: Basically we are building a pyramid, but in this case we are starting at the top and moving down and continuing to get more and more definition as we go along.

MR. FEEZOR: Tim, if you --

UNIDENTIFIED SPEAKER #2: (inaudible)?

MR. OEMICHEN: On the Board of Directors, the proposed recommendation is -- and we distinguish between the formation stage and the operational stage, and we felt that there was a significant difference between the two, and therefore our expectations for who should serve on that formation board will differ somewhat from who will serve on that operational board. And so our proposed recommendation is prior to operation of the entities -- so we are talking about

the formation stages -- the initial board should include persons who are eligible to purchase health insurance, but we recognize it's going to include others as well. And the reason why we said it should include persons who are eligible is because we wanted to have that continuity between the formative board and the operational board, or as we would say in the upper Midwest, that initial board and the operational board. But, by the new way we said this, we are anticipating there is going to be other people involved in the initial Board of Directors. Once that entity becomes operational, however, then we believe that the Board of Directors should be elected by a majority vote of its members, as required by the statute, who receive insurance form the cooperative. And so then the -- and we'll flesh this out a little bit further as we go on to the next page as well -- but basically saying that the Board should be elected by the majority vote once it's operational, but there is no member when you are in the formative stages, and therefore you are going to have a little bit different type of Board of Directors. So, again, it's not a lot of specific language there,

but it's to make sure that everybody understands we are talking about two different Boards at two different parts during this process.

Going on to the next slide, and this will help flesh it out a little bit further, we believe that there should be flexibility to allow for representation from employers and providers, who are also members of the co-op itself. So we talked about the individuals being the voting members and being eligible to run for the Board of Directors, but in some cases, -- and I can think of several; the health care co-ops that testified here at last meeting -- they have practitioner positions on their Board of Directors, and they actually state in their Bylaws for a certain number of practitioner representatives, some management, some others. But, as we'll get on later on, we do think there has got to be a limit to how many of those types of representatives are on the Board of Directors itself, but we are trying to look at -- trying not to be so prescriptive and allow for flexibility on who serves on the Board with a limitation I'll get to shortly. To get to that point, we believe that HHS

should establish a clear preference for creation of a nominations committee, have that outlined in the formative documents -- typically that would be in the Bylaws of the entity -- to nominate eligible director candidates, and then within that, have evidence of a charge to the nominations committee to try to push people forward into the Board who meet certain criteria, such as expertise on financial, human resource, or other relevant expertise; not saying that we don't want just the peer consumer member on the Board, but it's important for the success of these entities that we do have qualified persons on the Board, who have some level of expertise, to make sure that we have a well-rounded Board, and that again is consistent with some of the testimony that we received at the last meeting.

Again, require transparent disclosure of potential conflicts of interest; so what we are saying there is HHS, when they are reviewing these grant proposals, should be looking for evidence of that. And this next bullet, the third bullet on the page; require Board of Directors' elections incur within the first

year of operations . . . we are not so hung up on that first year. What we are saying is, once the consumer membership has been determined, then the Board should start looking at transitioning to the Operational Board, and start having elections by the membership for that Board of Directors and transition out of that initial Board. The concern we had here is se feel that it’s important to have some kind of nudge to that entity, so that they don’t try to operate with that initial Board for too long of a time period, because that’s the time period in which they could maintain control of that entity, and the longer that happens, that could potentially go more towards being an improper type of relationship. Because you are going to have -- in some cases, we are anticipating you may have insurers who, just because they are good people want to get involved initially and help form these entities. Why they would do that, we don’t know, but if that did happen, we would want to make sure that that involvement will cease once we get to that operational Board of Directors.

And then probably most importantly in terms of a black line here, we highly recommend to HHS that consumer members should comprise at least 51 percent of the voting membership of the Board of Directors, and we believe that that's necessary to be consistent with the statute, so that the voting majority on the Board -- it could be more than that, but it's got to be at least 51 percent for it to be considered a consumer type of entity.

Preference for the articles or bylaws and indicating a Nominations Committee intent to nominate more candidates for the Board of Directors than there are seats; so we would like to see contested elections in that as well. Any questions on that? Yes, Barbara?

MS. YONDORF: Yeah. Can you comment -- I am totally in sympathy personally with the at least 51 percent of the voting membership being consumers, and I really understand that, but one of the things I am concerned sometimes is our going beyond what the statutes say, and the statutes say, you know, all the members have to be -- I mean, the members have to elect the Board of Directors, --

MR. OEMICHEN: Right.

MS. YONDORF: -- the Board of Directors has to approve it's bylaws and how it operates, and this is saying that we are going to add *you should*, *you must* have at least 51 percent; and so, I guess OSIO can do what it wants with that, and certainly it's consumer-operated plants, but I am just wondering whether we strongly recommend that preference be given, or something? I just don't know if you guys have talked about the *should* as a condition. And, the final thing is just, in the early years, it is possible that you only have 400, 500, 600 people initially of individuals and in small employers and their employees, and you could actually have some difficulty getting people to participate in those earlier years. So, again, personally I agree with you, but I don't know whether that's something in an out year that you try to achieve, or what your group said about that?

MR. OEMICHEN: We had a pretty extensive discussion. Pat, did you want to make a comment on that? You had your hand up, and I want to make sure we

get to every member of the Governance Committee on this talk.

MS. HAUGEN: Yes. I believe our final discussion was that this should be a *shall* --

MR. OEMICHEN: Shall.

MS. HAUGEN: -- versus a *should*, but that the reality of being able to implement that is going to take into the true operational phase, where you actually have qualified trained consumers that can be a part of this; so that window and transition period was discussed.

MR. OEMICHEN: Yeah. And, I don't know if any of the other members of the Governance subcommittee want to talk to that. It looks like Mark?

PROF'R HALL: Well I got there to late for the *should/shall* strong, medium and weak preference discussion, but I think that Allen highlighted that at the beginning, and I do think, you know, when we are done with all these, you know, recommendations, it might be worth re-evaluating that; whether it's our role to pronounce a *shall*, or if we just express sort of degrees of preference. But, suffice it to say, we

had a very strong preference for the majority voting, but I would be more amenable, I think, to a qualification that says that most or all of these sort of strong recommendations could be, you know, waived in exceptional circumstances or balanced with, you know, the complete picture of what the applicant is proposing. So I am a bit reluctant also to make any particular recommendation in absolute that could never be -- that could never have an exception.

MR. OEMICHEN: And, Rick.

PROF'R HALL: That's simply my own two-cents worth.

MR. CURTIS: And, we did talk about this transition issue, and I think the final recommendations to the Secretary from the group should emphasize that this is, in part, a matter of scale, and where something does have a slow ramp-up, then it will have to be a longer period of time before a permanent Board takes effect.

MR. OEMICHEN: And, just by nature of a PowerPoint, we weren't able to put all of those items into this, but we had a discussion with the Chair last

night about what type of text we would putting in the report, so we will be certainly including all that.

MR. FEEZOR: All right. David?

MR. CARLYLE: Yeah. I am just trying to sort out the nuances, and it's kind of the words -- you know, the members -- you know, when you talk about your operational board, you say the Board of Directors should be elected by a majority of its members. You know, are the only people on the Board going to be members? I mean is that what you meant, --

MR. OEMICHEN: No. No.

MR. CARLYLE: -- or you specifically did not mean that?

MR. OEMICHEN: No. We are talking two different types, and I am not sure I am going to explain this as well as I should.

MR. CARLYLE: Well I'm talking about the second Board, the operational board, not the foundational board.

MR. OEMICHEN: Right. Because we could have said that the Board could be anybody that the members decide to elect from wherever they come from, and we

felt that that would have been too extreme of an example, and we said no, no, no, the Board of Directors ahs to have some relationship to those buying the products and services of that insurer, at least some of them do. And, in this case, we set on 51 percent, a bare majority -- it could be more than that -- but we said it was not sufficient, from our reading of the statute, to just say the members of the cooperative could elect anybody they want to from wherever they had come from to the Board of Directors. We just didn't feel that that was acceptable.

MR. CARLYLE: So the operational board can have people who are not members, --

MR. OEMICHEN: Yes.

MR. CARLYLE: -- but not in excess of the majority?

MR. OEMICHEN: Yeah. As I indicated earlier, it could be practitioners; it could be whoever the Board feels has the relevant expertise they need to have on that Board of Directors outside the actual consumer members of that Board of Directors. So we are trying to keep it fairly flexible, but, to one extent,

we are being fairly prescriptive by saying 51 percent of the voting control of that Board should come from those buying the products or services of the insurer. Sounds like Congress.

UNIDENTIFIED SPEAKER: (inaudible) state in this question. When I hear the 51 percent, I am reminded of the Bureau's requirement with federally qualified health centers that I have worked in for years and among the homeless, and the need for consumer input. I agree wholeheartedly, but I also want to separate in my mind between having a clear mechanism for consumer input and having absolute prescription when it varies from a community health center in one city to one in say a rural area. And so I just wonder when we are trying to not be absolute it seems like in this, is there room to say what it is we want, which is, I think, a clear mechanism for consumer input with a preference for, and with a directionality that we want it to be maybe majority, but in the beginning, to have a little more flexibility? It just seems like the same preference versus even *should* or *shall* with a description of what their plan is.

MR. OEMICHEN: Mmm-hmm (in the affirmative).

UNIDENTIFIED SPEAKER: Because frankly, having 51 percent isn't a magic number, in my opinion, --

MR. OEMICHEN: No.

UNIDENTIFIED SPEAKER: -- but, having a plan and something that takes into account seems important.

MR. OEMICHEN: Well, we tried, as I had said before, distinguished between the formative stages and the operational stages, first of all, and separate out who is going to be on the Board of Directors in that time period, because of the different needs at that time.

UNIDENTIFIED SPEAKER: Right.

MR. OEMICHEN: And, I don't know about the other members of the Governance Committee; I am happy to include some text in the report saying what we want is a clear mechanism for that consumer input, and I am familiar with a lot of different models by how that happens. Last night we had this discussion of the *should* and the *shall* on this one, and I am sure we are going to have further discussion on the *should/shall*, because the fact of the matter is we don't decide this

issue. Whoever is reviewing the grants for HHS is going to decide whether it's sufficient or not. I think what the Committee was really trying to say though was we really think it's important for that consumer voice, for that consumer voice to be on that Board of Directors, because that's the governing body that's going to decide who gets the contracts, what the contracts say, all of that, and that's why we really feel it's important to have strong consumer representation at that level.

MR. FEEZOR: Jon?

MR. CHRISTIANSON: So, just to make sure I understand, all members of the Board will have to be appointed through an electorate process?

MR. OEMICHEN: They will have to be elected, yes.

MR. CHRISTIANSON: Okay. So, in the Finance Committee, we talked about the desirability of having financial support for these organizations beyond government money, and using an analogy in the venture capital world, if I am an angel, I'm going to want an appointment to the Board in return for my donation of

start-up money; so is it possible the committee could think about whether all positions on the Board would have to be fully elected positions particularly in that first initial Board?

MR. OEMICHEN: Well, the initial Board, we are not going to have that issue on the formative Board. It's only once we get to the operational phase will we have that issue. And we are trying to be fairly flexible about who can serve on that other 49 percent, if you will, and it could potentially be a hedge fund person. We read the statute to say that the Board has to be elected by the members, and that that was an absolute requirement of the statute, so we don't feel like we can vary from that. What we tried to do is look at what types of relationships can these entities have; whether through joint ventures, partnerships or whatever -- and hopefully I'll get to that in just a moment -- but, as far as electing -- as far as appointing a hedge fund person to that Board, I don't think the statute allows for that.

MR. CHRISTIANSON: Well, the members could certainly vote --

MR. OEMICHEN: If the members vote for it, yeah.

MR. CHRISTIANSON: -- to accept the --

MR. OEMICHEN: Right.

MR. CHRISTIANSON: -- money and appoint the owner, right?

MR. OEMICHEN: Right. But, as a contractual agreement, --

MR. CHRISTIANSON: Yeah. I mean, do you think that that needs to be clarified in your recommendations, or do you just think that's something that everybody will figure out?

MR. OEMICHEN: Oh, I think we will be defining this all a lot more fully in the report.

MR. CHRISTIANSON: Yeah. I think it's an important point to remember as, you know, -- so we -- but --

MR. OEMICHEN: Right.

MR. CHRISTIANSON: Yeah.

MR. OEMICHEN: Right.

MR. FEEZOR: Pat?

MR. NOVAK: I think that, in our discussions, the challenges is to more clearly maybe define this interim period in the start-up, because one doesn't want to be so prescriptive that you limit the success of the organization, but yet make certain that it is consumer-governed, and consumers are clear decision-makers, to not be just cosmetic on the Board long-term; so I think that's some of the challenge going forward.

MR. OEMICHEN: And that was the whole reason why we wanted contested elections, for example, to the extent possible. We did not want to have self-perpetuating Boards of Directors. There are plenty of examples in the mutual insurance world where that happens, and even though they are considered cooperatives, we typically, as a cooperative community in the upper Midwest, don't associate much with them because they don't act like consumer-governed entities, even though technically under state law they are. And, we'll try not to get off in the deep weeds on that, but if you want to have a further discussion later, I would be happy to do that.

MR. FEEZOR: Tim, and then we'll try to get the next one.

MR. SIZE: Yeah. I just want to emphasize what I heard Jon saying, because I think I have the same concern. I also want the majority of the Board to be members. I prefer that term, than the consumers. But also I want to make sure that we don't box ourselves in a corner and not be able to have good strategic relationships where it would be totally justified had other individuals, who were not members, or not primarily have any membership role on the Board, just as long as -- so I don't want to go in either extreme.

MR. CHRISTIANSON: Right.

MR. OEMICHEN: So let's get into those a little bit deeper weeds on the next slide.

Related entities -- and this was an area of significant discussion, because we wanted to allow for flexibility by the cooperative, as the term is used in this statute, with others, to try to get the expertise, the financing, whatever you need to make this successful. So we have a series of proposed

recommendations. The applying entity -- so that entity which is applying for the grant or the loan from HHS -- must be a non-profit consistent with the statute, and then to carry out the purposes of the statute, the entity could own any legal subsidiary area for profit or non-profit, but the controlling interest and the proceeds must narrow back to the benefit of the, in this case, to use that term again, the co-op. The parent company of a grant or loan applicant cannot be a for profit entity. And the Committee felt pretty strongly this co-op cannot be owned by somebody else that's for profit; that that would be a significant issue with the statute.

Partnerships or joint ventures would be allowed, so long as the appropriate benefits accrue. The co-op members -- and I am sure every member of the Advisory Board is familiar with joint ventures -- but, typically there is, from whatever is going to be considered the profit, financial or otherwise to that entity, some of it is going to inure to the benefit of the co-op and some to the partner in that joint venture operation, and we account for that. We are not saying

all the profit, however it's defined, has to go back to the co-op, but the appropriate amount should go back to the cooperative. And so, by saying this, what we are indicating is it's okay to have other relationships, particularly where those relationships are needed to make this insurance cooperative successful, but that there has to be some limitations to meet the intent of the statute, which is basically that this is a non-profit entity that's receiving the grant.

Now I am sure there are going to be lots of questions about this.

MR. FEEZOR: Donna?

MS. NOVAK: I have more of a comment than a question. The owning for profit; there are a least a couple of loose plans that got very creative with not-for-profits, --

MR. OEMICHEN: Right.

MS. NOVAK: -- and started a for profit, and started moving all the business to it, so there should be a lot of restriction control.

MR. OEMICHEN: We had that discussion last night. We are planning to come up with those

restrictions. It’s well-known in the upper Midwest that when a co-op would like de-mutualize, what they do is they put all their profitable parts into some subsidiary and eventually sell off that subsidiary, and suddenly the co-op is no longer successful. So, yes, we are very aware of that situation, and we have to do some additional work on it, but doing this during the Super Bowl didn’t really allow for a lot of in-depth analysis.

MR. FEEZOR: And, Bill, as I recall, we talked about there maybe being some very heavy restrictive covenance with regards to any of the monies that go out about downstreaming any value or having prior approval on such.

MR. OEMICHEN: Right.

MR. FEEZOR: David?

MR. CARLYLE: Well I -- you know I guess I am just throwing out something I have thought about through the course of our discussions, and I don’t know whether it fits here or not, but it seems to me, if we have substantial provider involvement, some of these providers may be big systems that have multiple -- you

know, way exceeds what you would consider a definition of a small group; would it fit under something like this as a related entity that this entity -- that, you know, the non-for-profit could create a separate entity to take in that self-insured group or take in some kind of provider group that would then kind of not allow the substantially individual or small group designation to exceed, or -- you know, I mean, I don't know where --

MR. OEMICHEN: My quick answer to that is we discussed that. We haven't fully resolved that, and that's going to be part of our continuing discussion amongst the subcommittee members, because we were trying to get our arms around all the possible outcomes here, which I think is very difficult because we are trying to look at the expertises that we have of potential abuses, but also potential benefits could occur, and how could we make this a flexible enough model to make sure that we get the benefits, but yet prevent the abuses. And so we -- we still need -- we haven't had enough time to go through all of this to give a full scale recommendation today. So we'll take that example back, just like any other examples you

have as we continue to work on this. And I don't mean to punt. I don't like to punt, but, in this case, we have to punt to at least some of this, because we've just got to continue fleshing all this out.

I don't know about you, but we felt -- the four of us being charged with governance was putting a pretty significant burden on all of us to figure out a lot of these really good point (inaudible).

MR. FEEZOR: Just a teeny amplification, and that would be, there has got to be a way to do that; whether it has to do with governance and the contractual relationships and the partnerships of the co-ops, *per se*, --

MR. OEMICHEN: Right.

MR. FEEZOR: -- as opposed to the provider system that uses -- I mean there are different ways to skin that cat, and somehow I think this group has agreement that somehow that cat needs to be skinned.

MR. OEMICHEN: We are working to that end. Right.

MR. FEEZOR: Barbara?

MS. YONDORF: Yeah. Just a quick question on your second point; parent company of a grant or loan applicant cannot be a for profit entity. So this is an insurance company, the co-op, the insurance company is going to have a parent company; is that okay under insurance law, or what would that entail?

MR. OEMICHEN: Well, I think what we were saying is what we know can't be allowed. I am not sure we are reading that -- turning that around to say what might be allowed. We are just saying very clearly that the co-op that's applying for that grant or loan cannot have a parent that owns them that is some type of for profit entity because that defeats the purpose of the statute and the language of the statute. Did I understand your question? Rick?

MR. CURTIS: Let me just add, to clarify, this slide is only dealing with what kinds of relationships the non-profit can have with for-profits,

MR. OEMICHEN: Right.

MR. CURTIS: -- and, in essence, it's saying that the for profit can't be above the non-profit.

MR. OEMICHEN: But it could be below.

MR. CURTIS: It can be below the non-profit, or, let's say, to the side of the non-profit. So, we are sort of mapping out the geographic relationships that are allowed with for profits, if any, so we are not expecting such relationships, just allowing some --

UNIDENTIFIED PARTY: To clarify (inaudible), I understand -- we are not saying that there is -- that we are allowing a parent --

MR. CURTIS: Right.

MR. UNIDENTIFIED PARTY: We haven't made a judgment about that yet.

MR. CURTIS: Right.

MS. YONDORF: Okay.

MR. OEMICHEN: But, if there were to be allowed a parent, it could not be a (inaudible).

MR. CURITS: Right.

MR. OEMICHEN: That's what I was saying. All we are saying is what can't happen. We haven't said what could potentially happen there. We just felt it was really important to say what can't happen, in our view.

Going on to the remaining questions; the parking lot, IRS filing. We still have to educate ourselves as the subcommittee further on what it takes to be a 501(c)(29), as HHS works that out with the Internal Revenue Service. We are also looking at what types of relationships can we have with providers, with MEWAs (Multiple Employer Welfare Associations), and to the extent we can have those relationships, what type of conflicts of interest would be disqualifying.

Public disclosure and transparency; as I said, we want to get -- we want to make specific recommendations to HHS, at least in the larger category of what those disclosure and transparency guidelines ought to be, and again, we don't want to make it so transparent that it means you are giving up your whole proprietary business plan to competitor. We aren't talking about that. But, within the inner workings of the Board of Directors, for example, that everybody who is on that Board knows what the contract is, what it means, and who might have any type of relationship with that entity, to which they may be contracting.

Going to the next page -- if I read my watch right, I've got about five minutes left -- page two, exploring the ability to limit conversion to for profit or non-consumer-governed issuers. That's in the statute that it is a pretty significant concern; so we are continuing to work on how do we put some limitations on there that are consistent with the statute, to make sure we are living within the purpose of the statute. Overall, the concern obviously is that we would have this non-profit entity, get a grant or loan, and there very quickly be sold off or change to a full profit.

Next bullet -- explore prohibition on government instrumentalities established in a co-op. And here the concern was a state university, and in some cases, medical providers that are part of a state university system, and to what extent can we work with them? Because, I think the sense of the subcommittee was there would be some very proper relationships there potentially and very helpful relationships, but given the limitations in the statute, what can and cannot be

done in that case, so we are still going forward and finding that out further.

As noted by the next bullet; defining related entities and predecessors; we are still going to be fleshing that out further as well, and we are not going to totally be outlining everything for HHS to consider, but at least they have a pretty strong idea of what it is that the Advisory Board would propose to them in terms of what's beneficial and what could be potentially harmful.

Next bullet -- Can sponsors of existing health plans that are not health insurance issuers create unrelated non-profit issuers that are eligible for grants or loans; so are continuing to work on that as well.

And, Terry, you have kind of a questioning look on your face?

MR. GARDINER: (inaudible).

MR. OEMICHEN: I'm not sure I could. It was just one of the issues that we put up there to think about further.

MR. GARDINER: (inaudible).

MR. OEMICHEN: Yeah. I am not -- all I know is that there are a number of parties from around the country that have made known of their interest in applying for one of these grants and loans, and we are just looking at all these different types of possibilities.

Page three -- thanks, Annie -- in defining related entities and predecessors, are there restructuring options that would allow non-profit health plans that were issuers prior to that date in the statute to participate; and what does participate mean? And, for example, we had a lot of great testimony at the last meeting from cooperatives, and to what extent can they be involved in this? Right now they tend to read this as saying they can have absolutely no involvement, because they were all in existence prior to July 16th, 2009. But, to gain the benefit of the expertise, is there some type of relationship that would be proper under the statute, and can we define what that might be, to give guidelines to HHS? We don't know at this point what

that is; we are just saying we want to put that in the parking lot so we continue to consider that.

Then the next bullet -- if unrelated entities partner together, form a single co-op -- so you have a business association, a multi-specialty large group practice, a community association, all the different potential partners out there -- should HHS give some preference to those, because it shows significant private support, or a potential for better coordinated care, or any other number of pluses that we could potentially see, and so we are trying to basically give -- if HHS is presented with this type of applicant, whether preference should be given. So that's what we are saying there.

And then, to the last page -- how should the mission of the co-op with respect to responsiveness to consumers be demonstrated -- and, I think, David, that was a little bit of yours -- showing to what extent do we make sure there is meaningful consumer responsiveness in this model, and further define as part of that what it means to be consumer-focused and consumer-oriented, because, among other things, that's

in the title of this section of the statute. And then finally, what must the founding organizations demonstrate to ensure that governance will meaningfully include consumers once enrollment begins? We have one checkmarked already. We need to see the articles and bylaws at the time of the application, but what do we really need to see that's going to evidence that, that's going to be meaningful to HHS? So again, these are all parking lot issues, things that we are still -- not to say that we haven't already discussed this, considered this, but we were not ready to make a recommendation to you, as the Advisory Board, today on these various issues, as we continue to try to get our heads around all the potential implications of our recommendations.

So, with that, I think that I am on time.

MR. FEEZOR: Yeah, I'm going to -- the Chair is going to give you five extra minutes here, Bill, since you won the Super Bowl last night. What I would like to try to do, the last four slides that we covered are issues that the group is going to be taking back and doing more work on, and if there are some strong

issues or questions you want to put to the group, I am going to ask you to sort of share those with Bill during the break. Let me go back to, I guess it would be back to the beginning and do a quick check-off. And, the first would be the guidance that the sub-group has given us, that it should be a not-for-profit entity, that in fact is licensed subject to the state's laws, that is the applicant, if you will, and that -- as soon as we get clarification on what the 501(c)(29) is, and/or whether that's going to be absolutely required, or if there are some other flexibilities, it could be a 501(c)(3) or something like that -- that we would speak more to that, but that the entity itself has to be a not-for-profit licensed at the state -- or organized -- excuse me -- at the state. Anybody have major concerns about that, and is the expectation committee that then somewhere either before or by the time the money is committed that they will have filed for the appropriate IRS taxes -- and, Terry, that gets back to your thing; that the IRS doesn't say whether you are not-for-profit; they just tell you what your tax status is. Now --

MR. GARDINER: You're asking me?

MR. FEEZOR: Yeah. Is that - I mean -- any major concerns on that?

MR. GARDINER: Bill, (inaudible).

MR. FEEZOR: There are concerns with that. We will polish it up a bit and try to get some clarification of the sequencing of that.

MR. OEMICHEN: Okay. Very good.

MR. FEEZOR: And, at what time the IRS -- it very well may be that the IRS cannot issue the 501(c)(29) until we have in fact, --

MR. OEMICHEN: Right.

MR. FEEZOR: -- until HHS has enacted on it.

MR. WEBB: Right. And we specifically said we are not making any requirement about the tax. We are only requiring state corporate filings, period.

MR. FEEZOR: Yes. Well, and that there be the process or expectation that they would be filing something with the IRS at some point in time.

MR. OEMICHEN: And we did say that they need to show us at least intent of going forward with the

non-profit filing to meet the requirements of the statute.

MR. FEEZOR: Yes.

MR. OEMICHEN: But, you don't have to have that process completed at the time.

MR. FEEZOR: The second, and maybe one that was more on point is the definition of the consumer member; again, distinguishing the importance of that from the, what I call the initial operational or formation board, --

MR. OEMICHEN: Right.

MR. FEEZOR: -- but more as the term that will be much more in play once the co-op becomes operational, and that the member in fact an insured life. Discussion? David?

MR. CARLYLE: Well, I mean I just go back to raise what I raised earlier, and I hope Rick Curtis is right. I mean, to me, you've got the very real possibility that there are certain provider groups who really think they want to be part of the co-ops and want to, you know, move their members over to the co-ops in a group that is considered larger than a small

group, and if they do, you know, would those -- you know, if they bring in 1,000 members all at once to a big hospital system, you know, are they going in as members, or are they going in as a subsidiary separate from this group of members who are, you know, actually voting for the Board of Directors for -- and, I am just raising this as something we are going to have to contemplate ultimately, and you know, I am happy to live with this definition today. I just think there may be nuances we have to kind of debate in the future.

MR. FEEZOR: Yeah. But, David, if it's an insured group, they in fact become an insured life. Now, whether they meet the substantially all is a separate issue that we'll deal with elsewhere.

MR. CARLYLE: Right.

MR. FEEZOR: So, I mean, I would --

MR. OEMICHIN: Yeah. We have talked about what if a MEWA decides to participate in this so that you have a self-insured group; are those all considered members too? But, we felt as a baseline at least, to define member, as best as we could at this point, we had to say, because the non-profit is being formed to

provide insurance, that's the person getting that insurance.

MR. FEEZOR: Rick?

MR. CURTIS: Because of a couple questions earlier, this is perhaps worthy of clarification. I was confused about it during our discussion until you clarified. Putting aside the big employer issue, which is partly a statutory issue, how we deal with that, if there is a small employer, the small employer is an individual and their individual workers who are covered are each members, but you could have a co-op, and to me, in the report, we might want to sort of clarify this as a possibility that a given co-op could set aside so many board seats for members who are actually small employers. And, I think where this becomes particularly important is not for the small employers who participate in an exchange and their individual members are the ones choosing which plan they are in, but for the small employers who participate as a group, and they are really the purchaser and they are paying for most of it. And, where you might have the substantial amount, degree of that kind of employer

choice going on, I think it could well be critical to the success of the co-op that they have that kind of structural relationship.

MR. OEMICHEN: And I think the members of the subcommittee, we fully agreed that we would include that type of language. Just to give one illustrative example, I helped with a number of people forming the Farmers Health Cooperative of Wisconsin. On that Board we have Class A and Class B members of the Board of Directors. Class A are the consumers, the farmers, but we allow in agri (ph) businesses. Class B are the agri businesses, and they have several seats that they can elect. And, in a separate election it's all ratified by the whole membership, but there is a designation on the different types of seats, and I think we would think that that was just fine. So we will be including language in the report that gives that type of flexibility.

MR. FEEZOR: Donna?

MS. NOVAK: Just a quick one. It's only because it's brought up here. If maybe you could come back? I am assuming from our language that for the

purposes of this, what we are working on, we are really using the terms member and consumer interchangeably, and if that’s what we mean and you could give us a recommendation as such, I think it would clear up a little confusion about language. But, just for the --

MR. OEMICHEN: Yeah. And, I apologize.

MS. NOVAK: No. Just for the future.

MR. OEMICHEN: For me they mean the same thing, and that’s from heading the Consumer Protection Agency for six years. That’s how I tend to think. And so I saw them as synonymous, but we’ll definitely make sure that we clear that up.

MR. FEEZOR: Moving to the issue of conflict of interest -- Donna, I am sorry?

MR. NOVAK: I just want to get clear exactly what you are saying about the member. So, if you have got a small employer, and the employer, the owner, does not have their insurance through the co-op, but a number of their employees do, they would not be voting? Or . . .

MR. OEMICHEN: You know, who is paying for that insurance, the employer?

MS. NOVAK: Well, and that’s where I am kind of going with that?

MR. OEMICHEN: All right.

MS. NOVAK: They are the consumer, in that they are paying at least a good part of it, if not all of it depending upon . . .

MR. OEMICHEN: Right.

MS. NOVAK: So they were paying for it; they are just not covered, so would they be considered a member?

MR. OEMICHEN: At least as the way we have done the definition now, they would not be a voting member, but their opportunity would be to try to get elected to one of those other board seats if they wanted representation in the decision-making of the cooperative, but I mean we can talk about this afterwards and look at it further, because we do have some small employers in the Farmers Health Cooperative, where the employees individually decided to become a member of the co-op. There is no employer’s subsidy. And, in that case, we have said the employer does not have a right then really to serve, --

MS. NOVAK: Yeah, that's --

MR. OEMICHEN: -- but in a case where the employer is actually paying the premium, then I guess I can use my example; my company belongs to Group Health Co-Op of South Central Wisconsin. It's actually all my employees, including me, that have the eligibility to vote and run for the Board of Directors, but there is really no, nothing representing the employer within Group Health Cooperative.

MS. NOVAK: Okay.

MR. OEMICHEN: It's assumed that it's being represented by all of us employees, including me, as the CEO. And, I can run for the Board as an insured life, as the CEO.

MS. NOVAK: Okay. At least I --

MR. OEMICHEN: I know that may seem a little -- there are lots of different ways of structuring the Board until I think -- to take care of the concern, to make sure that that small employer is represented, so that they feel they have additional skin (ph) in the game, so they have an interest in participating.

MS. NOVAK: Yeah. Yeah. And they've got a little different perspective as employer.

MR. OEMICHEN: Right. Absolutely.

MS. NOVAK: They have a broader perspective.

MR. OEMICHEN: That's why we have the Class A and Class B seats on the Farmers Health Cooperative.

MS. NOVAK: Okay. And that's kind of what you are going to recommend then, at least for seats, if not voting member?

MR. OEMICHEN: Right. It was difficult to incorporate everything. We wanted to give you a pretty simple definition of what a member is, and then in the text of the report define that out further.

MS. NOVAK: We heard so much this morning about the importance of management, and that of course includes the Board too --

MR. OEMICHEN: Right. Right.

MS. NOVAK: -- and that they have some expertise, then at least the employer would have the employer building a business with a typed expertise.

MR. OEMICHEN: Right.

MR. SIZE: (inaudible).

MR. FEEZOR: Hit your button, Tim.

MR. SIZE: And, maybe to restate the obvious, in a co-op business model we use the member in two actually distinct ways. You can be a member of the co-op and then vote for members to serve on the Board of Directors, and you can be a member of the Board of Directors without being a member of the co-operative.

MR. GARDINER: Is this the voting member too?

MR. SIZE: Well we have been going back and forth using the word differently without distinguishing.

MR. FEEZOR: Okay, with that, any major suggestions or discomfort with the conflict of interest? My determination on that is basically it's a state-of-the-art conflict of interest, disclosure, Board of Education and the likes.

(No audible response).

MR. FEEZOR: If not, then the -- and the characteristics of the Board of Directors, major concerns, discussion points, recognizing some were preferenced and some were specific characteristics to look for?

(No audible response).

MR. FEEZOR: And then lastly, and I fear to do this since we are trying to get into break, related entities? That one -- and, Bill, help me, the effort there was to make sure that in fact the co-op, the entity receiving the grant in fact was the premier and was not subjected to any further controls?

MR. OEMICHEN: Exactly.

MR. FEEZOR: And that it allowed as many derivative or subsidiary enterprises as might be needed to carry out the functions of that enterprise, --

MR. OEMICHEN: That's right.

MR. FEEZOR: -- not excluding for profits, in some cases?

MR. OEMICHEN: That's correct.

MR. FEEZOR: Rick?

MR. CURTIS: If that's true, that sounds right to me. I think maybe we don't need the second sub-bullet, because there would be no parent company, if it has to be -- it has to be the parent company.

MR. OEMICHEN: Yeah. I think we were, again, just putting that as a negative just to make clear that that was not a situation we were going to recommend.

MR. FEEZOR: Terry?

MR. GARDINER: (inaudible) . . . you know what you have focused on here is, you know, sort of the judgment standard of these appropriate or inappropriate is, you know, where the benefits are flowing.

MR. OEMICHEN: Right.

MR. GARDINER: I think the other issue would be control; does the organization of the partnership or joint venture give that other party -- and lots of ways to write; get a few smart lawyers -- and, you know, actually gain control over that non-profit through the way it's structured? So I think control would be another judgment point, not just the flow of the benefits. We don't want to --

MR. OEMICHEN: And I think we would all agree. We had some of that discussion. We just didn't include that word in there, so that's very well taken.

MR. CURTIS: Let me just -- before that ditch that second bullet, we are not saying, I don't think, that the co-op can't have a parent. The co-op could have a non-profit parent.

MR. GARDINER: (inaudible).

UNIDENTIFED PARTY: The discussion just before that, as I heard Allen, he was basically saying the co-op, in effect, has to be the parent organization. It cannot be a subsidiary of something else. Did I hear you correctly?

MR. FEEZOR: But that is somewhat contrary to what the second bullet is, which is where you said it needs to be taken out, if that's the interpretation we are trying to reach.

MR. CURTIS: Right.

MR. OEMICHEN: Yeah. I don't think the working group has got to that yet.

MR. CURTIS: No, we did not.

UNIDENTIFIED PARTY: Okay.

MR. CURTIS: But it does relate to this difficult issue of relationship to provider organizations, and that would be a partnership rather

than it’s a subsidiary, I would think, if the provider organization needs to be the parent. It’s consumer-governed. We should not rush to judgment on this. Maybe this is another one of those things for further discussion.

MR. FEEZOR: Yeah, let’s take that one back and do a little bit more scratching with that one. Mark?

MR. CURTIS: and we will do that.

MR. OEMICHEN: Okay, let me just say, I thought the slide was simply addressing what relationships the non-profit can have with for profits.

MR. FEEZOR: Okay.

MS. STANLEY: This is Margaret. I have a question on that second bullet. Could a non-profit co-op that was in existence before the law went into effect have a subsidiary non-profit co-op that would be eligible for a loan or grant under the law.

MR. OEMICHEN: Margaret, are we talking about the original co-op, if I can use that term? Are they offering health insurance?

MS. STANLEY: Yes.

MR. OEMICHEN: So they are insurer?

MS. STANLEY: Yes.

MR. OEMICHEN: I would say that they can't under the law.

MS. STANLEY: Even though they are non-profit?

MR. OEMICHEN: Even though they are non-profit. The statute's language is they can't be an insurer prior to that date. It doesn't care whether it's for profit or non-profit; it just can't be an insurer. And, if they are an insurer before that date, they cannot be the owner of the co-op seeking the grant.

MS. STANLEY: Okay.

MR. OEMICHEN: That's only my individual opinion, but . . .

MS. STANLEY: Yeah. All right. Thank you.

MR. FEEZOR: Thank you, Margaret, and please speak up, Margaret, because we get so carried away here we forget that you are on the phone, so thank you.

MS. STANLEY: Okay. Thank you.

MR. FEEZOR: We will have the committee work at that specific bullet number two and what is or is

not meant, and then Margaret raised an excellent question; if it's not an insurer, but is a pre-existing not for profit co-op, then it's probably an interesting question. Maybe the exact question we might want to turn that on. So anyway . . .

With that, Bill, thank you and you your group very much.

MR. OEMICHEN: Thank you.

MR. FEEZOR: And, we will take a 10-minute -- which means we are back here at 11 o'clock.

(RECESS).

MR. FEEZOR: Donna, since we're in finance, I assume you will be much more efficient than the governance folks were in terms of the use of your time?

MS. NOVAK: (Laughs) Well, in Bill's defense, I noticed a lot of that was due to the audience participation.

MR. FEEZOR: Well, then maybe the Chair ought to rule the next out of order until then. Let's -- if we could, our next subgroup is the finance. Certainly a very important one, since we've said that sort of

we're one part sort of loan officer here, or at least thinking through the role that HHS would have. And as the earlier discussions this morning it talks into being able to predict what are reasonably good business plans, and then also sort of touches into the area of solvency. Though hopefully, as we make our recommendations, we will try to be efficient where there are existing mechanisms that provide the appropriate safety, accountability, dealing with solvency or whatever, that we can focus on the other aspects as well. But without prejudging it, Donna, share with us the work of your subgroup.

MS. NOVAK: Yeah. And that's a really good point, Allen. We really took the perspective of the loan officer versus the regulator. I think that was touched on a little bit earlier. But we are looking more from that perspective.

Our group, as indicated in the slide here, is myself and Jon Christianson, Terry Gardiner, and Barb Yondorf. And we've met a couple of times and really had kind of a similar situation as Bill. We have some things, I think, to recommend that we've gone through.

We probably want to polish them a little bit. And then we have a number of parking lot issues that either we didn't get to or that for whatever reason are still outstanding.

The charge of the subcommittee is to identify and provide guidance on the key issues raised to date, which are the needed capital formation; the forms of capital; solvency requirements; and measurement feasibility of the feasibility study and business plan.

We are looking at a process, looking at the financial and related elements of the application, benchmarks to use to judge that application. So what's going to be in the application, the benchmarks, and then structuring the loans and grants, the timing of them. And it's really the first bullet point here that we've been fleshing out in a little bit more detail than the other two.

Our recommendation at this point is to have a two-step process. The first step would provide matching funds for the development of the full-blown business plan if a full-blown business plan is not already in place, recognizing that some entities, in

order to do a business plan that would allow the Secretary or HHS to determine if the entity could meet their financial goals, they might need some financial support. We are talking about matching funds, though, not necessarily a full loan. The entity would have to have some of their own funds in order to finance the business plan.

Then Stage 2 would be the actual application for the loan for the start-up funds, phased-in funds, and the grant. So there are two applications that we're going to be talking about, the first one just to show that the entity is serious, and then the second one would be the full business plan.

For Stage 1, we have a number of requirements that were very similar to what we heard this morning: A plan for determining the feasibility in preparing the business plan, so a plan to plan; identification of the staff, either internal or consulting staff that would be preparing the feasibility study and business plan; a description of the development team, that kind of initial management team that would be developing the business plan and starting the entity; a high-level

plan, so kind of a first draft of -- of the business plan which would include what the target market was; the provider relationships that are envisioned; intended products' benefit designs; anticipated funding sources, so any funding sources that the entity felt that it would be able to draw on; activities to be done internally versus outsourced, kind of the business structure; and a budget for the development of the business plan, so it would be the budget for what the loan amount would be used for in developing the business plan.

Then the second stage would be basically very similar to what we heard this morning as far as what should be included in a good business plan. One of the first things is evidence that the entity is working with a state insurance regulator, possibly has already applied, but at least that they have been in discussions with them and know what's going to be required to get a license in the state; a plan to develop compliance capability to meet the federal and state requirements --before I started, I should have mentioned, too, that this is a summary. We have a lot

more detail on each one of these bullets. This is kind of the peak of the mountains. So this is a summary of a lot more depth and detail as to what would be needed in the business plan.

A description of the proposed governance and structure, showing how they would comply with the governance requirements, as will be defined; description of the initial board of directors. We also saw maybe a two-phased -- you've got your initial board and showing that they've got the depth in that initial board to be able to put a company in place and get it up and running that first 90 days to a year.

Then the business plan would include the target market and enrollment projections. We talked about the fact, as we heard this morning, that there would be some sensitivity in the business plan around those enrollment projections. What if all the enrollment projections did not come to fruition, what the financial plan would look like; proposed marketing plan; the product designs; the source of administrative services -- again as we heard this morning, how are those administrative services going to be delivered?

The proposed provider network, in a lot more detail than we saw in the first stage -- you know, exactly what arrangements were in the works, maybe even contracts being signed at the point where they were asking for the funds. Proposed risk management arrangements -- already have talked to some reinsurers, if that's their risk management strategy. Competitive analysis showing that they understand the marketplace, what role they'll be playing in the marketplace. Provider commitment, as I mentioned a moment ago, actual commitment from providers to participate. Financial projections for five years, and a funding plan which would include not only the funds that they're requesting from the federal government, but also other sources of funding, and at what benchmarks they would be required.

Now we get into the areas that we have not defined quite as thoroughly and that we still have some points that we're discussing, and that's the factors to consider in approving the applications for loans and grants. Again, as we heard this morning, how do you decide among competing plans which ones look like they

are -- have the most chance of success? How do you decide, even if there aren't competing plans, if this entity has a good chance of success?

The factors that we that we are discussing that we have identified for approving the applications or benchmarks, if you will, is one, that the plan demonstrates the ability to repay the loan, even within some stress testing of the business plan; competitive analysis showing that the membership projections are feasible based on the projected premiums and benefits being offered in the marketplace; signed letters of intent from provider groups. The recommendation -- our recommendation for timing of loans, what those benchmark points would be, we're still working on.

We're still discussing the whole area of financial reserves, risk-based capital and debts. Again, with the presentation this morning, how that plays in.

Identifying the appropriate methods for reducing risk, and external certification of the business plan feasibility. So what external certification would be required, opinion of an actuary

or CFA -- you know, some other professional outside of the entity that say yes, this looks like a good business plan.

Additional areas that we're looking at is the whole capitalizing on not-for-profit co-ops, recommending how the Secretary can structure the federal loans and grants to be most beneficial to the co-ops, with a goal of repayment. So there's a balancing there between encouraging the co-ops and providing the funds, but with the goal of repayment.

Guidance on activities which consist of the issuance, okay, guidance on which activities would consist of the issuance. One of the questions that we have here that we would like input on -- we'd like input on all of these, but one that we would specifically like input is the whole idea of -- and this is a quote right out of the regulation -- is substantially all of the activities of which must consist of the issuance of qualified health plans in the individual and small group markets. So that was the last bullet point on that slide.

And to elaborate a little bit more, what is

the latitude of the co-ops to participate in the large group market, and the ability to rely on enrollment in large groups in the early stages. So I think what we're envisioning is two things. One is the definition of "substantially all," and we got a little bit of guidance about what -- how that historically has been defined in the past; and also the idea that maybe "substantially all" would not necessarily have to be met in the first year. Maybe it could be part of the business plan that would be met in the future, with the idea that potentially a co-op could be very successful by starting with some large employer groups in the first year in order to get some of the critical mass that they needed, and then over time reduce the percentage of their members that were from the large employer market.

Are there any questions, comments, or input on this point that we're asking for input on?

Yeah? Mark?

MR. HALL: You want on that question specifically, or the whole presentation?

MS. NOVAK: The whole presentation.

MR. FEEZOR: The whole presentation.

MR. HALL: Yeah. So I was going to ask about -- with respect to raising capital beyond what was provided by the grants and loans. So after the testimony at the last meeting, I was convinced that, you know, co-ops definitely need access to other sources of capital. And it seems like it's essential to a business plan, and we heard more about that this morning. But then I went and read the American Academy of Actuaries' reports that estimates how much the capital needs would actually be, and I know it's just a rough estimate, but basically they seem to be saying that six billion should be plenty. And so I'm wondering if you have sort of put pen to paper in terms of how much more -- if they'll actually need more than the six billion distributed across the states, or if there's a decent chance that that will be enough to get them up and going?

MS. NOVAK: I guess there would be two issues. One, is that sufficient to get a number of co-ops up and running? I don't -- I have not put pen to paper to know how many co-ops we're probably talking about here

if you -- so it’s not just how much --

MR. HALL: Well, this --

MS. NOVAK: -- per co-op, but how many --

MR. HALL: -- this is the American Academy saying, Let’s assume an average of 40,000 members per state. And that’s significantly above what we had been bandying about as sort of the -- the critical mass number, which is 25,000 per state. So if they said 40,000 per state as a -- as a low number, then we would need somewhere between two and four billion dollars in capital. And if we assumed ten times that, we’d need ten times. So extrapolating, you know, these are all rough figures, they seem to be saying with six billion in capital, you could -- you could fund co-ops in every state that had average enrollment of roughly, I don’t know, 60,000 or something like that.

MS. NOVAK: It sounds like one, you’re making an assumption that there will only be one co-op in the state. I don’t know if I’d necessarily make that assumption, that you could potentially have more than one co-op in a state. And when you start fragmenting, you also need more -- more capital.

But then my other point was going to be not only looking to see if that's enough, but it also gives an investor a good feeling when there are other investors --

MR. HALL: Sure.

MS. NOVAK: -- to come to the table.

MR. HALL: Right. So if you --

MS. NOVAK: So I think you want those other investors at the table anyway.

MR. HALL: Right. So those were projections assuming that everything went as planned. But if things don't go as planned, you need access to additional capital. Yeah.

MS. NOVAK: Right. And I think we heard that this morning, too, that you need to have in your business plan financially how you're going to handle contingencies in the future and future source of funds.

MR. FEEZOR: David?

DR. CARLYLE: Yeah. A quick question and then a more probing question, maybe. The quick question is, they talk about loans, but in -- I wasn't on the subcommittee. Have we defined interest rate, or is

there -- is it no-interest loans, or I mean, is that to be determined, or --

MS. NOVAK: From what I can tell, it's silent on interest.

DR. CARLYLE: Okay.

MR. FEEZOR: The terms of the loan beyond the 5 and 15 are not defined.

DR. CARLYLE: The other quick -- more probing question, I guess, I've been talking to individuals. Some people talked about a way to consider the federal loan some kind of senior equity which would somehow, in the term of the senior equity, it would have some extra -- some extra ties that allows other investors to come in and maybe have a process where the other investors might get paid a little bit earlier than the senior equity because of the process. And I guess I didn't know whether that's a concept you have familiarity or have any thoughts whether that's a -- a valid aspect to this kind of enterprise.

MS. NOVAK: We haven't discussed -- we haven't discussed that, what the provisions would be compared other sources of funding, just what the sources of

funding would be.

MR. SIZE: I just want to go back to the $6 billion, $2 to $4 billion, 40,000-member comment. At least the way I look at it, the program isn't about how do we thinly spread so every state gets one 40,000 member new start. The issue is to try to be game changers, and I think the $6 billion from game-changing is a very small amount. So conversations about additional capital, that's why that's so relevant. But it was also an editorial comment. I was sneaking it in in terms of what I -- I think the program is about. Because a 40,000-member plan doesn't change any game anywhere, except maybe a really small village somewhere.

UNIDENTIFIED MALE: Yeah. One of the red flags that came out of our last session here back in January was the issue about large group. And hearing the testimony from our panelists about the fact that that made up only 10 or 15 percent -- the small and individual group only made about 10 or 15 percent of their members. And so that to me was a red flag. And I'm glad to see that you've brought that and

highlighted that as a -- can you delve a little bit more into the discussion that you've had, or to the degree at which you've discussed how is it that maybe we can maneuver a little bit, shall we say, to allow better access to the large-group market, but staying within the intent of the law?

MS. NOVAK: Again, there are two things. There's the timing, you know, that substantially all would not necessarily have to be met early on. And the other is what percentage would constitute substantially all. And there is some precedent that substantially all could be as low as 65 percent.

Barbara?

MS. YONDORF: Yeah. I completely concur with what Donna said and we discussed. And I would just note that we are pursuing and want to make, if we can, a recommendation on -- that activities consist of the issuance of plans. But if you interpret that as the issuance of plans, which I would say in the insurance world is -- that part of the sentence is fairly clear, it means plans. So 85 percent of your plans would be in the individual and small group market. So if

someone, if a large group came in the local hospital with 500 members, they were issued one plan, the issuance of a plan. So it's really -- I think those words, to the common person, at least, in insurance is clear.

It's possible, though, and we're going to explore more, the word "activities" maybe we need to make a recommendation on that, as well. But I do think exactly what Donna said about the staging and the timing. We know what it takes to get these things up and running. And you're not going to get sufficient lives, likely, if you don't try and pull in a base, as well as you may, in being creative in what you do, you may absolutely want to bring in some of your larger plans, your provider groups who are working on this with you, and not have them frozen out of something they were part of building. So we do not have recommendations, but just to give you a flavor of what we're thinking -- of what we're talking about.

MR. FEEZOR: Rick?

MR. CURTIS: Two parts of one general question, and that is with respect to prioritization.

I may have missed it; you may have clarified. But I would assume that the idea here is that HHS would be very selective on who can receive a Stage 1 loan rather than 20 entities in a given state apply for and get money to develop a business plan. The idea is you're granting to an entity that shows substantial promise, that looks like yes, this should qualify, but they need some resources to do the business plan. Is that the idea here?

MS. NOVAK: That's correct, yes. And that they show they really understand what's involved -- they understand the marketplace, et cetera. Exactly.

MR. CURTIS: Okay. And then secondly, I don't think we've discussed this as a group, but this issue of where the federal government is investing. It strikes me -- I'm asking this question because of Margaret Stanley's question earlier today -- and that is, where you have a geographic area which is already served by a cooperative that would meet all of our definitions, but it already exists, why will we be throwing a bunch of money at another entity to try to do the same thing? So it seems to me that in terms of

prioritization of where -- where these limited funds -- it's billions of dollars, but it's limited funds, are invested, that I for one would recommend that we advise the federal government that those areas be a much lower priority for the expenditure of funds to develop a co-op where one already exists.

MR. FEEZOR: Pat?

MS. HAUGEN: Considering some of the testimony we heard this morning of the importance of the capability and quality of the management team to the effectiveness success of the business plan, your -- your thinking, or I guess some thought on under your factors to consider in approval, that one should call out specifically an assessment or some sort of testing of the quality and capability of the management team as a factor in approval.

MS. NOVAK: You know, we've got that as far as resumes, history with management of plan.

MR. FEEZOR: Bill?

MR. OEMICHEN: And just a quick comment. I don't want -- I don't want there to be an implication based on what Rick said that the upper Midwest wouldn't

potentially be eligible for these funds, because first of all, co-ops that already exist don't necessarily have a marketplace that's the entire upper Midwest, like Group Health Cooperative is just Dane County, Wisconsin. So I just -- I don't want that implication to go forward, as that would probably cause some anxiety in my part of the country.

But my question is based on Vivian's testimony earlier today. Was there anything in your recommendations that you think are inconsistent with what she said? Because you're looking at a two-stage proposal. She seemed to indicate everything has to be set before it's eligible for a grant from HHS. And I just want to make sure that you didn't feel that what you're recommending is necessarily inconsistent, or maybe it's purposefully inconsistent with what she said.

MS. NOVAK: What I heard her say was that she heard the clock ticking and therefore collapsed what normally would be a multi-stage process. And we just felt that you were going to get a better, solid business plan if we provided some funds up front to

entities that proved that they'd already thought this through and had the wherewithal to follow through.

MR. OEMICHEN: And as stages -- a real quick thought -- as Stage 1, is that considered out of the $6 billion, or is this the foundation grant that you're talking about trying to get access to?

MS. NOVAK: No, that's not the fund. Yeah, it's -- right. This is a recommendation to the Secretary. So it has to be the Secretary's ....

UNIDENTIFIED MALE: I'd just like to make a quick comment on Rick's comment and try to tie it in with something that Tim said. I'm not sure that having one consumer co-op in the area is a game-changer. It seems to me like if we have existing consumer co-ops that reflect something about the culture and environment in that particular area and that's a potentially fruitful area for multiple co-ops, and if you would get multiple co-op insurance plans, maybe you would have a model for changing the game. And that may be more desirable than trying to invest in areas which over time have demonstrated very little, if any, receptivity to this approach to organizing the delivery

of any kind of services. So I think there's another side to that. I don't think it's quite as clear as gee, if there is one, we don't want to try to establish another one in the same general area.

MR. FEEZOR: The definition of -- would be, include the receptivity of the marketplace as well as the competitiveness or the lack of competition.

UNIDENTIFIED MALE: I'm just raising some caution against some blanket statement that we don't want to encourage investment in areas where there might already be one co-op.

UNIDENTIFIED MALE 2: More of a comment than question. You know, we're starting to talk about game changers and how we could have co-ops be elements of game changers. And I totally agree that $6 billion spread out over 50 states is not likely to do that. Again, and I don't want to belabor this, but I think it's important as we advise the Secretary that we are adamant that we explain how co-ops, not in a vacuum but with the exchanges, can be a game changer. And I realize it's out our -- out of our sort of focus of work, but it's incredibly important that we advise the

Secretary on what we believe is going to be the best environment for co-ops to work so they can be game changers. And so to that degree, I think we should be outspoken about the interplay between the exchanges and the entity that we are focused on. Thank you.

MR. FEEZOR: Dave?

DR. CARLYLE: Yeah. My question is regarding, you know, would -- do you think in finance committee or the Advisory Board is going to come back and make recommendations to the Secretary about how to proceed in broad stretches about the amount of money we would give to a prospective co-op for the capitalization, I mean, you know, part. One of the comments came back saying that significant initial capitalization is critical to the success of a co-op. We'd be better to have just one co-op succeed because it's adequately capitalized. Who creates that framework for what is adequate capitalization coming at least from the -- the federal funds? And is that our purview, or if it's not our purview, who will kind of set some guidelines for determining that?

MS. NOVAK: I think our vision is that it

starts with the business plan that is brought in with the application, as far as the needs for a particular co-op. I don't think we can say, you know, X amount per co-op or for a particular area. It starts with the business plan.

And I think what we're envisioning is to provide some guidelines on how to judge that business plan as valid and how to determine if the entity is -- can be successful, more than -- than how much per co-op.

Another item that I mentioned here that we're looking at is how to determining the timing of the releasing of the funds. Is there so much released at certain points in time? Again, that will be very much determined about the business plan, but any guidance that we can provide to the Secretary, we'd like to provide.

UNIDENTIFIED MALE: So I'm sensing there may be another issue that we haven't charged yet to a task force, which is this question of how the $6 billion should be distributed across the states. In other words, how much should -- the criteria for allocating

the money versus picking the applicants within a state. So I guess I'll just ask the Chair and those who charged the committee whether that issue has been sufficiently put to the committee.

On that issue, I just want to remind myself and remind others that the statute has certain constraints. The statute charges the Secretary to ensure that there is sufficient funding to establish at least one co-op in each state. So that sets some constraints on what we would be permitted to recommend.

MR. FEEZOR: Tim?

MR. SIZE: I tend to go too quickly to somewhere we haven't discussed, but it's kind of naturally come up. I mean, should we be recommending to the Secretary what the reviewers should look like? Because my guess is that if all the reviewers were actuary, we wouldn't fund anybody.

(Laughter)

And if they were all activists, we'd fund everybody.

(Laughter)

So that may be worth some consideration, by

some of us.

MR. FEEZOR: Trying to antagonize the chair of the finance there with your comments about actuaries?

(Laughter)

MR. SIZE: Oh, that’s right.

(Laughter)

I have other friends who are actuaries. It was actually him that I was thinking about.

(Laughter)

It’s a -- I mean, my understanding is that this body will not be doing that work. So there -- if we’re in the recommendations game here, I suspect we should give some thought to the composition. Because it’s all --

MR. FEEZOR: Put that on your side list. There are a lot of what I call collateral issues. We need to focus on sort of job one, which is the criteria of the applicants, I think. But if you --

MR. SIZE: Well, except I do bring it up, because I think that the way we write the criteria, if we have in our mind’s eye who’s actually using that criteria --

MR. FEEZOR: Right. Well, and if there’s anything that I took away from the write-up of the history of the HMO development fund, is either without adequate oversight or quite honestly, without the adequate funding of folks to oversee the program, that there’s some significant dangers there, as well. So -- but a good question, Tim, and we’ll put that to the side. Not to say that we’ll ignore it, but we’ll come back to it later.

David, were you ....

Further questions of Donna? This group is letting her off easy compared to what we did with Bill.

UNIDENTIFIED FEMALE: That’s because finance is easy.

MS. NOVAK: It’s fine.

(Laughter)

MR. HALL: If I could just make --

MR. FEEZOR: Mark?

MR. HALL: -- one more comment on the question of “substantially all.” We did discuss last time, and I think it’s been in the back of my mind in terms of the corporate organization, that it might be possible

to -- for the co-op to be part of a larger enterprise that markets to large employers, but that the large employer issuing occurs through a separate entity, a separate related entity under our related entities rule. So if the related entities rule would permit that, then it seems to me it would help address that problem in a different way.

MS. NOVAK: The reason for the large employer focus is to get the critical mass within the organization to be able to put together the administrative systems and everything else that's needed, as well as to have potentially another stream of profitability to protect against the risk from these other markets. So I'm not sure even within the governance if a related entity would necessarily solve the problem of creating that critical mass for the organization.

MR. HALL: Well, just to kick that around a minute, I -- it wouldn't necessarily, but I don't see where it necessarily wouldn't either. What I have in mind is, we started talking about this issue of a parent corporation. So imagine a non-profit parent

that owned two issuers, one for small, an individual market and the other for large-group market. And you'd have to have, I suppose, separate statutory reserves and everything for each issuer, and they would have separate business plans and that sort of thing. But they could certainly share management, and they could potentially share, I mean, certain infrastructure and other aspects potentially could be shared or coordinated in some fashion that might be feasible, I don't know. So just another possibility to keep in mind.

UNIDENTIFIED MALE: Is the finance -- and you may have said this already, just the cobwebs in my brain, I might not have heard it -- is the finance subgroup going to be making a recommendation to the Secretary that it work with foundations to try and provide some start-up funding? We talked about that at the last meeting, but I didn't know if you had talked about it here.

MS. NOVAK: Well, the step one would be the funding for the business plan; okay? And one of the things that we were going to make a requirement is that

it was matching funds -- that the entity had other sources of funds, other commitments. So that could be from another grant; it could be from a provider group that was interested in participating. But --

UNIDENTIFIED MALE: I think what I was suggesting is maybe a more proactive recommendation in here that the Secretary work with foundations to try to identify some additional start-up funding that might be available. So that's all I'm saying, is just an additional side recommendation.

UNIDENTIFIED FEMALE: Okay.

MS. NOVAK: Yeah. I think when you think about this, there's sort of several stages. And stage pre-one is having the wherewithal to submit the Stage 1 application. And that we don't have loan money for. And so I think that's where they're going to need technical assistance and maybe some outside funding.

We also actually -- some of us discussing last night said because they're going to need to do that, then for the actual Stage 1, whether we require matching funds may depend a little bit on what happened in the pre-Stage 1 and the commitments they already

have. And so -- so yeah, I think we'll look at saying something.

UNIDENTIFIED FEMALE: I'm hearing two things. I'm hearing that the entity should have other sources of funds, and maybe we should discuss that. I think maybe a recommendation would be they should have other sources of funds and .... But then I'm also hearing, should the Secretary kind of facilitate getting some of those funds? And again, from the perspective that we've taken of somebody lending money, not regulating, so that's -- in that perspective, you don't necessarily want to do a lot of handholding. You want to work with an entity that has the wherewithal to go out and find those things and to find the funding.

UNIDENTIFIED MALE: If I can just -- having been involved in lots of cooperative development, the initial barrier can be the big barrier of getting some initial funding to get the really motivated people to get the expertise they need. And that's all I'm trying to point out, is to the extent the Secretary has any helpful connections with foundations, that they can perhaps utilize those connections to help get some

initial funding. Because I -- I'm really concerned that a lot of states, we won't see any grant applications, just because the folks won't have the ability to collect enough money to even get started.

MR. FEEZOR: Having done a couple of similar start-ups, we probably want to think in terms of total resources, not just funding. Sometimes it's a lot easier to get some of those in-kind services contributed in the start-up phase.

Let me try to drive the group here a little bit and review Donna's work group's presentations. And I'm going to start on slide 4. And it has been put forth that there is at least sort of a two-stage funding process that's seen. And Vivian this morning in her testimony did say -- voiced her concern about the length of time for these entities to get up and going, and I think we all agree it's critical that they, to the extent possible, are ready by that time. But nonetheless, it is to sort of have a two-stage funding process. And we really talked about almost three stage, sort of preliminary application where you sort of draw on your local resources and then make the

application, that sort of preliminary application, and then -- and then you get the full-blown, in which you would get some pre-operational monies, let's say, and then operational monies.

Is there discomfort with the recommendation of the work group on that?

All right. Take that as a -- that's decided, or at least the recommendation going forward.

And then the next are some of the elements in the two stages. That would be slides 5 and 6. And my assumption is, Donna, not to speak unkindly of the work group's products, but it could be some of the testimony this morning in the 12-stage, there may be some stealing of some of those bullets that would go into here?

MS. NOVAK: Yeah. I'm happy to stay I don't think there were.

MR. FEEZOR: Or -- excuse me, over into probably slide -- slide 8 instead of slide 6. I apologize.

MS. NOVAK: I was going to say, I was happy to see there weren't any missing bullets. But I did jot

down a lot of notes of things to flesh out --

MR. FEEZOR: Okay.

MS. NOVAK: -- and to add onto some of the bullets that we had. And I guess as just a question of next steps, I guess the next steps would be to take what we have fleshed out and circulate that among the group, which is a little bit more in depth.

MR. FEEZOR: Probably with some narrative, and we'll be talking about that generally in the fourth subcommittee groups, when we talk about -- both calendar and then a little process going forward.

Terry?

MR. GARDINER: I think if we, you know, have any enhancement, it's really with these Stage 2 loans, where we're saying full-blown business plan. That's where we would -- we talked about last night in our meeting, like very thoroughly going through the McKinsey recommendation, matching it up to ours and seeing, you know, are we just using different words, or are there something that is actually new? But I think the Stage 1, we just -- it was all about showing that they've done enough homework and they're a serious

group that they would deserve some assistance to get a full -- so they could do a full-blown one.

MS. NOVAK: Right.

MS. FEEZOR: So in that stage would be the high level, meaning the emphasis there on the high level review.

Moving to slides 7 and 8, and this is where we get into a bit more detail. Terry, picking up on your comments that the business plan to include maybe some detail that might have come through, and also you said you had taken some notes, that there might be a little more narrative we add?

MS. NOVAK: We took some notes and did some mental matching --

MR. FEEZOR: Yeah.

MS. NOVAK: -- but we have to go back and do the physical matching.

MR. FEEZOR: Anything that -- major components there that might be missing? David?

DR. CARLYLE: Yeah. I guess -- I mean I'm not sure you want to say formally. But I think that the people who -- the applicants who receive the Stage 1

funding, hopefully the mindset is they're in the game now. And we had talked about at a previous meeting that there might be some interactive process where there would be a concert of the state regulator and HHS working kind of together along the process to help them become certified in kind of a dual fashion. And I think by them receiving that first funding and now they're responsible for starting to work with the state regulator, if our -- if the HHS office can also be part of that process in kind of a consultation with the state regulator, that would see another good value for that process -- that point in time between Stage 1 and Stage 2.

MR. FEEZOR: Dave, I think we've talked about a couple different things. One is there would be an interactive to help people bring forth good, solid detailed plans. And yet I -- something I'm going to probably take up with staff, if the normal process is sort of an RFI process, the federal government, at least in my experience, has been they keep a very distinct sort of hands-off until you submit the papers. So we talked at one point in time about trying to find

some sort of center of technical assistance that might help the plans in preparing their final app. And so your point is well taken. It would be very helpful to make well-intended, good apps a more realistic opportunity for being a succeeding organization. And yet at the same time, balancing that tension with what is normally sort of the federal hands-off, you submit it and we'll grade it approach. We may need to sort of see if we can reconcile those two without putting anybody in an awkward situation.

I keep trying to look for staff to say, "Allen, you're all wrong," or something on that. But anyway .... All right. So we have 7 and 8, and then --

MS. NOVAK: The rest is kind of "to be continued."

MR. FEEZOR: Does anybody have any burning comments they want on those issues that are continued to be worked on? If you have them, that starts with slides 10, 11, and 12. Take a quick look. You have an opportunity to either make some comments now, or certainly Donna and her colleagues will invite you into

the next conference call, if you want to talk about that.

If not, I would call out the one, and I think there was a question -- I forget who around the table, about trying to provide the Secretary some guidance on how those federal loans and grants might be of the greatest assistance to co-ops. And my assumption is probably in meeting solvency and capital requirements, and obviously we need to do some more work, I think, in that particular regard. Whether it's subordinated or senior debt or whatever, so ....

Any last thoughts for the finance work group? Bill?

MR. OEMICHEN: (Inaudible, off-mike)

MS. NOVAK: The CFA --

MR. OEMICHEN: What types of certification are you looking at for business plan feasibility?

MS. NOVAK: Yeah. We have -- so far, we've talked about certified financial analysts, CFAs, or actuaries. But someone with experience with insurance companies and business plans. McKinsey ....

MR. FEEZOR: On that point, Donna, how readily

available is that talent? And then how valuable have they been, as far as whether it's qualifying for bond underwriting or investment? Do you have any feel?

MS. NOVAK: Well, we heard this morning statistics that I've always heard, that how many companies fail in the know. They often are helped put their business plans together by experts. As far as available, I think we've heard from a number, not only this morning but at our last meeting, of entities that do help venture capitalists or that do analysis. How successful they've been, I think, is one of those situations where I think you're better to have had them than not, but there's not a guarantee. How's that? I think that's kind of my impression, is if you have somebody else coming in that's an expert that can say, you know, they've thought of everything; this looks solid, it doesn't look pie-in-the-sky, you've got a better chance than if you don't. But it's not a guarantee.

MR. FEEZOR: Last questions?

Donna, thank you and your colleagues for a lot of work and good work.

I have it as being about nine of 12:00. We're about five minutes behind our schedule. Unless anybody would like to re-order it, we'll stick to our original schedule. Be back here at -- is it 12:30? Since we're breaking a few minutes early, can we make that -- anybody object to we try to make it 12:30?

12:30 it will be. We'll reconvene, pick up the infrastructure report. We're likely to lose some of that ten minutes back, Mike, is my guess (laughs). And we'll keep this on. So we're back here at 10:30 -- I mean at 12:30, and a reminder to my colleagues -- if you have not looked over the summary of the last meeting, please do so. That'll be the first order of business when we reconvene.

(BREAK)

MR. FEEZOR: Going back on our agenda, the first order of business, as promised. Herb?

MR. BUCHANAN: Just to make sure this mike is working, I'd like to move for adoption of the minutes.

MR. FEEZOR: Motion without objection to be entertained. All in favor, say "aye."

Opposed?

MR. HALL: I had a question.

MR. FEEZOR: Oh, okay. Excuse me.

MR. HALL: Sorry.

MR. FEEZOR: Mark?

MR. HALL: So there's a passage here that seems to suggest that we recommend that all co-ops be NCQA accredited. This would be under "Elements of Success."

MR. FEEZOR: Can you recommend -- is it what we recommended, or is that what the panel has recommended that appeared before us? Where are you?

MR. HALL: So I'm on page 2, under "Elements of Success." And I had been thinking that when it says "key recommendations," that --

MR. FEEZOR: I --

MR. HALL: -- those are recommendations made to us.

MR. FEEZOR: First off, we hadn't made any recommendations.

MR. HALL: Right.

MR. FEEZOR: And that was the panel that was speaking on --

MR. HALL: Okay.

MR. FEEZOR: -- elements of success.

UNIDENTIFIED FEMALE: (Inaudible, off-mike) the panelists (inaudible).

MR. HALL: Panelists. Okay, then I'm fine. Sorry. I misunderstood.

MR. FEEZOR: All right.

(Voices off-mike)

Okay. All right. With the concurrence of everyone, we will try to put who were the panel -- panel members represented. That's what will make it clearer that those were recommendations made to us by other experts in this area.

With that, all in favor say "aye."

MEMBERS: Aye.

MR. FEEZOR: Opposed?

No one.

All right. Dr. Mike, you're up. Infrastructure.

DR. PRAMENKO: Thank you, Mr. Chairman.

We're heading into our next subgroup here, and this is the Infrastructure Subcommittee. We met last

Monday by phone conference and again this morning for breakfast to review and go over what we had done previously last Monday, and individual assignments over the last couple of weeks to obtain further information.

So the charge of the Subcommittee on Infrastructure of Co-ops -- myself, Herb Buchanan, Tim Size, David Buck, and David Carlyle. And thank you, Allen, for participating in some of our discussions, as well. And thank you to the staff for helping prepare some of the materials. It's much appreciated.

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.

So if you look at slide 3, Definition of Marketing. And the proposed recommendations: Marketing should not be defined -- should not be defined to include outreach and community education efforts. Applicants should have a marketing plan and an outreach education plan.

And we had further discussion about this this

morning. And as you've heard me before speak on this issue and we discussed this morning, there's a significant amount of overlay in marketing with how other aspects of health reform will help with this, specifically the exchanges. And we heard from our panelists last month in that regard that, you know, there has to be a level playing field in regards to some of the insurance rules. But a way to help market the co-ops could be done in through the exchange. So some potential elements there in addition to marketing efforts put forth just by the co-op, but working in concert with other entities in the state.

If you move on down to Integrated Care and Coordinated Care on slide 4, and you'll see the proposed recommendation. 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 important for their area. Rationale: The definition of an integrated care model involves the coordination of care for the individual patient, and applicant should have flexibility to develop a variety of models.

Now the discussion this morning was specific to what does the word "models" mean. And there's certainly elements of that that need to be discussed. For instance, the payment model. That's going to be important in how this functions, and whether that sort of encourages the coordinated care and the integration of care.

Does the model include elements like behavioral health? Patient-centered medical home? That is not -- you know, might need to be further well defined and be included in this.

And then the coordination of care in rural communities. Does the model include elements if that's part of the region that's going to be incorporated by the co-op? Is there a model to help coordinate that care in those rural environments?

And then elements of the model on how well the payer is coordinating with the provider network. So again, there's a bit of -- the committee really wanted to stress some of the elements of what made up the word "model" in this, because it is a bit vague in the current writing as we have it. It's certainly

something that we can flesh out and pursue down the road if we get feedback in that regard here. I think it would be important maybe to define that a little bit further. But that was some of the discussion this morning that you don't see on the slide.

Going on to the next slide, on number 5, Statewide versus Local Networks. Proposed recommendations: Coordinated care is more important than statewide operation, which is and could be very difficult. Some plans may be able to become statewide over time and should describe a plan for doing so. The rationale: It would be difficult for the new co-op plan to contract with the provider at reasonable rates. Second bullet point: Partnering with providers coordinating care on a local level and achieving consumer focus are important goals and necessary for success.

And we'd be interested in further discussion on this after we review here, but there is some significant concern in regards to the initial start-up geography or scope of a co-op and whether that should be stressed more in a more local environment versus a

statewide environment. And the discussion that if it is going to be statewide, that the applicant has, shall we say, a bit more to prove in their application on whether or not they can pull that off, simply because of logistics and how difficult that is to do the integration of care and the coordination of care at that level. And certainly a bit more feedback on that from the advisory group might be worthwhile to hear. And again, you go back to the definitions of integrated care and coordination of care and what that means, and how easily, again, a new co-op can help incentivize that and pull that off.

MR. FEEZOR: Terry?

MR. GARDINER: Yeah. I don't disagree with what is described here in terms of the tradeoff of these two important features, coordinated care and statewide operation. But I'm a bit concerned that it's sort of limiting, in that like we have two choices. You know, there's this choice of coordinated care versus statewide, when there could be other important tradeoffs with the statewide criteria. For example, two proposals come in for a given state, and one is

proposed to be statewide. But everybody who looks at it says, This is kind of a shaky financial plan. You know, we're just -- this looks much riskier. Versus a plan in that state that comes in that's regional in nature, and may it will grow, maybe it won't to statewide, but it looks a lot less risky. So in that case, that's not getting at whether either one did or didn't emphasize coordinated. But again, that would be, you know, I think HHS would then be evaluating a different tradeoff on the statewide criteria, even though statute says, you know, preference for statewide. But I think that they should be, you know, what good is it to have a statewide operation if it's going to fail?

MR. FEEZOR: Right

DR. PRAMENKO: Yeah. And this is exactly where the discussion is, is we had a bit of this earlier this morning, is we want game changers. And if you have a small plan in one corner of one state, how much of a game changer is that? And the whole co-op idea -- one of the main reasons for the co-op idea is for it to be a game changer.

And so yeah, you've got -- you know, if you were able to pull off a statewide plan, obviously that can be in the exchange for everybody in the state. If you form a co-op in one corner of one state, how much does that really affect your exchange for the rest of everybody in the state that doesn't have access to that?

Again, you go back to the important interplay between your exchange and this program, the co-op, and how much you want that to be a game changer and how much you just form the co-op and not expect a game changer. And again, I think we can have an ongoing conversation about how the co-op issue sort of plays with your exchange and to what degree the Secretary is going to want a game changer out of this versus setting up another small insurance group in one corner of a state.

MR. FEEZOR: Barbara?

MS. YONDORF: This is one where, again, where my sympathies are a hundred percent with you, but I am a little concerned about going too far outside of the -- what the statute says. So going back -- and these

are related on page 4 -- should using care coordination models like ACOs and medical homes, among other models, qualify for priority? Assuming that what the statute says is integrated care model, we could have a conversation about what that means. So we're really -- the question is we're sort of adding to that. And I would just say, although I really hate to say it, but you know, there isn't conclusive evidence about ACOs, and there's only early evidence about medical homes. So I'm not sure about giving them priority if there is something that's a strong provider network out there -- very strong -- and we know it's strong, but it's -- it's not an ACO or hasn't been certified as a medical home.

And the same, just a related comment on page 3. Coordinated care is more important than statewide operation. I mean, the statutes don't say that. What the law says is there's three things that shall be given priority. So if what you mean here, which I think some of us talked about, was sort of all other things being equal, that you've got to -- I mean, you have to have had strong financials; a strong business

plan. You have to have met those criteria. I'm just concerned about sort of either going outside the statute or putting more onus on somebody.

DR. PRAMENKO: What we're trying to do is get to what -- what are the rules that this advisory panel can come to that's going to create the greatest percentage of success for the co-ops that hopefully come out of this portion of the bill? And the belief of this subcommittee was that if a co-op is put together and it has those elements in it, the chances of success are greater if it has an integrated or coordinated care system to work with.

Now that doesn't mean the Secretary can't elect an applicant that's more statewide. But we felt, and are advising that if they are that, they have something to prove on their application to suggest that they are ready to take on that task. This is not saying that they're prohibited from, you know, using that application and awarding them funds. It's just that we wanted to make the statement that there's -- it's a different level to try to do it at that level versus a more regional scope.

UNIDENTIFIED MALE: And I mean I -- I don't think we're actually at odds here. I think it's just the compressed language. We didn't really write that, and now we're trying to expand on it. It is all things being equal, that if a statewide group obviously has got all the other ducks in order, you're going to make your investment there rather than local. I think that goes without saying. I think what we're maybe making somewhat an editorial comment is, don't hold your breath for that in very many instances. That is extremely difficult to do. So therefore, we're just teeing up the fact it's okay that you don't go statewide. In fact, we think that's probably going to be a minority number of the cases.

And I would add to that, too, our conversation was more than just about the integration issue. I mean, active involvement of consumers on your board is a lot tougher when you do it in a statewide group versus local, you know, provider relations. Just go down -- anything that's got geography as a component, you just make it a lot harder. And I think most of us believe that these new starts are going to be quite

challenging as it is.

So I think, if worded properly, we're not at all in contradiction of the statute, but --

MR. FEEZOR: Dave?

DR. CARLYLE: Yeah. I guess I'm just going to emphasize something I really care about strongly, and that is the wisdom of the Act in part, in my mind, is that it did mention the integrated care, and -- and we have to change our view of how we pay for health care. And that's one of the reasons why we talked about having reimbursement models be part of what we asked for when they're described in their integrated care. and that's where the tension might be, is can you create initially that integrated care model with a reimbursement formula across the state when you -- when you don't have the ability to engage the providers throughout the states. It's a tension that the reviewers are going to have to look at. But I really believe strongly that it's through integrated care with different reimbursement models, is that we're actually are creating a different system that people are going to hopefully receive a different type of care and

better care and more cost effective care. So I do think that the tie-in of integrated care into this co-ops and the fact hopefully we add a reimbursement need is important.

MR. FEEZOR: Dave, you make that comment notwithstanding the fact that I think both speakers this morning said that might raise the risk profile a little bit on your model.

DR. CARLYLE: Correct.

MR. FEEZOR: Okay. Jon?

DR. CHRISTIANSON: So maybe it's just a matter of when. Because it seems to me like if the priority is going to be given to statewide, all else equal, then statewide win. I would come in with an application if I were a local or regional plan that says okay, I'll state local. I'll be statewide in X number of years, and here's my plan for getting there. So I -- that's my guess as to if you were playing the game here and looking at the legislation, that's probably how you would play it.

MR. FEEZOR: Donna?

MS. NOVAK: I circled the word "should." Is

it assumed that a local co-op would have a plan to go statewide? Because I can certainly see situations where a local co-op that was very provider-based felt that this was their territory and their expertise and had no intention of going statewide.

DR. PRAMENKO: Again, important discussions about how much you want to see the co-ops shape the health care system of each of the particular states, and, you know, to what degree that has an effect. Again, you're going to have to look outside the co-op program to get that done.

MS. NOVAK: It could be -- I could envision a situation where a state only had one geography that would benefit from a co-op, and it would change maybe not the whole state, but it would change that -- that area significantly. But wouldn't be -- we haven't defined what the ideal environment is for a co-op.

DR. PRAMENKO: Right.

MS. NOVAK: But one area of the state would possibly not be necessary for a co-op and another area would benefit from it. I could see that.

UNIDENTIFIED MALE: And we seem to be talking

about this as though there’s one co-op in the state. I mean, you could have a co-op in one corner and a co-op in another corner, and that might have a big impact on the health care system in that state. Even though neither one of them is statewide, you would have a co-op presence statewide.

DR. PRAMENKO: And Allen, you’d made the statement regarding increased risk. We already know that probably a good percentage of these new entities will likely fail, and we’re stacking up some risk here, and to what degree can we counteract that risk by other things that either this Board does or boards or HHS does in other elements of the reform package, i.e., the exchange?

All right.

MR. FEEZOR: (Inaudible, off-mike).

DR. PRAMENKO: Yes.

Slide number 6, Co-op Management. The charge: What are the characteristics of proposed co-op management that would lead to sustainable co-op formation? The proposed recommendations: Experienced management with expertise in health insurance and

finance is essential. And then point two: Difficulty in recruiting experienced management to a new start-up organization might necessitate a reliance on consultants and vendors. And comments made last week and this morning include possible joint ventures. Some of this was discussed without other groups this morning about how -- you know, whether it's finance, whether it's management, whether it's one of the upcoming elements in IT and its partnerships in management and how that could be encouraged with some of the recommendations. The time frame, again, was noted to be very tight. And to make this happen within a reasonable amount of time, some of those partnerships will probably be necessary.

UNIDENTIFIED MALE: So in terms of recommendations, am I to interpret the first bullet as you're recommending that the co-op hire experienced management with expertise in health insurance and finance? And if so, how do I interpret the second bullet? Are you recommending a reliance on consultants and vendors when that's not the case, or -- that seems like more of an observation that it's going to be

difficult to do this. So can you put that in a recommendation format for me?

DR. PRAMENKO: Yeah. Go ahead, Tim.

MR. SIZE: The defense is that it's obviously ideal if you can have fantastic, ideal, experienced management, et cetera, who just happen to show up looking for a new challenge. I think most of us know that's not going to happen very frequently. So what's Plan B and C? Plan B, we talked about I think with another panelist this morning. You know, you have someone who's really good at start-ups and doesn't have the depth in insurance companies, and then they contract in that. And then three is a strategic alliance, where you're actually depending on another corporation that already has those pieces together.

MR. FEEZOR: (Inaudible, off-mike).

MR. SIZE: I -- I wouldn't be quite that way. But I think that there are three main genre of options that, depending upon what's available in that market and that situation, we expect the applicant to discuss why they chose one over the other. My concern is, is that we not come out with a bias that precludes the

second or third options we mentioned, because I think they're going to be the ones most available. And if that bias gets communicated, we then tend to have people probably make the wrong choices, where they're just -- I just don't think the pool is going to be as deep as we would like for people willing to act as employee for a new start-up.

MR. FEEZOR: Dave?

MR. BUCK: (Inaudible, off-mike) state that it's not really a recommendation, it's just this is what we mean by inferences.

MR. FEEZOR: Mike, I guess I was a little surprised that it was not a richer number of categories that management might have expertise in. And one would be systems integration or systems interface, if you're talking about financial systems, claims systems, and so forth.

DR. PRAMENKO: That will be in the coming slides ahead.

MR. FEEZOR: In the IT later on?

DR. PRAMENKO: Hm-mmm.

MR. FEEZOR: And then the sort of quality

improvement, process engineering, maybe even care management or clinical. Even though we implicitly, because we were talking about it being linked with integrated care or other points of care, we would assume it's in there. But if it's not there, I'd sure want it somewhere. I mean, I just --

UNIDENTIFIED MALE: We have pages of stuff like that.

DR. PRAMENKO: Yes.

UNIDENTIFIED MALE: This is just what was picked up in the slide.

MR. FEEZOR: All right.

DR. PRAMENKO: And again, plenty of information on what we want out of integrated care and what that means. And you could have an application that could really tell you if they're thinking along those lines, especially if you're talking from certain folks that -- say that you have a provider network that's wanting to apply for a co-op. You could certainly tell by the application if they're thinking about the triple aim versus if they're thinking about profits, just based on their application, whether

they're mentioning things as you just mentioned. Investment in population health; investment in HIT/HIE; investment in peer review and quality control could tell you a big -- could really tell you and point you in the right direction on their application if they're heading in the right direction.

UNIDENTIFIED MALE 2: One thing from -- that came out of the McKinsey testimony this morning was the concept of, you know, part of what you're looking in management, especially if you can't hire this experienced team that's already done five start-ups of health co-ops, is that at least they have -- management has the ability to integrate all of the pieces. So that might be a comment that you incorporate in this. Because we are maybe dealing with the less-than-ideal. Maybe it's just a comment.

MR. FEEZOR: (Inaudible, off-mike).

DR. PRAMENKO: Very good.

Slide number 7, Provider Networks. What options are available to co-ops to develop provider networks? Since it is likely that non-provider applicants will not have provider networks in place at

the time of application, what showing should be required to provide evidence of capability to develop an adequate provider network? In your proposed recommendations, applicants need to provide evidence that they have had preliminary discussions with a range of providers and the providers have expressed an openness to contracting with the new insurer. Evidence of an understanding of the provider contracting process; where they will get the expertise to develop a network. And so that's individuals and resources.

And comments on these, again having to do with first level versus second level application process here. There's -- as far as how in-depth this needs to be for that first level that we've been talking about versus the second level, the second step being much more concrete relationships, i.e., contracts with defined providers, as opposed to discussions of that and interested parties. And so obviously there's a difference between the first step and second step. And then there's a significant amount of interplay here with what was discussed at the finance committee prior to lunch.

UNIDENTIFIED MALE: Just a general comment here. You've qualified this with non-provider applicants. I think we're going to need a little subgroup as sort of a joint -- couple of people from governance and a couple of people from your group. I presume that the ongoing co-op is -- has to be the individual members on the board, that there are a number of us who think the most -- among the most promising models here would be a partnership between something like that and an integrated delivery system -- it could be hospital-based or physician-group based or some other thing --that there would be some sort of a partnership. We all use different terminologies for this and we all have different assumptions about how it might work. And I suspect different things could work in different situations. But because so many of us really want to think that that could be the game changer and that has the greatest promise, I think it will be worth sort of fleshing out that a little bit and trying to choose terminology that is -- that doesn't appear prejudicial against something that's promising. To me the very phrase "provider network"

suggests a PPO construct with contractual, loose contractual relationships with large numbers of providers, as opposed to what I just alluded to. So I would say provider networks or -- and I don't know what the other word is.

DR. PRAMENKO: So are you asking us to just be a bit more descriptive of what an application would look like as -- with a provider network and one that's without a provider network?

UNIDENTIFIED MALE: I -- well, one that is sort of a, for lack of a better term right now, one that's partnered with existing provider organizations versus one that's going to operate like a traditional insurer with a broad provider network.

MR. FEEZOR: Tim?

MR. SIZE: Well, and this is probably just an add-on to what you were saying. But I would think that part of the preliminary discussions would be with not necessarily provider networks, but TPAs or other folks that have put together provider networks that the co-op is interested in contracting with, particularly if it wants to offer a PPO product. And it seems to me most

of the environments we would be in, you would need to offer a product like that to be successful. So I would -- I guess what I'm trying to say is maybe loosen up the language a little bit, or -- because you won't necessarily be in discussion with a range of providers. You may be in discussion with somebody who's -- if you want to get going, somebody who's already got those contracts in place.

DR. PRAMENKO: So specifically, where here would you be concerned about the language? So is there a spot there that ....

MR. SIZE: I think the language depends on what kind of product you think you're going to offer. And I think this language assumes a particular product where you're going to go out and talk to providers, a range of providers. If you're a co-op, you're thinking of a smaller regional product or something like that, but you're still going to have to have a broader statewide network or some other network to be attractive in the marketplace. So it's not so much what's there, it's what isn't there.

DR. PRAMENKO: Okay.

DAVE: Yeah. I think this language was drafted to reflect kind of a "build your own network" approach. And what we're saying, we're as likely or more likely to rent or partner with, and so we need more inclusive language for all three of those models.

MR. FEEZOR: Mike, I just -- I underscore the term "adequate provider network." Putting aside a minute, Rick, that you're needing to distinguish of how that engagement might become. As an old regulator during the HMO days, we always said "adequacy of network." And so you had the applicants come in, "Well, we're going to sign up this network and this network and this physician and that," and they had this nice letter of intent. And so many things -- sort of like going down the aisle. A lot of things happen between entering the church and the time you get down to the aisle and the nuptials are engaged, we found, is point one.

And point two, I suspect in a fully developed market like this, adequacy is going to take on more than just the numbers of providers who are going to be taking on at a time in 2014 where there's going to be a

lot of increased surge in demand. But what's going to be really key -- I don't know how you can do it, but if I were being a reviewer, I would want to talk -- sit down and when you bring to me the adequacy of your network, it's the adequacy not only of the commitment -- is it a genuine commitment there, or how far down the aisle are you -- but quite honestly, what the terms are. Because you can have 500 providers, but if they're all 10 percent above the prevailing insurer, this entity ain't going to hunt very long. So I just -- my sense is, and look, I don't know how -- you can't ask them to give pricing structure here. But those providers who are going to be a part of it have to understand that if these things are not truly competitive, that I think the opportunity for them to grow as many of us would like to see them grow is going to be pretty limited.

Dave?

DR. CARLYLE: Yeah. I think that from the subgroup, you know, when we first kind of delved into this question, I think there was that sense of either build or rent. But I think Rick adds on a whole

'nother flavor and a third -- kind of a third rail option, is that if you take on a system and a system becomes a partner, that you're not really -- you know, the system is part of the co-op. I mean, I think that's something that needs to be kind of envisioned in some way through our -- through our terminology. So I think we probably need to take this as an issue to come back to, which we knew we were going to have some issues to come back to anyway.

UNIDENTIFIED MALE: I would just -- I guess I agree with Rick so strongly, I would emphasize throughout all of our reports we would do well if there's this threat of strategic alliances, which is a different business model than simply developing a traditional like group health co-op kind of thing. It's totally -- very different. And I think that we can either encourage or discourage that in terms of how we write up our -- and pull together these thoughts.

MR. FEEZOR: Barbara?

MS. YONDORF: Yeah. Just a quick note, and it's something you brought up before that I would just highlight. You know, in the new world, you're also

going to have exchanges who are going to be looking at this. It's pretty much part of -- part of their mission, I'm sure. When you become a qualified health plan, people are going to take another shot at provider network adequacy. And so just a footnote is consider, you know, does someone have to do this three times over? They have to do it for the application; they have to do it for the insurance commissioner; they have to do it for the -- for being an exchange.

And the other thing is -- and we don't have to talk about it now -- but you know, the first thing you're going to do in your application to the Division of Insurance is to say what are you. And you could be an HMO. And I'm not sure when you talk about those strategic alliances they could end up looking like or intending to be an HMO or not. So -- I mean, you're going to have to cross that line when you submit your application on what those things are.

MR. FEEZOR: Jon?

DR. CHRISTIANSON: Just a follow-up comment to David's comment. I'm wondering if rather than characterize it as build or rent, it should be, when

you're thinking about this, characterizing it as build and rent, because I think you're going to build a local network and you're going to have to rent a broader network to sell your product. So I think it's important to keep that in mind.

DR. PRAMENKO: Especially in those real rural areas that decide to make a co-op and they don't have a tertiary care center in that geographic area. They just won't even have an option to be part of the network. They'll have to rent that tertiary care.

DR. CHRISTIANSON: Yeah, and you're not going to be able, with no enrollees, to go out and negotiate good rates. That's why you rent networks. They've already done the negotiation. They've borne that cost, and presumably would have better rates than you would be able to get, because they're aggregating purchasing power.

DR. PRAMENKO: Okay. Let's move on to the next one, then.

Slide number 8: IT Systems for Administration and Clinical Coordination. The charge: What should applicants demonstrate to indicate they are developing

or will be able to contract for adequate IT systems for administration, enrollment, claims, payment and customer service, and clinical coordination? The proposed recommendation: Applicants need to provide appreciation of the importance of functioning IT systems 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 have capability of implementing by 2014.

Again, you go back to first level and second level elements of an application. The ideas, and in the second level sort of hard-wiring that with contracts for certain IT systems. So you'll need to be thinking of first and second-level application process. Again, more interplay here with the finance group recommendations.

We did have conversation this morning about, you know, does the application acknowledge the existence of RHIOs in their state? Have they had communications with the RHIOs? Are they going to establish their own HIT system, as opposed to linkages with an exchange? Do they -- are they showing

knowledge of that? Are they showing conversations in regards to the development of IT -- other programs that are existing in the states now from other programs and the interplay with those systems?

UNIDENTIFIED MALE: Okay. What's a RHIO?

DR. PRAMENKO: Regional Health Information Organization. I'm sorry. And those have been established in the last few years to help start guiding the health information exchanges in states.

MR. FEEZOR: Questions (inaudible, off-mike) things that might have been omitted or that you think ought to be added? Donna? I mean, not Donna, Pat?

MS. HAUGEN: Just the language "appreciation," I'd just suggest tightening that up a little bit, because I can appreciate something without having the specific understanding of what are the elements and the urgency and the difficulty of the implementation. I think "appreciation" may be --

DR. PRAMENKO: Too loose?

MS. HAUGEN: A bit soft relative to the IT environment.

MR. FEEZOR: Tim?

MR. SIZE: Yeah. And similar to that, this is going to be another constriction in the conduit of development. I mean, the qualified companies and individuals, given all of the movement in our country, these new starts are going to have to compete with much bigger players to get the skills in the company's time. So you may get a contract, but you may find real difficulties getting them to implement that contract with you quite as quickly as you need be. So I think a lot of care has to be -- as these applications you're reviewing is just yeah, they've identified an IT vendor, but how many years later are they going to be able to get that vendor really to work with them?

DR. PRAMENKO: And that really is where we can hopefully see some folks that are knowledgeable of the regional health information organizations in their states, because there's some organizations really on the ball in that regard and could really be helpful in the co-ops in getting their IT systems up and running, with existing programs that are already present.

MR. FEEZOR: Jon?

DR. CHRISTIANSON: Okay. I think you kind of

answered my question, because I just wanted to make it clear that the IT systems, again, as you have up there for enrollment, claims, payment, customer service, and it is certainly -- there are certainly people that you can contract with to do that out of the box, so it's not the same problem as "let's go find somebody who can implement an electronic medical record system that will somehow tie together all the providers in our co-op." So I just wanted to be clear that we're talking for sure about the former. So you don't necessarily -- when you say "acquire," it may be a contract with companies that do that --

MR. PRAMENKO: Correct. Just as with some of your other management issues, you can certainly deal with an ASO in that regard and get some of the data management systems in place really quickly.

MR. FEEZOR: David?

MR. BUCK: I feel it's my role as a Texan to beat a dead horse -- (laughter) -- about the definition around integrated care. We really didn't have a definition in -- as I've experienced today, I think there are many definitions. Or not definitions, but

many assumptions of what integration is, whether it's financing, health care delivery, payment. And I think maybe when we meet again, we can identify some examples of -- of integration, since we didn't want to be prescriptive. But maybe if we at least gave examples, we might be able to ferret this out a bit.

DR. PRAMENKO: We hope that horse can be reincarnated (laughs) and developed anew, yes.

MR. FEEZOR: Other questions or comments? Tim?

MR. SIZE: Yes, another -- it hits our group, but I think it hits everyone's group. There's been a steady drumbeat, and maybe it's in the statute more tightly than I understand, of the magic date of three months before 2014 to get these things up and going. And at least the development work I've done, I'd rather do it right than on time. There will continue to be new starts in our country with the exchanges for the indefinite future. I think it's just another tension at the review stage, and I think we should invite the applicants to discuss the tradeoffs between being ready to have people insure them the first month of the

exchange versus, you know, coming in six months or a year later. I mean, I think in general, certainly I came into this conversation understanding the complexity of it, and it hasn't gotten less complex as we've talked about it. So I think that's something that I'd recommend that the Secretary think deeply about is the practicality of having 100 percent of the grantees be up and going in time for 2014. However desirable that may be, it could lead to some very negative consequences.

MR. FEEZOR: And as it was said this morning, the reality is that a 2014 start means about a late summer 2013 readiness and beginning enrollment, or beginning -- let's see, we can't call it marketing -- outreach.

Further comments or observations?

Well, Mike, you proved me wrong with your eloquence and succinctness in getting this one up. I figured there would be a little longer dialogue. Must be the sugar flow is keeping you after lunch here. But thank you very much, you and your group, for all of your work.

DR. PRAMENKO: Thank you, Mr. Chairman.

MR. FEEZOR: Ms. Yondorf?

MS. YONDORF: So the last group is compliance, timeline, and sweeping things that we haven't discussed which didn't fit neatly into some other category. And from the get-go, we decided that the major thing for this meeting we would just work on is the timeline issue. And then coming out of this meeting and we'll discuss later on is some other issues that need to be addressed or that came out of your groups, and we'll be talking about that later on.

So this is a timeline that we've developed, and sort of decided to put it into different categories. So you see the first set is the Co-op Advisory Board, and a lot of it is what we've already done. Based on the conversation we had today, though, I like to fill in some things. So after "Second Advisory Board Meeting and Subcommittee Work," let me ask you to add some dates or proposed dates. Over the next two weeks, the subcommittees or the work groups need to pretty much finalize their recommendations. It's clear that probably every group simply will not be

able to get to everything, but we are on this tight timeline. So you might want to prioritize or make sure your group talks about the things that you think are the most important and report back if you say, you know, sorry, we didn't have a chance to get to this, but maybe just informally these were some of our thoughts. So that would go on from February 8th to the 21st, and what we're thinking about is asking groups to sort of have an outline. You don't have to have written the report. But I think it's what people are doing anyway; you all talked about sort of detailed information under the bullets that you've given us, so that's fine to continue with that.

Then we're thinking the last week in February we'd have a process for sharing those work products, because that's all that they are, work products with the other members of this Advisory Board. And the other members would be asked to look them over and say, I have a really burning issue. But only really burning issues, because we're just -- it's the timeline that we're on. So if you have a really burning issue -- and ideally if you have a really burning issue and some

suggested language, because as came out here a little bit, someone would identify an issue and then the group would say, “so how would you change this language?” so that they’re sure they know what you’re suggesting, which they don’t have to accept.

Then we’d have two weeks in which the staff would take what you’ve written and write it up as a report in conjunction, checking in with the Chairs of the groups. So then we’d have a draft that we could discuss at the next meeting, and that is March 14th. That’s the date, right, Barbara? So that is the date.

So is that okay with everybody? We just -- if you were wondering what we were huddling over over lunch, it was the timeline. That’s what we were kind of working backwards on our deadlines.

Yeah?

UNIDENTIFIED FEMALE: I just had a clarification. So what we give staff is an outline, or more filled in than an outline? And then do we give them an outline and they fill it in? Do we give them a document that isn’t -- it’s more than an outline that they polish and put the comments in, or ....

MS. YONDORF: They turn it into sentences, so to speak. So I mean the kinds of things where -- just what people have done here. You know, we've got sort of a big bullet with lots of, I think, little bullets underneath it. That's what I assume most groups are doing, rather than writing out long paragraphs. Part of the reason for that is we need the report to be consistent among the groups. This has got to look like one report from all of us, and so it's really helpful for staff and the Chairs that work on it that we've got a real consistency of style in how we're writing. So if you say, you know, "the business plan, dot dot dot dot, shall include these things," now some of you are going to have a sentence, like this is what we mean by this word. But you don't have to write a report volumes. The staff will put that together in a consistent style, or we'll work with them -- your Chairs will work with them. Does that help?

UNIDENTIFIED FEMALE: Yeah. A little bit. I had thought our group was going to do more of the writing, and --

MS. YONDORF: Right. Well, what we looked at

was we've only got two weeks, and almost every group said, We've got some major issues that we need to resolve and we're not even sure we can get through all of those. And so our thinking was just that that's the most critical thing, is that you've got a recommendation on issues that you set, as opposed to writing it up beautifully (laughs).

UNIDENTIFIED FEMALE: Perfect.

MS. YONDORF: So is that a -- a game plan for that timing?

MR. FEEZOR: So the subcommittees have to get theirs in two weeks, or basically the 22nd of February, which is Tuesday two weeks from tomorrow.

MS. YONDORF: Yep.

MR. FEEZOR: And then the following couple of days, staff will sort of put together the bullet drafts that will go out that week for all of us to take a look at, and then if we have some real concerns -- you know, I've still got a problem with how Dave Buck wants this thing to be done, and I want to be on that. I'm picking on you, Dave. Then I'd make that known in comments back. But then starting after -- well,

starting about the 28th --

MS. YONDORF: March 1.

MR. FEEZOR: -- through March 11, staff will be putting together, with involvement of the Chairs, the work group Chairs, any conscripted volunteers, a first draft that would be mailed out on the 11th -- that's the Friday before our meeting on the 14th. So we would be coming back and discussing issues on the draft committee report on the 14th.

MS. YONDORF: And let me underscore for everyone, these are just working documents. I mean, I just want to make that really clear, that we're just talking about working documents. These are no policy decisions that would be made. That would all be in an open process here with the ability for public comment.

So then I think the regulations, these are -- this is what OSIO told us. And this is on a fast timeline. But you heard from the testimony, and we all said, it's got to be a fast timeline. You've got to get the -- as fast as you can get the regs out and released. But there are also requirements of federal law.

Then this is the issue on the second page of first and second round applications and awards, and we may or may not need to discuss this, because we've talked about it a little bit. So watching those timelines, you get the first -- we're suggesting that there's two rounds of requests for loan and grant applications, and we'll talk about why that is. So the first round would come out as early as possible, which is fall 2011. We'd also request that if you're not going to apply in the first round, you at least give us a notice of intent to apply for the second round. And that's because we've got to know, you know, what else it looks like is coming in. I mean, do we think we're going to have to divide up money amongst potentially 600 applications or 15? I mean, just some sense. We can't wait.

Then we have late fall. So we have about two and a half, three months for the applications to be due. We note that that's a tight turnaround time, but we also have the sense that there are some groups out there that are really pretty far along. They've been thinking about this; they've already got some

feasibility studies; they've been thinking about it for a while, and hopefully they will be able to come in. And also groups will want to come in because if they're going to be ready for the exchanges, to be in the exchanges, they probably are going to need to get money sooner, rather than later.

So the awards are announced hopefully early winter of next year. Somewhere in there -- January, February, somewhere in there. Then there would be a second round, and again we note the same notice of intent. And the request for loan grant applications would be released in December 2011. You can see the second round are received, and the awards announced. So there's about a three, four months' difference there.

Now the issue has been raised, well, wow, that second group may be getting, you know, the staged loans and everything so late in the game, are they really going to be ready for 2014? The problem is, we don't really want people to sort of crazily be rushed to get in this first app in a really short amount of time and they really haven't thought enough about it. In fact,

they may -- then their application may fail because it was so poorly thought out. And so give them more time, even though they may be squeezed on the other end, or they might not make the exchange initially. I mean, we all know that's a serious downside, but maybe not the end of the world. But we're trying to accommodate getting the money out and getting some of these groups that are ready to go to be ready by fall to have that application in, and other groups that really are just going to need a little more time. So this is an area for conversation.

Yeah?

UNIDENTIFIED MALE: And the way we've talked about it, we've had a first round which people would not have -- would need like the 20,000 version plan of operations, 20,000 feet. And then the second round would be the very nitty-gritty, concrete application. If somebody didn't apply to that first round, when they'd be applying to that second round, are they expected to go with the 20,000 feet plan of operation, or are they going to be expected to have that -- I mean, is it still a two-step process, even though

you're applying at the second stage timetable?

MS. YONDORF: Yes. (Inaudible, off-mike), and I think we were assuming that you still could have the two stages, whether your application round one or two. Now maybe if you've waited longer for the two stages in the second application process, you'll be ready to get through the first stage more quickly. We don't know. And I mean, for all of these, we're going to talk about the timing and the benchmarks, and -- no, but I don't think we were -- there was still an opportunity for two stages for each application.

MR. SIZE: If I can just -- the way I understand, a round and a stage isn't the same thing. Each round has two stages, and this was not prepared with an explicit reference to the staging that was on the finance committee.

MS. YONDORF: Yeah.

MR. SIZE: And then I guess, but if you add it -- I'm not trying to be negative, but it just seems that it's not clear to me how this timetable is consistent with the staging from the finance committee. Just amount of time that presumably, I mean if they get

Stage 1 monies, they have to spend some of them before they have the knowledge and the content to actually apply for Stage 2 within the first round. And then the second round would be for people who are more willing to be compressed on 2014 date or actually go beyond that.

MR. FEEZOR: Tim, first off, we undertook trying to lay out some sort of timeline for all of us to think about it. It really hadn't appeared anywhere. So it was a first crack, and it was done in advance of any of the subcommittee reports.

MR. SIZE: Right.

MR. FEEZOR: So again, I think you have a valid concern that we need to make sure that this in re-draft form to the extent we make it available, that -- and I guess we will -- that it will sync up with the recommendations that are emerging through the process.

MR. SIZE: Yeah. Maybe not to go too quickly or too radically. I mean, I think to do the undoable, and I appreciate how hard this was as a puzzle, is that my guess is you may just simply want to construct a second round that doesn't even pretend to be able to

have people ready by January 1 of 2014. It's my intuitive sense I don't see how it can work. And then the first round may be stretched a little bit to have time to get the staging in.

MR. FEEZOR: Okay.

Mark?

MR. HALL: Yeah. So to drill down a little further, now this calls for the first round awards to be announced by, let's say, January of 2012, which is two years before you have to be live. So that, I mean, it leaves two years to get up and operational.

And then round two is only three months later, so you have, you know -- I know you have to be out marketing before -- before your policies take effect. But in any event, perhaps there's enough time for two rounds of awards.

But I have another concern, which is is there enough time to really review these applications? So I had been thinking that we'd have like a -- you know, some type of technical expert evaluation team assess the business plan, and there might even be some kind of face-to-face interviews and that sort of thing, rather

than just look through the paperwork and say, "check, check, check, check." So some of these timelines for the review of the applications seem pretty short, like a month or two. Is that sufficient? Or will --

UNIDENTIFIED FEMALE: Can HHS answer that?

MR. HALL: Or will there perhaps be more of that in-depth evaluation perhaps for the Stage 2 financing. So maybe Stage 1 financing can be done pretty quickly based on paper submissions, and Stage 2 depends on, you know, getting more of the operational team together. So maybe some of the staging could deal with some of the elements of more in-depth application review.

UNIDENTIFIED FEMALE: Just to answer your technical questions: Typically the review process for grants has -- has run at about 60 days. And typically we have asked for objective and/or expert reviewers to come in, somewhat analogous to the NIH review process. And it is anticipated at this point, and I want to -- I don't want to write anything in stone -- that we would have panels of expert reviewers come in who would be able to review in approximately a 60-day period.

MS. YONDORF: Any more comments on page 2? These are good issues, and we'll clarify. Yeah?

DR. CARLYLE: Yeah. This goes back to something that I think we were talking about in the earlier discussion, is that if you receive the first award or first -- success on the first application, I mean it seems to me there's two ways you could think about it. Number one is that you receive a successful application and now there's further funding down the road if you meet certain criteria. So it's not really a re-application process, it's just meeting benchmarks -- if you don't want to say benchmarks, meeting certain criteria by which you are successful. And if that's the case, it may not be necessarily to do it on a strict timeline that everybody has to meet the same. It's just -- I mean, you may negotiate that applicant by applicant, saying "You have three to four months to get here, and if you do, you get that much money. And if you get there earlier, maybe there's a process where you can apply for the money earlier." Versus a whole -- you apply first, and now you have to re-apply in a whole new method and get reselected. And I guess I'm

not sure the Chair's and HHS's mindset of which of the two, or if I'm wrong, maybe there's not two options.

MR. FEEZOR: Rick?

MR. CURTIS: To clarify, the Phase 1 and Phase 2, I assume, is an option, that if you have an applicant that is not in position to develop an adequately detailed work plan and so forth and they want to get a Phase 1 grant, they can. They've been chosen on a competitive basis, so that if they meet criteria of adequacy, that having done Phase 1, they would then automatically qualify for Phase 2, I assume. Those are -- that's my understanding of how this would work, not necessarily a correct one.

MS. YONDORF: I think we were -- I think we were thinking -- finance talked about this. We were going to come back for structuring and timing and weren't ready. But I think the thought was sort of as just described. There's a Phase 1 and a Phase 2. You can't get Phase 2 funding if you haven't met the Phase 1 benchmarks. So if you submitted an incomplete business plan, you're not getting Phase 2 funding. Or if in Phase 1 you determine that it's completely

infeasible -- am I answering your question? Yeah, but otherwise it's presumed that if you -- you're not reapplying if you've done what you are supposed to do for Phase 2 and it's complete, you get the Phase 2 grant. And if you've done Phase 2 correctly -- is that what you're asking?

MR. CURTIS: That was part of it.

MS. YONDORF: Okay.

MR. CURTIS: The other part was, if you have a -- you happen to have an applicant with a lot of resources, they can go ahead and get the Phase 1 done in their original application?

MS. YONDORF: Yes.

MR. CURTIS: So they're just applying for the whole nine yard to begin with, they could do that?

MS. YONDORF: I think that would be our recommendation.

MR. CURTIS: That's what you meant?

UNIDENTIFIED FEMALE: (Inaudible off-mike).

(Laughter)

UNIDENTIFIED MALE: And this may have been answered. So if I'm getting a Phase 1 grant or loan

and you -- HHS decides that I'm not capable of proceeding to the next step, what's the repayment process for that? Because it really is just a loan. It's not a grant. And that's a parking lot issue. You don't have to answer that right now.

And then the second parking lot issue I have on process is, do we as an advisory board have a role after March of this year once we get done? And if we don't, again for the parking lot, are there restrictions on, to the extent that we would get involved in any of these efforts -- and I brought this up at the last meeting, but as a statewide cooperative association, Wisconsin and Minnesota, for example, it's not unlikely that interested groups -- a number of them already contacted us. We don't charge for our assistance, so there's no money involved; but are we barred from helping them to get going? So -- parking lot.

MR. FEEZOR: Okay. We'll provide information on that. It'll probably be in written form, or we'll get it out to you.

MS. YONDORF: And then the rest, I think, is

just the facts. The only thing -- correction, I think I'd make on page 3, the last page. Co-ops that are ready to do so, enroll first exchange members. Brian indicated that would be October 2014. So I think we need to change that, or put October through January 1 or something. Or maybe just fall?

MR. FEEZOR: Yeah.

MS. YONDORF: Okay, fall.

MR. FEEZOR: Yeah. And it may be driven by the exchanges as much as anything else.

MS. YONDORF: Yeah. It just -- you have to get -- you've got to get your membership cards and everything in their pocket by January 1st, so they have to be enrolled before then.

MR. FEEZOR: We'll make the change on that.

Further discussions or questions on the timeline? And again, Barbara and OSIO staff, thank you for sort of putting that down so we could all see it out there. And I will make the corrections, and it should say this is not an official HHS/OSIO timeline. This is simply as this committee sat looking at what seemed to be logical, what is to be expected so could

sort of get an idea of the work and also help any interested applicants sort of at least think out loud a little bit in terms of what we think might be there.

MS. YONDORF: You know, what I didn't tell you is -- and I'll tell you some of the questions that our group had, which some of -- some of which you may have addressed when I said that there's -- there's other questions we were waiting to address, which was part of the charge.

So how should application reviewers (inaudible) multiple applications from a single state? And some of you have that as pieces of yours.

Under what circumstances would HHS discontinue funding of a co-op? And what are -- what circumstances might those be?

Should applicants be required to demonstrate engagement with local and state insurance regulators in knowledge of licensing requirements? I think we've addressed that one.

Should applicants be required to provide a work plan or other evidence of effort to ensure that the co-op will meet federal exchange standards for

qualified health plans? We didn't directly address that, but we did sort of commented on that, so we'll come back with that.

Can HHS talk to foundations about supporting plan grants, providing technical assistance? I think we all decided, please, please do so. So that may be taken care of.

And what are the elements of technical assistance that could be provided to grantees? We'll try to pull together the things that you have suggested and maybe some that you haven't thought about.

MR. FEEZOR: Obviously, Barbara's group has some work ahead of it. Any other questions of sort of the process?

Let me, while we're talking about some other issues that this committee may take up, and since we're running about 25 minutes ahead of our calendar, part of what we had planned to do so that we can still maintain the public comments at the time scheduled, since I think that's important to give some predictability on that, I'd like to move up one of the things that we had planned to do or planned to ask you in our final

session of today. And that is, are there some questions that have -- that we have -- or issues that we have thought about that have not either been assigned to one of our four committee buckets, if you will, that probably need to be considered? It may be that we consider it and say, "Hmmm, we don't want to say anything about that"; or it may be that it's something.

One that jumps out that I think we would all admit is the purchasing council, the importance of that to make the co-ops competitive, cost-effective, and some linkages. And that one is one that we did ask, Barbara, your committee to take a look it. Though as I think about it, that may get right back into -- may have some bearing on certainly the -- the business plan that I think would be brought out, to the extent that that becomes significant. So that's one kind of issue.

An issue that some folks sort of surfaced to me was that we, and I think wisely so, did not speak to the issue of agents or producers. And yet if you looked at the -- some of the responses to the request for comments that came out, that's obviously a big

issue for certain groups. The reality is that it may be that the state exchanges may, in fact, drive that relationship more than co-op preferences, at least with regards to inside the exchange. But let's just keep our minds on that. It may be as you think about it as you fly back, that that's one you'll ....

One that we touched on early, and we -- I guess we can certainly say we make a recommendation on it, is the issue of since the Secretary can mandate that these entities be considered a qualified health plan -- can basically force it to be a qualified health plan -- is that a forever issue, or that at some point in time, after say five or ten years of operation, they should be able to make it on their own merits, particularly if you're in a state like a California or I guess a Massachusetts, where there in fact is -- I call it a prudent purchaser, a active purchaser role for the exchanges.

UNIDENTIFIED MALE: Can I ask for clarification on that? Just -- you're suggesting that there's language in the Act that requires that co-ops be included in the exchanges?

MR. FEEZOR: That was my reading.

UNIDENTIFIED MALE: And is the effect of that to sort of waive the qualified health plan approval process for them?

UNIDENTIFIED MALE 2: No. They'd have -- my understanding is they would have to meet all the criteria to be a qualified health plan, but they could not be excluded by a state that happens to be exercising the option to decide which of the qualified health plans are in the best interests of consumers and small employers. It doesn't say it this way, but in effect it's saying these are in the best -- offering this is in the best interest.

UNIDENTIFIED MALE: Okay.

UNIDENTIFIED MALE 2: My understanding is that it has to meet all the standards and criteria to be a qualified health plan (inaudible).

UNIDENTIFIED MALE: So none of those are waived, okay?

UNIDENTIFIED MALE 2: Right.

UNIDENTIFIED MALE: Right. So once the co-op meets --

UNIDENTIFIED MALE 2: Federal.

UNIDENTIFIED MALE: So say the co-op meets --

UNIDENTIFIED MALE 2: -- other stuff --

UNIDENTIFIED MALE: Yeah.

UNIDENTIFIED MALE 2: -- then they wouldn't necessarily have to meet that.

UNIDENTIFIED MALE: Assuming the co-op meets the standard QHP requirements, then the exchange -- exchanges are supposed to accept them and can't exclude them simply because we don't need another competitor, or other sort of discretionary criteria. Okay.

UNIDENTIFIED MALE 2: Allen is asking if we want to recommend that not be a permanent, and the statute did not address it. My own view would be that because it did not have an exception to it, that so long as it continues to meet the federal standards, it continues to qualify to participate in the exchange.

MR. FEEZOR: And I'm not throwing these out for necessarily debate or resolution, but just some questions that, as you fly back on a plane, do any of them rise to the sufficient concern that we ought to speak to it and try to address it in the proposal? And

I was not trying to make a recommendation. I'm just simply saying for instance, would it be limited or unlimited or whatever, so ....

So those are a couple of issues. And certainly we talked about, and I think this probably would fall to the -- maybe to the finance committee: are there some conditions on the loan, the loan repayment? Is that something that we want to go a little further in terms of recommending to the Secretary that some terms or aspects of that -- we talked about in the loan, certainly the protections against significant material holdings being downstream somewhere as being one of the safeguards. So are there some conditions of that loan instrument that we ought to think in terms of?

Dave?

DR. CARLYLE: I guess, yes. Are you asking for other topics? Because I have another topic, so ....

MR. FEEZOR: Or just -- again, topics, let's put them up there and then let's think about them. And it may be that -- well, we may assign them to a bucket,

I mean to a committee to try to take a look at if they have time in the next two weeks or bring back for this group. But it doesn't meet the threshold of concerns enough that we need to -- we want to think about it.

DR. CARLYLE: And I don't know whether it reaches that threshold or not, so I just throw it out. I mean, the big topic last meeting was the whole idea of profits and how to deal with profits and how the mandate is to turn profits around. And when I went back and talked to the local co-op people I know in Iowa, they gave a term I had never heard. I just ran it by Bill and Tim. And there's a term called "delayed patronage," which, you know, I might defer to either Bill or Tim to talk about. But that is a way that apparently co-ops are able to -- to guarantee some money back to the co-op member, but not immediately, which might be a way to kind of protect the co-op for some time length while still maintaining that those profits ultimately will go to the co-op members. And maybe I'm distorting that, but I just heard that.

UNIDENTIFIED MALE: Mr. Chairman, there is no requirement that a cooperative distribute all of its

profits every year. Many boards of directors decide to do two things: number one, to distribute some portion of the net earnings -- we don't like to use the word "profit" that much -- but some portion of net earnings back to the membership; and then some of it either is unallocated or allocated. If it's -- what you're talking about is allocated equities, so they put it in the member's name, but they don't necessarily ever have an intention to distribute that out to the member. But because it's put in the member name, as soon as it's put in the member name, it becomes deductible to the cooperative.

And so we could get into the deep weeds very quickly here looking at cooperative taxation. But you're right, from what -- you don't have to -- the main point is, you don't have to distribute all of your earnings every year. Boards of directors are vested with a lot of discretion to decide what to retain in order to expand, modernize, or whatever the cooperative business.

MR. FEEZOR: Tim?

MR. SIZE: I mean, but we're talking about

cooperatives that are also tax-exempt for federal purposes. I'm not sure they would be sending cash to members anyway? And so -- because I think that the issue is more for our statute around if you have all this money laying around, you're supposed to improve the product or the price, as opposed to anticipating giving a cash or a patronage dividend back

UNIDENTIFIED MALE: I'll just mention again, not that I want to get into this, but the issue I mentioned before lunch that appears to me to have been raised but not assigned, which is, is anyone seeking our advice on how much money to award to a particular applicant? No one's seeking it.

DR. PRAMENKO: Just two things on this issue of net revenues, because the statute has its own language on that, and I didn't see it in the minutes from last time, but we talked about it. Especially in the initial years, if they're going to be prudent and they're going to succeed, they're going to need to set aside resources for future growth and capacity. I don't know how we handle that, but I think that should be definitely a high priority part of whatever our

recommendations are.

Secondly, as we've discussed, this is sort of a difficult one, but providing whatever guidance we think is prudent and doesn't overstep what we know about co-ops that are forming strategic alliances with providers as part of -- part and parcel of what they are, while I don't think we can anticipate all the things that should be allowed, we probably can anticipate some things that at least some of us think should not -- would not pass muster where it becomes just a front for really a provider-system-run co-op. And I don't know quite how to define that, but I think that oversteps what many of us have in mind.

UNIDENTIFIED MALE: I'm -- I'm certainly hoping, and you're a member of the Governance Subcommittee, that during the next two weeks we'll try to attempt to address that as much as possible.

MR. OEMICHEN: Another issue that -- maybe it was just out and I missed it, but I know it was raised last time and some side conversations this time was the desirability to meet the intent of the statute to find a way consistent with the statute to deal with existing

non-profits and help them grow. And I know there's more than a few out there that may be looking for guidance around that. Is there any conceivable way, you know, if they had to give up a license and reincorporate, or form a new partnership or something? Now, maybe the answer is no to all of the above. But I would think that's something worthwhile for us to address.

MR. FEEZOR: I thought it was to hire Bill and get that advice on how to convert to a co-op. But then you've got a conflict (laughs).

UNIDENTIFIED MALE: So is it fair to say that it's not clear that any and all ways have been blocked by the statute? It's only that the most obvious way is blocked?

MR. FEEZOR: Other issues that --

UNIDENTIFIED MALE: That is a question. I was just curious. No one have any speculation?

UNIDENTIFIED MALE 2: I'm happy to speculate.

UNIDENTIFIED MALE: Oh, good.

(Laughter)

UNIDENTIFIED MALE 2: So this is about the

types of corporate entities that could receive the grants and loans?

UNIDENTIFIED MALE: Yeah. I mean there is that line in there, you know, they can't have been an insurer before such-and-such a date. I just -- I mean, so that poisons an explicit application by an existing small non-profit co-op oriented that's doing everything that we're talking about being good to do. So I was wondering what, if any, other -- what's the significance? How do you operationalize that? Does that mean that they can't, like, change their name? Or they can't create -- bring in some new people and reincorporate? I mean, what could they do or not do and still be consistent with that prohibition?

UNIDENTIFIED MALE 2: Yeah, I think the working group has to still get to the question of the involvement of existing issuers.

UNIDENTIFIED MALE: Okay.

UNIDENTIFIED MALE 2: And there's specific statutory language -- I forget whether the word is "sponsor" or "relate to" or whatever that we'll have to look at and think about. But yeah, it's on the parking

lot.

UNIDENTIFIED MALE: Okay. Good, thank you.

MR. FEEZOR: I'm hearing that's probably governance. And then the -- I think Rick -- we'll assign these more thoughtfully a little bit later. But certainly the net earnings and somehow dealing with the need to reinvest capital for the prudent growth of the organization is one that we probably ought to take it on. I mean, it's just it would seem to me, and probably have that in the finance committee.

UNIDENTIFIED FEMALE: Yeah, we have that.

MR. FEEZOR: Okay.

Further issues? Yes, Mike?

MR. OEMICHEN: I think it would be a good idea for us to have some sort of laundry list of items that applicants should be considering that work in parallel with the co-op plan. Topics that have come up here that we know would help encourage the development and success of co-ops, not necessarily directly related to co-ops, but items that their state should be thinking of and doing as we develop the co-ops in the environment that they're developing in. Is that clear?

In other words, advice in regards to the environment outside co-ops that can encourage the co-ops. As states form in a legal process over the next two years, the other avenues in health care reform that are occurring simultaneously with the co-ops. We have discussed items here that will help the co-ops, but not necessarily just restricted to the co-ops. The exchange, and the development of ACOs. And I believe with the panelists that we've heard from and the -- the amount of knowledge, myself excluded, here at this table, I think there are some worthwhile elements that we could pass down the way to HHS about what should be occurring simultaneously in relationship to the exchange, ACOs, and the co-ops intertwined.

MR. FEEZOR: Tim, let me ask you again, your comment about some of the existing non-profits, whether there is a path to salvation for them, for lack of a better term. Are you thinking there of general existing co-ops? Is that not-for-profit provider sponsored plans and/or maybe even government not-for-profit managed-care-type entities that are largely in the government provider business? Because I mean, all

three of those have some interesting nuances.

MR. SIZE: Yeah. I mean, I know. The one that had come in my mind, obviously, was the one in Wisconsin, which I think looks exactly like what we're talking about here, is consumer-owned. But your other two categories, I'm sure at least in theory, exist somewhere. So I just think it's in the country's interest and in the intent of the statute that we look at that question to see if, in fact, there are ways that are respectful of the statute, but allow the learnings of those enterprises to move forward and participate in this program.

MR. FEEZOR: Mike?

MR. OEMICHEN: Yeah. You know, I come from a community that has a health plan that's non-profit. It's not a co-op. It wasn't formed as a co-op. It was originally an HMO; it's now just simply called a health plan, Rocky Mountain Health Plans. And I totally agree with Tim. It's unfortunate that they can't be -- there can't be further investment in that particular company. They know how to do this. They're already there. We have a shortage of brain power to do this in other

areas, and I would second Tim's concern that that's a resource that we have sort of cut off at the spigot, and we need to find ways to utilize their knowledge base and expertise to help formulate the new plans.

MR. SIZE: And it may be -- I mean, the access to this capital may be such an attraction in that area that they'd be willing to have a separate licensed entity which they treat as a second risk group that then has the benefit of these dollars. And that would be, in my mind, would go quicker than you think. But I don't know if that would be on its face prohibited or not. So I think we should be teeing up some advice on what is or is not possible for such entities.

MR. FEEZOR: Okay.

Rick, do you ....

MR. CURTIS: I, for one, want -- I'm a big fan of Rocky Mountain. But I think it would be a diversion of scarce brain power. Because I think it would be very difficult to draw the line once the -- you know, where do you draw the line between it and a mutual, and between the mutual and a not-for-profit Blues plan? And I think the law is pretty clear that if you're an

existing health plan, you're not eligible for these funds. But it's a key reason I was suggesting, and other members disagree with me, that it just -- where you have something like that, why would we be investing money to create a competitor which would reduce the viability of both of them? And I think, to me that's where the issue is.

UNIDENTIFIED FEMALE: Yeah. A related question that just occurred to me with that, and maybe this is -- I'm being a simpleton, we got the question of we don't want a for-profit to buy up the not-for-profit, and how we ensure that. I'm just wondering, though, what if five years from now two co-ops, an existing one and one formed under this, decide they want to merge? Both non-profit co-ops? Is that -- have we really addressed whether or not that could occur? And if it did, I mean, do you just return the money of the co-op that we funded --

UNIDENTIFIED MALE: Or if they merge into a newly licensed entity, I mean does that prohibit or not? I agree with you, Rick, in terms of I wouldn't be looking for work-arounds from very large organizations.

But I think there’s a fair number of really small start-ups, the very people who have struggled without the value of this statute, and we’re saying, “You can’t play.” So I’m hoping there’s ways by creating a new corp. that they feed into or they become part of a strategic alliance. We’ve talked strategic alliances much today, where we could at least paint a pathway where they could be part of a new entity and so that we wouldn’t lose the investment those people have made indigenously in the trenches.

UNIDENTIFIED MALE 2: I’ll just jump in. It is something, obviously, the work group needs to work on. But the statute does say that the co-op can’t be a related entity or have as a predecessor an existing insurance issuer. So existing insurance issuers cannot be related to or predecessor of co-ops. So obviously that’s, you know, the legal language. We can start to kind of brainstorm what the sensible limits of that language is. But it’s, you know, pretty firm language.

And so one possibility, for instance, is there’s -- I don’t see anything obvious in that language that would prohibit a management team from

leaving one existing company and going off and starting a new existing company with new and different assets that doesn't have a corporate relationship with the old company.

UNIDENTIFIED MALE 3: But could the old company sell the enrollees to the new company?

UNIDENTIFIED MALE 2: Well, sure. That's an arm's-length transaction. And so --

UNIDENTIFIED MALE 3: A small co-op? The members might find that a very prudent --

UNIDENTIFIED MALE 2: So -- yeah. We can start to explore what is the plausible meaning of related entity and predecessor entity.

MR. FEEZOR: Jon?

DR. CHRISTIANSON: So I think the -- just going back to the political discussion, the public option and then the co-op, was the need to interject more competition in health insurance markets, particularly in the exchange. And that's why they're supposed to be new entities. And I think that's a principle that can maybe help us through some of these questions.

DR. CARLYLE: I'm just kind of following up what Michael said about some kind of language somewhere talking about things applicants ought to be doing on a local level to -- to make sure they have soil that's fertile for their co-op. And he talks about the exchange. And I'd also make reference to something we didn't talk about at all today, but I think there's some -- there probably is at least in some states the need to change some state law regarding certain activities, you know, certain activities like co-ops. And I just got an email from somebody who said the Illinois Health Reform Council has made a recommendation that Illinois law be amended as necessary to remove barriers that facilitate formation of not-for-profit member co-ops that would be able to solicit funds through co-ops. So I mean, that's another avenue, that a state law may have to be changed in order for people to -- to have the entity they want within their state.

UNIDENTIFIED MALE: I'm actually helping them on that. (Inaudible, off-mike) concerns about that. And obviously time is of great -- great concern in

regards to some of those legal issues with the timeframe that we're dealing with.

MR. FEEZOR: One of the issues that's implicit in what Brian said was about meeting state solvency standards. And I failed to ask him this morning how many of those states have guaranty funds which existing insurers would contribute in case somebody went belly-up, and is that a liability that we should expect co-ops to have to deal with. Because certainly I think one of the things that probably ought to be a part of their business plan is a noting of whether or not there might be some liability to a state guaranty fund. And Donna, we may want to pull that one out as a specific item to be thought of.

And those of you who -- we'll probably have a couple of additional bullets to be sent out to the various committee Chairs here within the next two days or so. In case you didn't pick up on -- in case you didn't see them coming in the discussions around the table, they'll be formally coming over -- under the transom or over the transom, whichever the case may be.

With that, then our next -- is a break first?

All right. We will take a -- we will take a ten-minute break and be back here at 2:20, at which time we will go into public comments.

(BREAK)

MR. FEEZOR: We are heading into our period of public comment. And Annie, we will have some that have -- that are here present and some that are on line, as well?

ANNIE: Yes. We have some that are here present, and we're going to open up the line at the end to see if there's anyone on.

MR. FEEZOR: I'm going to let you go ahead and do the triaging and call the individuals up, if you would.

ANNIE: Okay. So we'll have Babette End, Emily Katz, and Roger Heis come up.

MR. FEEZOR: Come on, Roger. You'll be a -- a thorn among roses there.

(Laughter)

Babette, since you made a trip all the way in from Las Vegas for this, why don't you lead us off?

MS. END: Thank you, Mr. Chair. I'm really

happy to be here this afternoon. Thank you for having us. I did travel from Las Vegas, but last time I didn't, and I was sorry. I missed the snow, but -- I chose to get up at 5:00 a.m., but not being able to see the conversation was not as good as today, and I learned a lot. So thank you for having another public comment session. And I am glad I got to this one, because you're moving pretty fast. And by session number three, there might not be a whole lot more that you guys can add to your plates.

I work for a large self-funded Taft-Hartley plan, which is an ERISA plan. And I wanted to be here today because I haven't heard you talk very much in these meetings about the ERISA plans. And I have heard you talk about what are some other models and what are some other partnerships that might be created with non-profit, self-funded health plans that are providing high quality.

The ERISA plans were formed out of the ERISA statute that passed in 1974. And starting in 1976, several hundreds of self-funded plans developed over the next 25, 30 years. Most of them are still

operating. They are very financial sound, and I work for one of those. The HERE IU Welfare Fund has existed for almost 30 years. In Las Vegas -- I work specifically in Las Vegas on health care policy. We cover 120,000 members. We are the largest not-for-profit in the community, and we are the only really compelling competitive force against a for-profit community that's really dominated by United Health. We are not included on the exchanges, because self-funded plans were locked out of the exchanges. So I think we're trying to figure out a way that we can thrive through the co-ops, and we also think we have a huge amount to offer the co-ops as you develop them.

We see ourselves as possibly being a really good partner. We currently in Las Vegas cover large employers. Taft-Hartley funds are comprised of half employer and half union trustees, so we're used to this give-and-take and this make sure that you provide competitive rates, make sure you're getting as fiscally responsible care as you can on one hand, and on the other hand, making sure that the consumer has what they need and we're providing as many -- much of our return

back to the consumer as we can to make sure the union side's happy. So we're used to that.

We're also used to competing in very complicated, competitive markets. And several of you have talked today about the importance of understanding the market that you're going into with these co-ops, and I can't tell you how important that is. We wouldn't be alive today if we weren't really good at that. And knowing your market, knowing your provider base, knowing the geography, knowing the competition -- it's just essential. I mean, we need everything else, but you have to know those things to be successful.

So I think -- I'm hoping that you will consider a model that will be able to allow the non-profit ERISA plans to either, if required, become state licensed, or somehow provide a path for us to be able to join the co-ops in a way that we can provide our knowledge, our TPA experience, our ability to do claims adjudication, our ability to run plans, our ability to do direct contracting, our ability to run case management programs and work in hospitals with discharge planning. Las Vegas has the only

freestanding generics free pharmacy in the country, and we started that six years ago. It's now the busiest pharmacy in Las Vegas because of its free generics. So we're extremely committed to the non-profit model. We're extremely committed to our members. Taft-Hartley funds are so consumer-driven. They -- they really, if they get at risk, it's because they're over-consumer driven. They really need the balance of fiscally responsible management on the other side, because they really do devote all of their resources back to the actual fund.

What we would like to envision is someplace where we are able to compete for the awards and then expand, be able to use our large employer base to be able to create some financial stability for the co-op to develop with a small employer and individual market base coming over time. So some of the things you said seem to support that idea that substantially for individuals and small employers could actually be something that happens over time. We would love to participate in that.

And mostly, we just want to make sure that all

of our hard work over many decades is protected and that we get to participate and use our expertise in the next wave of what health care reform becomes. And I think that's it.

We'd love your questions.

MR. FEEZOR: (Inaudible off-mike) three have -- all three have given their presentation. That's okay.

Roger?

MR. HEIS(ph): First I'd like to thank the Board and all the committees for the work that they've done. They've really done a Herculean effort here relative to the kinds of efforts, for example, I've seen other industry kinds of committees make in other situations, and also given the fact that in those other situations, typically all of the Board members or panel members are basically receiving salaries and compensated by the folks that, you know, (inaudible) are not operating on a volunteer basis. So I think that the effort is fantastic.

Having said that, I think that what I'd like to address or make some comments on are some things

that came up today. And I apologize for the fact that I may not have the best and the crispest presentation, because I will just be working from things that were said and some notes that I made.

First, a general one. Many times in what's been presented today, the word "marketing" has been presented. And I don't think that that is the word to use here. I don't think "marketing" adequately describes the kinds of membership development and membership communication efforts that will have to be undertaken by co-ops, these particular co-ops. Cooperatives in general, not the co-ops contemplated under the legislation, don't market, typically. Marketing is not the thing that they do. They don't go out into the mass market and basically say, come in and buy my product. They are attracting members who want to participate in the governance and the operation and the growth of the organizations that they are talking about. And therefore, I think that when you use the word "marketing," unfortunately you are playing into a restriction in the legislation where marketing is restricted. And I just don't think, you know,

characterizing the membership development and membership outreach, membership communication and product communication and membership benefit communication of potential cooperatives with their members should be characterized as marketing, in general.

With respect to the timeline that came up here, certainly again appreciate the efforts. And I think that given the public comment and everything, it will be almost legally impossible for HHS to consider applications before August 15th if you -- or September 15th. I think that's correct. However, I think that to contemplate a process where a cooperative cannot obtain start-up funds, and especially the Stage 1 start-up funds that are contemplated here, until February or March of next year is basically going to cause a situation where almost every cooperative group, including ourselves, contemplating operating in the four-state area around the District of Columbia will not have any gas in the tank. We're going to run out of gas well before March or April of next year. And so I think that, you know, a much shorter and quicker

turnaround process for approving Stage 1 applications, (a) for accepting them as soon as possible, and for (b), turning them around basically in the order in which they are received, could be done in a process of a week or two, and would give co-ops access to immediate start-up funds which they are going to need and require.

On how much to award an applicant: The study done by the American College of Actuaries -- I don't have the title here in front of me, but which has been referred to several times here today -- is very instructive also on estimating the amount of start-up funds that might be required. On a national basis, they estimate it to be $750 million for all states, which if you divide that by 50 is roughly $15 million. So I think that that is reasonably instructive for you to look at, and I would suggest that that is a minimum level of start-up funding in both Stage 1 and Stage 2 that the Board ought to contemplate and that HHS ought to contemplate. If you look further at the assumptions in that report on which those numbers are based, those amount of start-up numbers are based on as efficient

and lean an organization -- efficient being primarily contracted out, lean in terms of the small number of managers, administrators, and other parties involved in the situation as possible. So therefore someone contemplating a different business approach than that, it certainly could be looked that they might need well in excess of $15 million. So I think that $15 million per state ought to be -- per co-op, really -- ought to be looked at as the minimum that you ought to be expecting.

And that leads me into a discussion of stages. I believe that there's one more stage of funding which is implicit in what you're saying, but wasn't explicitly talked about. So that in fact there will be three stages of HHS funding and then one pre-HHS funding stage. So there are actually four stages, so let's walk through that.

The first stage is funding that's for pre-feasibility to get potential co-ops to the point of making any application to HHS, which given the two-stage process that was discussed would be to make the first Stage 1 application. Then there would have to be

-- then on the basis of that funding and outside funding, there would be potentially an application for Stage 2. Stage 3, it seems to me, cannot happen -- Stage 3 would be the application for solvency funds for those grants, those 15-year grants, which should be distinguished from the process for applying for the five-year loans for start-ups. That Stage 3 cannot happen until and unless the co-op has entered into substantial discussions and has proceeded a long way down the road of achieving basically a sign-off from the state, on the preliminary sign-off from the state. Because it's only on the basis of that business plan that the amount of risk-based capital can be calculated. So at some point, in consultation with the state regulators, the appropriate amount of risk-based capital, whether it is a minimum amount or a maximum amount, that answer will come out. And it's only at that time that the co-op could make application to HHS for the amount of funds required for the solvency and other consequences.

It would seem to me also that the -- what Allen talked about, the guaranty funds. In our

discussions with the Insurance Commissioner of the State of Maryland, she has made clear to us that immediately upon approval of the license, that a co-op in Maryland would probably be required not only to make a contribution of -- she pegged it between one and $10 million dollars -- to the state guaranty fund, but also to make or have the resources basically to make -- so that the State could make a call on a risk adjustment fund that has to do with a community rating plan that's already in place in Maryland with individual and small business markets. So in addition to risk-based capital, there are two other kinds of things -- two other required uses of funds which I believe that the Board and HHS should take into account and become part of the 15-year solvency funding grant. In other words, you should not fund a one to ten million-dollar contribution to the state guaranty fund out of five-year start-up loans. They should be funded out of the 15-year one.

Matching funds with respect to the Stage 1 development: I can certainly understand, coming from my own corporate finance background, having worked in

the health care field and the non-health care field with approximately 500 start-ups, I can certainly understand where the Board is coming from in saying that it would be extremely helpful to the Secretary that they basically have some outside validation that someone else had put up some money and believed this cockamamie business plan that the co-op is putting forward, all right? Having said that, it is going to be extremely difficult -- extremely difficult -- for a co-op to cross that hurdle, all right? The thing -- the major problem is, if co-ops were for-profit organizations, it would not be nearly so difficult to cross that hurdle. But these co-ops are going to be non-profit organizations. And as non-profit organizations, the sources of funding are few and far between. And for a potential co-op, for example, to go out and solicit grants from a foundation, now those foundation grants would have to be made in line with the corporate charter and charitable purposes of that foundation. And in talking with IRS representatives, establishing a co-op under the ACA in general to offer health insurance through exchanges is not a charitable

purpose. And so therefore, I think by imposing this matching fund situation, although I can certainly appreciate how that would be very, very helpful to the Secretary in prioritizing and assessing various -- I think as a practical matter it's going to be extremely difficult. Whereas, some sort of matching support, and it may not be in the form of matching funds, I think is much more appropriate in the Stage 2 process, and that matching is much more likely to be found not in the form of cash grants, but in the form of in-kind contributions. Actuaries may be willing to do certain work up front and give you that work product. The other side of that coin, however, is that by the process of co-ops entering into those kinds of relationships, there is a quid pro quo. And it is highly unlikely that you are going to get any professional legal counsel, any actuarial firm, any TPA-er to come forward and provide you with a raft of services if you cannot say to them that they are very, very likely, presuming that all the rest of contractual standards, cost and everything to be met, that they're going to be considered as a business partner. And to

try to separate those kinds of things completely, while I can appreciate the problems it causes you, I don't see how you can do those things. If you're -- if we can't get non-profits set up and you force us into the arms of basically doing vendor and interested party financing arrangements, those things are doable, but they're going to cause problems in the other areas.

I would be very interested to have the Board discuss more how it is that the formation of a non-profit organization to make the Stage 1 application protects those individuals that are involved in that from legal liability with respect to the loan. I understand the general corporate shield from liability. However, as a corporate financial advisor, we are often called upon to advise both for-profit corporations and non-profit corporations as to whether some course of action is prudent and to deliver a professional opinion on that basis. And this is the main mechanism by which boards of directors in for-profit and non-profit corporations protect themselves from having made an imprudent decision, all right? I would have to tell you that on the basis of all of the facts that I know

today, it would be extremely difficult and almost impossible for our firm to deliver an opinion that taking down a large amount of money from the federal government is prudent. In other words, that -- a prudent business course. It may meet the requirements of the law; it may do the good things that the Secretary wants; it may increase competition in the markets. But from a point of view of risk and reward balancing, the risks clearly are in the ascendance here. And, you know, it is going to be a leap of faith based on a lot of good work and business planning and other kinds of things to -- for a non-profit organization to take on a $15 million loan and say that this could in fact be repaid with some -- any kind of assurance. So it’s, you know, I don’t -- therefore, I do not believe that a non-profit doing that would be, by the action of forming a non-profit, would protect those individuals who are making the application from liability.

Yes?

MR. FEEZOR: (Inaudible, off-mike.

MR. HEIS: Yes. The last one.

In terms of the McKinsey recommendation that basically the business plan, that all the i's be dotted and the t's be crossed and that every section be fleshed out, I don't think that is realistic. I understand how McKinsey gets there because of their clientele base, but coming from a clientele base of smaller and start-up organizations, you never get that kind of a business plan, all right? And to the extent that you do, the i's are dotted and the t's are crossed in very convoluted and mealy-mouthed statements that allow you to have the appropriate exit if certain things don't come true, all right? And in order for -- to come true, you have to make some assumptions. You have to make assumptions about how the exchanges are going to operate. What if they don't operate that way in your state, you know? You have to make certain assumptions now about how providers might operate, and in fact how they might endorse your product. What if those things don't turn out to come true? I mean, we can make the best basis and make the best approach that we possibly can, but having all of those i's dotted and t's crossed, especially at a Stage 1 or even at a Stage

2 application, any independent review board you put together is going to poke holes, big holes, in all of those applications because that is the reality of the situation that we face. Once exchanges are in operation, maybe some things will change.

Thank you.

MR. FEEZOR: Thank you, Roger.

Yes, ma'am.

MS. KATZ: Hi. Thank you, members of the committee and Mr. Chairman. My name is Emily Katz. I'm with Care Oregon. And I'll be happy to explain a little bit about who we are, and that's really why I'm here is to provide you with some lessons from the perspective of our health plan as we sort of try and find our way to 2014. And also I have some questions that hopefully won't create more questions. They're actually questions that I heard discussed today. Some of them definitely came up. And then I have one recommendation. So I'll try and keep it within just three minutes and then I'll -- I guess we'll be taking questions.

So Care Oregon is a not-for-profit. We're a

community-based Medicaid health plan. Medicaid is our primary business. We were formed in 1994 when the Oregon Health Plan, which is Oregon's Medicaid waiver, was just a whisper. And that's based on the use of the prioritized list and managed care -- you know, we can get into all of that. But this is when it was in its infancy. So the local health departments, our primary care association, and our local hospital, OHSU, came together to form Care Oregon under the common aim of providing access to effective primary care outside of the traditional commercial insurance market. This was, like I said, in 1994. And now today we're the largest Medicaid health plan in the state.

And this did not come easy at all for us. We almost went out of business in 2003. Back in '94, OHSU took all of the risk for our hospitalizations. Our local county FQHCs took all of the risk for primary care. It took us three years before we really got formed and on our own. So I wanted to sort of provide you with that lesson. So it was 1997 we became a fully independent risk-bearing not-for-profit.

It wasn't until 2004 that we were really

stable enough to truly build up our solid reserves and begin investing in a world-class provider network and case management system. And so we feel like a co-op is going to require, or might experience some of these same lessons and that we have some expertise to provide. But it just goes to show you what goes into really making a plan from start to successful.

So today our primary business is providing over 135,000 Oregonians who are on the Oregon Health Plan with access to high quality care. We have a subsidiary, which includes a Medicare Advantage special needs plan. We have about 6,000 dual-eligible members. And recently we created an --

MR. FEEZOR: Is it -- excuse me. I've got to ask. Is it for-profit or not-for-profit?

MS. KATZ: So Medicare Advantage is for-profit. But it's owned by Care Oregon, which is a not-for-profit. And recently we created an LLC to start new community health clinics, which are applying for FQHC status, so now we're actually becoming a provider ourselves.

We believe that establishing or partnering

with a co-op as envisioned in this law has a lot of potential in Oregon. Stakeholders there are watching this provision closely, and we're convening that table right now. We've got members from business and labor and the Governor's staff all there and listening. So we're trying to prepare that if we need to flip a switch quickly, that we can do that, because I'm hearing the timeframe is really quick. But this is at the same time we're starting our legislative session in the state, where they're going to be determining the way our health insurance exchange gets established. And so as we're looking at what a qualified health plan will be for the exchange, we're looking at what it means to be a qualified health plan with a co-op. We have the expertise, the infrastructure, provider networks, administrative capabilities, but not marketing capabilities, because we're a Medicaid plan and that's forbidden for us in Oregon. But given our growing relationships with our members, we just feel like this is the type of relationship that can get translated well into the co-op program. The ability to manage and communicate effectively with a sometimes

difficult-to-serve population is an area that's going to be a critical function of the co-op.

We believe that our members could benefit from the consumer engagement called for in this type of a plan. And to that end, I have questions.

The way Care Oregon currently operates, our subsidiary, the Medicare Advantage, is licensed through our state insurer -- or insurance division. But our Medicaid business, our primary business, is not. It's solely -- it's contractual. So we also don't serve in the individual or the small group market right now. And so I was wondering, I mean, does the definition of health insurer or issuer prior to the July '09 date include people that are issuing or plans that were issuing in just the small and individual group markets, or is it -- a Medicaid plan be included in that? And since our subsidiary is licensed with the state, would that be an exclusionary piece, that we have this one line of business that is licensed with our state?

And then is our Medicaid contract considered state sponsorship? Because I know that that's something that's called out specifically in the bill.

And so those are just questions that we would like you to consider. I don't expect to have an answer right now, unless you would like to provide me with one. But the recommendation I have for the group is something that's new from the health care law, the recently passed or the ACA or pea-pock(ph) or whatever you want to call it. There is a section there that assesses a fee on health insurers, and that's in order to raise funds to pay for all of this, for the whole bill. But that fee, there's an exemption. There's a 50 percent exemption, I think, for just not-for-profits. But then it goes further and exempts what we call safety net health plans, but they provide a definition of who's exempted from this fee, because they're trying to sort of separate what a traditional for-profit insurer is from maybe people that -- maybe other plans that they don't see fit collecting this fee from. I don't -- well, so here's the definition. You're incorporated as a not-for-profit under state law, and as such, no part of the earnings, you know, go back to shareholders. No substantial part of the activities is caring for propaganda or attempting to

influence legislation or intervening in a political campaign -- this is all familiar. And then more than 80 percent of the gross revenues of what you receive from government programs that target low-income, elderly, or disabled populations, and it calls out the programs. And so basically, if you're a not-for-profit that doesn't do what a not-for-profit is supposed to not do, and 80 percent of your revenue comes from these government programs, then you're exempt from this fee. So this is a definition that I thought would be interested for this group to look into more, just to see if there's pieces of it that might fit into what you're consider a qualified health plan could be. So we believe that that definition maybe fits within the spirit of co-op and might be able to accommodate these existing not-for-profit community-based plans that serve public programs. And I know that's an issue you're grappling with. So we would encourage you just to see if this definition could be relevant to co-ops as you move forward with rulemaking and the regs. And even if we're not permitted under state law, we really are looking to be an effective solutions partner, so

whatever expertise we can be able to provide for the group, we're happy to work with you in whatever capacity that you would like.

Thank you.

MR. FEEZOR: Questions of our three speakers? Mike?

MR. OEMICHEN: Thank you all for coming to testify. It's much appreciated.

Roger, we heard you talk about the timeline. I'd like to hear from Babette and Emily your views on the timeline, with the discussions you've had in your communities about this.

MS. END: Thank you. I'll go first.

We are just starting our relationship with the DOI. I think that when the presentation this morning occurred talking about the general business plan with the 10 or 12 key points that need to be in a plan, we really believe that we have all that already. The one thing that we don't have is the relationship with DOI. So our effort right now is figuring out with DOI how we would get licensed and what kind of timeline that would need. And honestly, I haven't heard you talk about

this a lot, either, but out in the -- out in the war, out in the states, DOIs are overwhelmed with needing to get the exchanges going, needing to even figure out their role in the health information exchange, and needing to figure out the licensing all the way around of these plans. They're not looking for a lot more work.

So I think for a whole new brand of us -- right now we're licensed as a 501(c)9. For a whole new brand of us to come on board, we would need some sort of expedited process or some sort of technical assistance, as you were talking about, to fill that role for us, so that in the first -- you were talking about this first wave of grants, which I think is a great idea. Then we would need in that timeline to be working with DOI and to be doing whatever we could with the DOIs in the separate states to be able to get to the licensing board, look-alike licensing or whatever was possible through this program.

Other than that, I think we're in an ideal situation to meet any early deadline, because we do have a relationship with our members. We don't -- we

have brand loyalty over 30 years. They really trust us. We have all the pieces of a health plan in place. We have the fiduciary responsibility already in place. We have the reserves in place. We have to have reserves as a Taft-Hartley plan. We have everything else. That's why I think this is an ideal opportunity to let us be the foundation and build out from there.

MS. KATZ: I think there's a lot of the same fatigue going on in Oregon. We just started our legislative session, and it's going to go on through mid-summer. And we were -- we were looking at this timeline closely. Folks at Care Oregon were really hoping that we wouldn't have to even think about this until the end of the legislative session, which frankly, I don't think -- I don't think that that would be advisable. I think, we are looking at this now, but the stakeholders that we've convened definitely have expressed some -- I don't know what the -- like compassionate fatigue I think is the right word. I mean, there's been so much health care reform discussion going on, and there's things that absolutely have to get done this legislative session. One of

those is that we're going to have to change the law to allow co-ops to form in Oregon, because actually there is a prohibition against that. But that's sort of the easiest thing we can do right now.

But I think we're going to have to get this group to a different place. I think right now, they really have a lot of faith that the co-op can work. They want to see that it can work and then get it delivered to them as a product so that they can deliver their members, whether -- I mean, we have large employers at the table and we have unions at the table saying, if you can show us that this works, we'll come to the table. But they want the product here offered to that -- you know, I mean, and so it's harder for them to be part of the group that's developing the product right now. There was less of a willingness. But that doesn't mean that it's not there. We just have to cultivate more of it, I think.

MR. FEEZOR: Mark?

MS. KATZ: We're an uber-collaborative state, so I don't doubt that we can do it.

MR. FEEZOR: Mark Hall?

MR. HALL: Yeah. Babette, I was curious. You said that the self-funded Taft-Hartley type plans were left out of the exchanges. And you see the co-op as a way of kind of getting involved with the market changes that are going on. So I was curious, what -- if the co-op structure were not available, what would keep you from essentially doing the same thing on your own? That is, forming an insurance company and selling, you know, through the exchanges.

MS. END: I think there is going to be limited ability for a lot of different models to succeed in these states. I think that we don't exactly know how the exchanges are going to work out. But I think that their effort to bring people into what looks like it's going to be mostly commercial insurance will leave some desire for non-profit care. I think non-profit health care provides the best possible model for people, and I think it would be very attractive to people if they can get a non-profit insurance plan that they can -- particularly one that's consumer-driven like us that they can be part of. We certainly have a lot of loyalty.

But I do believe that it would be very difficult for us as a Taft-Hartley to start over again in this community where another non-profit co-op was also starting. I think you would be putting them both at risk. And I think that it's important that everything be developed in a way that the ones that are good at it now have a chance to succeed and grow, and the ones that don't have anything have a chance to start, and the ones that are working on the exchanges provide sort of another competitive force.

MR. FEEZOR: Rick Curtis.

MR. CURTIS: You were all here earlier today, so you know about our discussions about provider organizations and the relationships. From your -- I assume that in Oregon, you are someplace like south central Oregon? I don't know where you're located. But for each of you, you're in the Washington, D.C. Capital area, multi-state, but I'm not sure you're talking about statewide, and I have no idea if you're talking about statewide or the Las Vegas area or what.

So any comments the three of your respectively have about the wisdom of assuming that you did qualify

to be a start-up -- where do you see the tradeoffs coming down between starting regionally based with strong provider relationships versus statewide?

MS. KATZ: I think in Oregon, the regional approach would definitely work better, given sort of the way we're oriented. It's very sort of regionalized. Care Oregon itself, we're based in Portland and most of our membership is from the Portland metropolitan area. But we are in 18 out of the 36 counties across the state, but that's simply because there are certain counties where there's no mandatory managed care. There's not just -- I mean, there's hardly any providers whatsoever. And so it's really just impossible to get a network out, you know, in certain parts of Oregon. It's frontier in a lot of the parts of the state. But I think regionally, that would jibe well with what the state is now considering with their exchange and maybe doing regional health authorities. And so I think that that approach would be -- would work well, at least for our state.

MS. END: Nevada is still trying to figure out its information exchanges, and they're breaking it

down. They're trying to figure out if they're going to do a state model for that, and they're just starting on the insurance exchanges, or if they're going to do a regional model. And that is because in Nevada, we're so heavily dominated population-wise in the south, in the Las Vegas area. And then the north is a very far geographical area away from us, and then there's the rurals kind of between everything. And with the providers, they're heavily concentrated either in the south or the north, and everybody struggles in the rural areas for everything. It's always hard, and nothing's easy there.

But I think that we consider ourselves ideal for a regional model. Perhaps we could grow into a state model. I think regionals are just much better when you're trying to figure out physician networks. I don't know about every state, and I haven't heard you talk about this, either, but we have so many physician shortages that it's going to be really difficult for -- I don't want to get off track too much; there's so many things that we probably should be trying to talk to you about. I'll write comments. But I think it's going to

be very difficult for a provider who is depending on a large for-profit for much of his income now to join -- join a co-op or some other model that also has that for-profit's feet in -- as a partner in any way inside the non-profit. Because then they're kind of held hostage by both of them. I think the attractiveness to providers of a co-op is a completely alternative approach to being able to be -- doing care differently than the for-profit model. And so I think, number one, I would do it regionally for sure, or allow that, and do it state by state depending on their needs. But I would also make sure that when you're considering these partnerships, the idea of a for-profit as a partner, even though you wouldn't allow it as a parent, I think you have to take into consideration what impact that's going to have on the doctors. Because it isn't just their for-profit status. It's the market share that they take up with that doctor's time. It's really important to understand what happens to the doctors in this.

MR. FEEZOR: Roger, a quick observation on the regionals?

MR. HEIS: Yes. Our choosing to take a regional approach was not based on providers. It's based on our assessment of the overall -- where the actual underlying market is in this particular area. And with respect to providers, we believe that we're going to have to institute a new set of incentive and payment mechanisms with respect to providers. That is going to unfortunately mean that we are going to have to recruit providers one by one by one as time goes on and try to expand out from a regional base to a statewide base in all four states.

MR. FEEZOR: I want to thank all three of you. So we can stay on time -- we have other folks that we need to be getting up here -- the one question that I might have for you: your self-funded plans, do they have retiree liability, or is that still deposited with the employer?

MS. END: I think it depends on the plan, and I'd hate to give you the wrong answer. I will find out. Our plan does not have retiree coverage. We just have a special plan for people between 62 and 65, but we don't have a special retiree plan. But I'm -- I'll

write up more about us. I know you don't have time today to hear about us, so I kind of skipped that. But we -- we really would love your attention to look at the way we're designed and what we have to offer. And I would love to come back or provide you any more information about the funds. Thank you.

MR. FEEZOR: Babette, Roger, Emily -- thank you. Thank you all very much.

UNIDENTIFIED MALE: If I could beg the Chairman's indulgence just for one second. I would like to -- if there's some way to have an ongoing dialogue with respect to this issue of profit that would allow some things to develop, I don't think the process of writing down some definitions and making some comment would be as advantageous as some further dialogue.

MR. FEEZOR: All right.

UNIDENTIFIED MALE: And I understand that that can't happen right at this second.

MR. FEEZOR: Thank you.

And I have one name up here. I don't know who all you have there.

ANNIE: Jerry Burgess.

MR. FEEZOR: All right.

ANNIE: Barbara Gilberton. And Adam Schwartz.

MR. FEEZOR: So Jerry, Barbara, and Adam.

Jerry, go ahead.

MR. BURGESS: Thank you.

I am Jerry Burgess. I'm with Healthcare 21 Business Coalition in Knoxville, Tennessee. I'm the president/CEO. And I think I'll give you a 30-second background on myself because you'll then understand some of the comments I'm going to make and on our coalition.

I was about 16, 17 years in hospital administration, so I understand the supply side. And I'm the founding president of a business coalition for the last 13, 14 years. So I understand the purchaser side of what we're talking about here.

Healthcare 21 is a 501(c)3. So I've been very intrigued by your discussion today about for-profits, non-profits, and 501(c)3 to 29, I guess. And we also -- we have a multi-stakeholder board, which I think is interesting, given your discussion. I have physicians,

health plans, brokers, all of the supply side on the board with the purchasers, who are employers. Generally speaking, they're self-funded ERISA plans, not small employers, that are members.

And one of the comments I wanted to make about the structure of the board for co-op is that the buy side far outnumber the supply side. And the reason for that is that even if there are only a minority of supply side providers on a board, because they're insiders -- and I was a hospital administrator, so it comes from that experience, too -- because they know the health care system so well, they tend to divide and conquer the rest of them. And so I think 51 percent is not enough. I think the buy side has to be two-thirds, three-quarters to offset the insider knowledge of the provider side. And that's having spent half my career on one side and half on the other. I used to try to divide and conquer, so I understand that.

The other comment is about consumers. I was a little bit surprised that you defined "member" as the insured person. And you know, I have -- I'm very excited about this whole effort. I think it's a grand

experiment, and very optimistic about where it may end up, even though I know there'll be a lot of casualties along the way. And I have a real compassion for the consumer and the consumer voice. But in working with many -- I go to enrollment meetings with my purchaser members, generally ERISA plans. And I can tell you that -- and deal with their unions and their various consumer groups. And I can tell you they, too, have their own agenda. So we shouldn't think of consumer as being a purely objective group to be on a board. Their agenda is entitlement. You know, their agenda is, I can be a diabetic and be out of compliance and still get my insurance covered the same way. Or I can be obese and not have to change my lifestyle and still get full coverage, that I don't have to have skin in the game. So I think you have to be very careful about when we say consumers are these board members. They bring to the table, the insured people, bring to the table this entitlement mentality. And as I read the reform law, which I'm excited about many parts of it, the part where the Secretary can increase the incentive, you know, from 20 to 30 to 50. I'm very

excited about that. Because that increases consumer engagement and deemphasizes or mitigates some of the entitlement.

So I would -- I would propose that there be -- that the employer, small employers, be given a majority of seats, and then consumers so many seats, and suppliers so many seats. But that's from my own experiences.

The other thing philosophically that I -- you know, that I want to lay on the table is that the critical mass is extremely important. We all understand, I guess, risk pools in insurance. And I would hope that there would be a way to allow larger businesses, maybe still fully insured. You know, some of my members might have 300 to 500 employees, but still be fully insured, and would benefit from being a part of a co-op and would help the critical mass. And so I think you -- this whole "what's a small employer" should be an expanded idea.

I also would recommend that other arrangements be considered that already have a critical mass. For instance, I have 12 employees. I myself get my

insurance through a PEO, which 2,500 covered lives. And that would add critical mass if somehow the PEOs could be captured into this co-op. PEO is a Professional Employment Organization, where you have like dual employers.

You know, related to ACOs, absolutely what's great is the convergence of this dialogue providers are having about ACOs and this idea of insurance exchange and co-ops. And definitely, they make great partners. I think be very careful, though. I heard some of this discussed today. They should not be -- they should not be in any way sponsors or have spawned through another organization the co-op. I would be very leery of this sort of provider dominance that can occur. And even though I fully believe in integrated delivery and think that should have come 20 years ago in America when I was a hospital administrator -- it should have come maybe in the days of HMOs -- there's a real danger, I think. Even the President, the administration, and the Secretary understand the real danger with integrated delivery systems is monopolistic behavior. And we have that in Tennessee. I may have two ACOs that eventually

shake out in Knoxville and three or four in Nashville and one or two in some of the other cities' markets. And we're going to have a real problem with the monopolies and their behavior. So be careful how much you encourage integrated delivery. You have to put some checks and balances on that. Again, that's why they should not spawn or in any way control the co-ops.

And then related to grants and loans, you know, it started out loans and grants, and then I know through the politics it ended up you've got to pay it all back. But I would propose that if we end up sponsoring a co-op, which we'd like to do as a business coalition is to -- we've already put some of our own money into that. We're trying to raise money through charitable gifts to a 501(c)3. I agree with the gentleman who said getting private investments is going to be difficult, because what are you investing in? Right, it's a non-profit. It's very altruistic when people give money to this.

But let me say that I think if over time the co-op is successful and meets your objectives, maybe there's an incentive put in place that as they meet

performance objectives, you can forgive some of those loans. I think that would help plough money back into mitigating premiums for small business and individuals.

About individuals and small business, I would -- knowing how different those -- and I'm sure you're experts, you know how different those markets are. And it takes a lot of resources and expertise to be in just one of those two markets. You might consider allowing co-ops to phase in. That is, start with small groups; phase in individual. Maybe they could offer one or the other on the exchange 2014, but not -- but phase in the other one. So I think you double the need for resources and expertise when you ask them from the get-go to be in both markets at the same time.

And this is just an idea. This may be a very bad idea. But I assume that these employers are going to have employees across state lines, and maybe there should be a networking of co-ops so that my employee who's in Missouri can be in the co-op in Missouri. You know, kind of like the Blues do with their Blue card idea.

And just to sum up my comments, I think you

are right to think about no individual or group that's going to sponsor a co-op today is in the insurance business, so none of them are going to have all the expertise they need that are insurance company expertise to immediately be a co-op. But they should have some of those expertise, and they should show the ability to bring together the other expertise. I think that's the way to look at it.

And if you want to understand coalitions better and what we do, we are a member of the National Business Coalition on Health. Andy Webber, our president here in Washington, D.C., and I'd be happy to be a resource and help you connect with coalitions if you want to do that.

Thank you for your time.

MS. YONDORF: Thank you. Just to tell you that our esteemed leader has left, not dropped dead, which is usually when a Vice Chair takes over.

(Laughter

But he's delegated to me. So -- yes, sir.

MR. SCHWARTZ: Good afternoon. My name is Adam Schwartz, and I'm the vice president of public

affairs and member services with the National Cooperative Business Association. And it's a delight to be with you once again, and thank you for your very thoughtful deliberations.

I can't tell you how many congressional hearings that I've sat through which I would have really given a tooth to be able to do what I'm doing right now, and that's be able to join the discussion at the end of those discussions. And I really do thank you for your very deliberative and thoughtful discussions that you've had today and the last time you met, and obviously what's been going on with your working groups outside of the public discussion, as well. And to say that, you know, you're already operating like a cooperative, because you are a bunch of volunteers, and most cooperatives operate with volunteer boards. So congratulations on executing that cooperative principle already.

I'm going to try and keep my comments fairly brief to the subgroups that have already reported as a way of offering maybe a little bit more guidance as you continue your discussions.

First, thanks again, and I concur with the governance committee's recommendations in which you have already reached consensus on forming both a formative and then operational board. I think that makes a great deal of sense. And also appreciate the very delicate balance that you're trying to achieve in both providing some flexibility, yet being proscriptive as to how these cooperatives should be formed. At the end of the day, my association is very concerned that whatever is called a cooperative acts like a cooperative. And that is really the bottom line of where we're coming from as this debate continues. We're very concerned about health care access in this country, and that is obviously the reason why the reform act was passed. But as the leading national organization of co-ops of all types, protecting the cooperative brand is of great importance to us.

I think the 51 percent threshold that was discussed on the Board as the absolute minimum -- and I appreciate your comments that it should be higher; we would certainly be very supportive of that. The idea of making this from the outset that there be

competitive elections I think is also a very important proscription that you can put forward and begin to create that culture. I realize that there are the -- some of the continuing discussions that have to be had on the IRS filing, the MIO(ph) conflicts and public disclosure and limits on conversion. The conversion language is also going to be of great interest to us, because we would not like to see a repeat of some past mistakes where cooperatives get a jump start with government assistance and then later convert, usually to the profit of very few. So that is something of major concern.

On the question of state and local prohibition of being involved in the formation of co-ops, I'd like to offer one possible suggestion of how you might be able to maneuver through that. There are number of public purchasing cooperatives. These are where states and localities come together for the public buying of certain goods. It could be things like road salts, you know, just name it -- office supplies, whatever it might be. And they do so, and they create cooperative entities and then go out and purchase those goods. I

don’t know if that will met the letter of the law as giving enough separation between state ownership or not, but it’s certainly something that you might consider going forward.

On the related entities question of being able to use the experience of existing cooperatives with the regeneration or generation of new cooperatives, that is something that is really one of the great aspects and one of the real joys of my work, is how cooperative the people are who are attracted to this business model and there willingness to share their information. I work with a group of food cooperatives that have created an online free resource for new cooperatives. They will give away business plan and financials of how to make their operation successful, simply because they want to see other cooperatives succeed in other communities. Not to be able to use that resource of the wonderful panel that you had last time of group health in Wisconsin and Health Partners in Minnesota and Group Health in Washington State would be a real shame and a travesty. So I would hope that we can find a way to negotiate around that issue, but in such a way that the

crack that may be created does not create such a large crevice that other entities are able to take advantage of it in a way that is not supportive of what we're trying to do. So I do think that, you know, I have great empathy for the task ahead of the working groups in regard to that.

Another resource that I would like to offer t you, there are 29,000 cooperatives in this country right now. That means by a conservative estimate there's about 250,000 people that are serving on cooperative boards across this country. That's a very large number. Now, I'm not saying that every one of those folks is an expert in cooperatives, but at least it's a starting point. And a good number of them have received a significant amount of professional training in what it means to be a member of a cooperative board. And I think that's a resource that we should take advantage of, and we'll be happy to help you connect with those types of folks.

In regard to the finance discussion, there's a very popular saying among cooperatives: No margin, no mission. If we don't make money, we're not going to be

in business to do what we need to do. So while I'm appreciative of the concern about where profits might ultimately have to end up, I hope that's a discussion that we get to have in the not-too-distant future. Right now I'm probably a little bit more concerned about capital adequacy of these new entities as they get off the ground. But cooperatives have found very innovative ways of being able to maintain an adequate capital base. And I think Bill had spoken about it. You allocate the capital, but you do not return the capital. Subchapter T, farmer cooperatives do this all the time, where they return only a certain percentage in cash and are able to retain the earnings. So the business model is mature enough that it's dealt with a lot of things that I think that you'll be grappling with.

In regard to the infrastructure issue, appreciate the definition of marketing, that it will not be considered education and outreach. I think that's a very, very good initial step to go forward in that definition.

In regard to the co-op management, I noted

that the experience required was to be in health care or finance or IT. I would hope that one criteria that would be preferred, if not mandated, that some experience in the cooperative business model be part of that as well, or at the very least the ability to be trained in it in the not-to-distant future, and the willingness to understand some of the unique features of the business model.

In regard to the criteria and process, I appreciate the Powerpoints that were put up here. I hope that they'll be publicly available just as soon as possible, and I hope that the timeline that was discussed will be available as soon as possible, as well, so that we can maybe have some insight as to what makes the most sense from the standpoint of co-op creation as well.

MS. YONDORF: Could you start to wrap up your comments, please?

MR. SCHWARTZ: Yes. Absolutely, okay. That's where I was getting to. And I guess the final comment would be, you know, just thinking back as to why a co-op, as to why this idea came about in the legislation

when Kent Conrad offered it as a sort of a third road. And that's because it does represent a different way of doing business that allows the member owners to be in control of it. And it's not without some irony that as this discussion is taking place right here, just a few blocks from us the Treasury Department is mulling over how they're going to reconstitute Freddie Mac and Fannie Mae, and we are going to -- believe that the co-op solution is going to be one possible alternative there, as well.

So with that, I thank you very much. If anyone's interested in learning a little bit more about it, there's a wonderful new book called "Humanizing the Economy" that goes through cooperatives both in this country and other countries. So I thank you for your time.

MS. YONDORF: Thank you very much.

Any questions from the Advisory Board?

Yep, Rick.

MR. CURTIS: You know, I think what we're lacking on the stop conversions, I haven't heard anybody that's in favor of conversion of co-ops to for-

profits someday in the future. I haven't heard anybody suggest any specific ways -- I personally have thought about hey, that's what poison pills are. But -- so maybe not now, but in writing or whatever, I think we could use some ideas on how -- specifically how would we prevent this? What can we recommend to HHS on methodologies?

UNIDENTIFIED MALE: We would be happy to provide some language to that effect.

MS. YONDORF: Rick?

MR. CURTIS: Alex -- Jerry mentioned the advantages of having purchasers on. Bill has told us it's not at all uncommon for co-ops to have Class A and Class B members, and I assume then allocated proportionate seats to each with -- and several people have wondered about well, if the small employers are paying a large part of the bill, how do you make sure they're represented on the board? Is that the typical way across different kinds of co-ops that have both small employer and individual members to address this issue? And do you have any specific suggestions as to guidelines you might suggest?

MR. SCHWARTZ: It definitely does exist. It is not uncommon. It depends on the nature of the co-op. Certainly my background is with rural electric co-ops, and they have multiple classes that serve in the leadership of that. So there's different ways. I guess the problem, you would need to respond a little bit to the structure that you're looking to create. We could possibly come up with a couple of different scenarios where that takes place. But clearly it is an issue that other co-op sectors have wrestled with. We'd be happy to provide more information on that to you.

UNIDENTIFIED MALE 2: And I have -- this is politically incorrect, to a degree. But you mentioned how invaluable the previous panel was last time. It was Group Health Cooperative, Health Partners, and et cetera. And I think virtually everybody on this panel agrees with that. I learned a tremendous amount just in that brief period of time and read the materials that were provided and on the previous panel today. I don't know quite how to articulate this, but having had an association of cooperative-like entities in the

past, my own experience was this: they were, as you're suggesting, very happy to share information and insights with each other. Unless they were sharing insights and information with entities that were not going to compete against them in the same local market. And that's one of the reasons I was suggesting you consider recommending that where there is already a qualified cooperative, that there is -- that shouldn't be a priority for new funds. Because I'm afraid of that being compromised, that willingness to provide technical assistance and free information accessible to any entity. Do you have any observations in that regard?

MR. SCHWARTZ: Well, I'm sympathetic to both the point that you made and to the point that Dr. Christianson made, as well, about wanting to have some sort of competitive tension there as well. There are enough impediments in the statutory language that are going to make it very difficult for these entities to be successful to begin with -- and I commend you for trying to navigate around some of those impediments -- that where there's an operating cooperative that's

meeting the basic guidelines of what we're hoping to create, that let's leave well enough alone for a little bit of time. Let's make sure that the entities that receive the initial funding have the highest degree of -- possibility for success, and let success beget more success. That is, though, my personal opinion. As I must say, I neglected to give the disclaimer. Because these comments were made in the time basis to react, obviously I've not been vetted by my superior, so I need to have that disclaimer on the record.

(Laughter)

MS. YONDORF: The gentleman from the great state of Texas.

MR. BUCK: I wanted to understand better about Board representation. You mentioned that consumer versus employer and gave two examples, one being a diabetic that was poorly controlled, and the other was a obese patient, and incentives in their alignment therein. And I was trying to think through consumers on the board and employers on the board and how you indicated bias of consumers. And of course, we all have a bias. How would you see the bias of employers

getting to that preventive piece? Because I think employers, they could provide membership to sports facilities, or they could -- so I was struggling to see what value added the employers would bring to the table.

MR. BURGESS: Oh. It's -- for two or three years now, the trend is very strong for employers to do a lot more than incentive to a fitness center. I mean, they're taking literally what the Secretary now is expanding to 50 percent different margin, to really saying to people, "I'm going to have to raise your premiums 10 or 15 percent. However, if you identify your biometrics, go to a health coach, and improve those biometrics, you don't have to pay that." So they're using very strong financial incentives, up to the 20, 30 and 50 percent, to incent people, consumers, to change their behavior. Which is a very difficult thing to do, but I think a combination of the changing culture with an employer, which many of my employers -- across the country, employers are experimenting with this -- changing culture, like the vending machines. Take the Coke machines out, you know. To financial

incentives, to support systems, like good motivational health coaching. And those are the kinds of things I think that would be embedded in these products that would help bend the curve.

You know, the way these -- the way a co-op is going to, as a start-up, compete with the big health plans in our communities is that it has to be very innovative and play by different rules, such as integrative care and consumer engagement. And my comment is that if you're not careful, if you put too many consumers on there, they will be against the things that would incent them to the right behavior that would bend the curve, the cost curve.

MR. BUCK: Is there any evidence in the literature that you could cite that we could look at for this to help educate us better?

MR. BURGESS: Sure. I mean, I can't cite it here, but I'll send you that. Yeah.

UNIDENTIFIED MALE: Yeah, I -- my guess is we all can find evidence on both sides of this issue. I mean, I know a fair amount of the literature in terms of wellness. At least in our part of the country, and

I think in other parts, a very conventional way. And it's what I do with our organization, which has 70 employees. I have a wellness committee, and I give them some guidelines of what I'm trying to accomplish and I have them go at it. I find them nothing but enthusiastic. So I -- I find your comment about the prejudice of members to be an opinion, and not necessarily one we all hold. Nor that the literature, you know, formally supports.

MR. BURGESS: Well, yeah. My opinion just comes from my experience.

UNIDENTIFIED MALE: Yeah. I have experience that counters yours, so we --

MR. BURGESS: Yeah.

UNIDENTIFIED MALE: -- I think we just averaged it out.

(Laughter)

MR. BURGESS: That's fine.

MS. YONDORF: David Carlyle, and then Pat?

DR. CARLYLE: Adam, one thing we haven't discussed much today is some kind of vision for multi-state regional co-ops or some kind of, you know,

interaction between co-ops of contiguous states. I mean, is there models in other venues of co-ops that would allow people to kind of look at how you could imagine, you know, co-ops side by side to somehow cooperatively save in some way?

MR. SCHWARTZ: There are. Unfortunately, though, they're ERISA exceptions, and they've been granted such. So without the exception or without some new statute that would allow for that interstate kind of transfer, it's going to be difficult. We do have members who are currently running in-state plans with great success on a cooperative basis. So that is, I would hope, through the purchasing council something that we might be able to overcome and do on a interstate basis. I think that's still up in the air as to how we're going to do that.

One other question I think that might want to throw out and put in the parking lot as well, is will the co-ops that are incorporated under this statute be required to incorporate in the state in which they are going to serve? Because there are advantages, sometimes, in other states that they might want to use.

So that might be something -- I'm not offering an opinion yet on that, but it might be something that you want to think about.

MS. YONDORF: Pat? And then Bill.

MS. HAUGEN: Just a brief comment back on the discussion on consumer and employer bias. I think this comes back to the question of an appropriate level of criteria and rigor on the selection -- nomination and selection process of those members on the board, such that if that process works, then some of these issues of individual bias -- because individuals shouldn't be on a board if their own personal issues are of their concern on a consumer basis versus the benefit of the population being served and the success of the organization.

MS. HAUGEN: Thank you.

Bill?

MR. OEMICHEN: This is more of a comment directed at Rick, because of your continuing comments. Just so you know, when we created the Farmers Health Cooperative of Wisconsin, Group Health Cooperative Pete Farrell who was here last time contributed almost

$75,000 worth of time from himself and his staff, with the idea that we would be competing with his cooperative and he was fully happy to do that because of the sixth cooperative principle, a cooperation among cooperatives. I can't speak to your experience. But at least in our part of the country, cooperatives realize that oftentimes they're helping to create a competitor, but because of the overall cooperative philosophy, they're happy to do it. So I wouldn't want to disqualify cooperatives being created in areas where other cooperatives are already existing. If that's helpful to you at all.

MR. CURTIS: I wasn't suggesting disqualifying. I meant it was a matter of priorities, and seems to me a bigger priority is elsewhere. And that was really -- that's interesting.

MS. YONDORF: Okay.

MR. OEMICHEN: Well, we'll disagree on that point.

MS. YONDORF: And if -- yep? Last comment.

UNIDENTIFIED MALE: Sorry, a lack of discipline on my part. (Laughter) The -- I think a

lot of people, like in the restaurant business, say the best way to increase their business is to add another restaurant with exactly the same cuisine on that same street. And I can certainly see to the degree that you brought a second cooperative insurance company into the same market, it may give more credibility to the model. And so it may not be totally altruistic to help create an (inaudible). I mean, there are different points of view.

MS. YONDORF: Well, I'll just take the liberty of making a last comment and then thank the panelists.

Having served on a federally qualified health plan, which is not a cooperative but is 51 percent member-owned, I have to tell you the big advantage of members was nobody arguing about their diabetes. It was saying, "Consumer complaints isn't working the way that you said it would work. The prescription pharmacy isn't working the way you said it was working. I can't get access to a specialist. Your plan was confusing about the benefits." It was invaluable to have people, in my experience, actual members who say "this isn't working." Or, no matter how hard we try, a lot of

people are nervous about complaining to their insurance company, thinking it'll be cancelled or they won't like me or something like that. But when they know that there is a consumer member on the board that they can go to and express their complaints, that's been really powerful.

So I would just say that that's been my experience, including with very inexperienced people, but frequent users of the system. So they see all the places in the system that aren't delivering necessarily what you thought you were delivering and that that is the strength of consumer-owned and operated. So I'm expressing my personal opinion.

MR. BURGESS: I just -- thank you very much for that comment. And the only informal research that we've done among our health care cooperatives is exactly that. While they may not have been able to counteract the high increase in costs in their area where they're serving, the member satisfaction is by far way and above their competition, in most part due to the peer review that people like them are serving on the panels that are looking at the decisions that are

being made.

MS. YONDORF: Go, Bill. Only because you're a Packer, and it's your day.

MR. OEMICHEN: And your cheese is still on the end of your pen, and I appreciate that.

No, this is published data, and it has been peer reviewed at various times. Wisconsin publishes -- the only state in the country that publishes consumer data, consumer complaint data, from all sources. And they actually rank companies on basically how many complaints each company has gotten, what type of complaint, how that complaint was resolved. It's the only state in the country I'm aware of that publishes that data. They also do breakdowns between different types of corporations. So corporations, cooperatives, partnerships, whatever. Two hundred thousand complaints and inquiries would come from consumers while the time I was head of Consumer Protection. And I can tell you that fewer than ten of those complaints a year were against cooperative businesses, which tells you they have a different complaint or dispute mechanism. And what a number of academics have said is

it's because of the membership, the consumer membership on that board of directors. It gives them a different way. So I'm just supporting what Barbara said, that there's actually data out there that's supporting that's been published by government.

MS. YONDORF: Thanks very much for your comments. It's very much appreciated.

So now it's time --

ANNIE: We have one more.

MS. YONDORF: Oh, there's someone else? Thank you. I'm sorry.

ANNIE: Mark Rust.

MR. RUST: Thank you. Mindful that I'm pulling up the rear, I will be very brief.

My name is Mark Rust. I'm Chair of the national health law practice of Barnes and Thornburg, a law firm with 500 employees or so spread across ten states. I made remarks in writing last time. I won't -- so all the rest of my stuff is on record.

I just wanted to raise two points for the consideration of the committee very briefly. And they kind of grow out of my experience as a health care

lawyer. One has to do with an issue that was kind of a recurring theme having to do with profits in a not-for-profit organization and what kind of rules you should suggest related to the language that's in the statute. And the other has to do with this issue of provider involvement in the co-op.

First of all, with respect to the not-for-profit nature of this co-op, it should be remembered, and you were struggling earlier with the phrase that says that profits should be -- should come back and inure to the benefit of members and how exactly do you define profits; to what degree do they inure to the benefit of members? It should be remembered that even though the drafters of this legislation really liked the idea of the cooperative form and liked the spirit of the cooperative, the drafters specifically chose not to adopt the cooperative form for this health insurer. In fact, because it is a tax-exempt entity that is going to get federal funding, necessarily it had to choose the non-profit state form, following all the rules of tax exemption.

And a fundamental rule of tax exemption, one

you can't get around, is that nothing may inure to the benefit of an individual. If it does, then you can't be a public charity. You can't be a tax-exempt.

So the language that you're dealing with in the statute I see as sort of a semantic tautology that you don't even have to deal with. It's saying to you an organization shouldn't be treated as a qualified non-profit health insurance issuer unless any profits, however that's defined, made by the organization are required to be used to lower premiums or improve benefits. That's another way of saying an organization is always going to have -- you heard it several times -- no margin, no mission. It will always hopefully have revenues in excess of expenses. But it's always going to be really hard to define exactly where that line is of the amount of excess and where it should go. And that should be left up to the business, because particularly in insurance, you are going to want to set -- you're going to have a year where -- of good results, another year of good results, and then a third year of catastrophic results. And the business has to decide that. But what the legislation is saying is

that to the degree that you can define profits or there is any excess, when you use it to lower benefits or improve quality, that inurement to the benefit of individuals is not a violation of the statute.

So from a lawyer's point of view, normally what you do is after -- in the article of -- in the bylaws, you say, Our mission is to go out and serve the particular region, to have low-cost health care, et cetera. And then you'll repeat the language of a statute like this. And to the degree that there are profits or margin, they will be used to lower -- to lower premiums or improve the quality of health care. And then you just leave it to the business after that to decide in what fashion that should be done. So I don't think that you really need to make any suggestions as far as regulatory language on that.

The second issue that I'd like to address is the issue of the tension that's obviously arisen between providers who are involved in the formation of a co-op and -- on the one hand, and on the other hand, various groups that we refer to as either consumers or other sorts of members or employers, et cetera. My

recommendation would be to do no harm, and where less is more, realize that as many of your speakers have said, there are so many obstacles to getting a co-op off the ground. You have to ask yourself, who are the people who really have the motivation to take all the gambles that are necessary to get one of things off the ground organizationally? There's a blistering timeline involved, and there's issues of who's going to put up the money and the chicken and egg question -- before money starts actually coming through, who's going to put the money to actually write the business plan and think through the feasibility? In some locations, it may be that an indigenous group of consumers or activists, et cetera, want to be able to do that. But in the main, you're going to be looking for someone who has a motivation, sort of an intrinsic motivation, to get something like that off the ground. And by and large throughout most of the country, you'll find that that group is providers. Because providers, in addition to being people who understand how care is delivered, also pay for care. They're also consumers, in that they go out and buy insurance on behalf of

themselves and their employees. That could be large physician organizations; it could be hospitals, et cetera. And for many years, they have been trying to figure out how to deliver a better product that isn't just a fee for service product. It's been very difficult for them to deal with the world of insurers, because insurers have by and large listened to their ideas and sort of rejected them, not contracted with them on that basis, no matter how much theory there is out there about clinical integration and we can do things differently. Insurers basically have not engaged with providers on that basis unless it was just to put the whole risk, all of capitation, on their shoulders based upon information that insurers had and providers didn't. Oftentimes providers dealt with that very badly, because they made a bad deal.

They still, however, are in the game of trying to figure out how to deliver that product better. And very frequently, they are able to come up with a way to deliver it better. And provider-sponsored HMOs are good examples of that.

So I don't think that what you want to do is

stifle creativity and stifle the natural motivation of who may be the people who are coming forward to initially organize an effort like this. I don't think that any provider organization thinks that over the long term they are going to dominate any board. Just about any rules that are written are going to ensure that the right board is going to end up governing this organization. But in the beginning, you don't want to artificially cut off any of their motivation to get such an organization going with artificial rules that somehow treat providers as separate and apart. I think we've said several times that if a co-op is going to be successful -- we've heard it from a number of -- from testimony in both meetings -- (a) their biggest hurdle is going to be to get a provider network together; and (b) that provider network is really not going to work for that benefit plan if all that it's doing is accepting its typical discounted fee for service. It's got to be something more innovative. And that innovation is going to have to come with the providers being full sponsors.

So it may be that you want to use the term

“provider-sponsored” when you’re talking about this tension, and not talk about the -- obviously nobody can own a not-for-profit or dominate the board, but just to get a conceptual idea of where a co-op springs up in tandem with a provider organization, how might that sort of an idea be treated, and essentially really reinforce that sort of a scenario, as opposed to work as an antagonist to it.

Thank you.

MS. YONDORF: Thank you. Those are excellent points. And questions?

Yeah. Bill, I think, and then Mike.

MR. OEMICHEN: Just going to ask, do you think any of the recommendations we’ve made to date, because you’ve been here both days, are inconsistent with anything you’ve just said?

MR. RUST: Well, I think that the idea of saying -- well, we’ve gone back and forth about the 51 percent members. And what I think that I heard where that ended up is that a member is anyone who is -- who has insurance coverage, and that does not exclude, therefore, providers. So I would say that that’s

correct. If, however, you set out -- the way the conversation's sort of going later in the afternoon, if you said, Boy, we really have to focus on providers and somehow make sure that they're not a part of the board or that they're a smaller part of the board, I think that would be inconsistent.

DR. PRAMENKO: And Mark, thank once again for coming by and providing testimony. And I fully agree with you, and at the risk of sounding self-serving, since I'm one of the providers -- physicians on the board.

Do you have any specific recommendations as far as what, you know, this first tier start-up board and then the follow-up secondary board? If I'm hearing you correctly, you want us to be very lenient with the -- with the start-up board in that regard. It sounds like we're on the right track there. Is that -- am I understanding you correctly?

MR. RUST: I think that's right. I think the work that you've done so far in thinking through the phasing makes a lot of sense. I have a couple of organizations -- well, two different states. One in

the north, one in the south, at different stages of organization. And the start-up phases that you're talking about make a lot of sense. And there's two aspects to that. Where are they going to get the money, and your phasing in of the grants makes sense; and second, who is that? Usually they start off with a steering committee that turns into their initial organizing board. And to the degree that initial organizing board has no constraints on it, that's good. So that's good.

I would normally -- bylaws would say, you know, if it's a board of 12 members, the term is going to be so many years. And then let's say if it's four members over the course of four years, three phase off and are elected by another three over the course of time. And so I would see a natural transition to a permanent board over a period of time. But it would be a significant period of time. The people who went through all of the difficulties and chaos of the first few years and learned a lot from it, you wouldn't want to push them off the board too quickly. And to the degree that those were people who were verboten people

-- you know, providers or something like that in your view -- then I think you wouldn't want to be pushing them off the board too quickly or phasing out an election too quickly. But you'd want to do that over time, replacing them little by little.

MS. YONDORF: Thank you very much. That was really helpful.

MR. RUST: Thank you.

MS. YONDORF: All right. Do we have any other public members? Comments? Okay, cool.

Well, I think we've discussed a lot. Are there, based on the public comments you heard or notes, additional notes you've taken, are there other points anybody else would like to make?

UNIDENTIFIED MALE: More of a question, and I guess maybe to staff. I'm concerned that there are places in the country, and we're hearing from folks that have kind of been following this very closely -- I'm concerned that maybe there's areas that don't know about the co-op portion of the bill. And I'm wondering if HHS has any plans to get the word out sooner than when our timeline comes out to get people thinking

about this in areas of the country that are not thinking about this.

UNIDENTIFIED FEMALE: The short answer is yes. And we have been using various avenues of outreach that are at our disposal, including I think as most of the people here will say, having very much an open door policy to anybody who has heard about it and wants to talk about it. But there have been efforts to reach out to consumer organizations and others to get the word out, and those efforts are ongoing.

MS. YONDORF: Thank you.

David Carlyle?

DR. CARLYLE: I guess that since this is our second to last meeting together, and since we'll be going into a meeting, I would just -- I know Allen's gone, but you know, there's this sense, well, what do we do after this final meeting? And personally, as the Advisory Board having put this much work into our product, I mean, I would have the Chairs think about a meeting nine months, 12 months, whatever in the future to kind of reassess kind of what we've done and then what the progress is after the first awards went out.

I mean, I just think that as an advisory board, we could take some of that experience and kind of see whether what we've recommended and what the Secretary chose to do, how it played out in real life. So I would have the Chairs think about that.

MS. YONDORF: Thanks. Yes?

UNIDENTIFIED MALE: Just a comment on the proposed schedule. So as I understand it, we are going to have subcommittee work and then staff is going to draft, and then when we meet on March 14th, we're going to finalize? Or is that another working draft and then we're going to meet after March 14th to finalize?

MS. YONDORF: We don't have in the schedule meeting again, but we do have a period of time -- I think it's two weeks -- before -- after we meet to sort of take a count of the things that we talked about, voted on, said we wanted to come up with -- a final draft. And I don't know whether we end up doing that by phone or email to get people's signoff on it. But we are not going to meet again at this point after March 14th.

UNIDENTIFIED MALE: Okay. My suggestion would

be that I think in both meetings, even though things are moving very fast -- for a typical federal government process, this is like a hurricane, I suppose -- that we've had a lot of good comment and panels at both meetings. And the materials we're going to consider on March 14th, I think we should make those public before March 14th so people who have been following this, people who have expertise, could comment to us before -- before we meet on March 14th, not after the 14th. Because it sounds like we're going to be kind of final. So if we really want to take benefit of everybody's input, we could have them published publicly. I mean this is, you know, it's a draft, but so people would know what our draft is, and then any input people have they can give to us.

MS. YONDORF: Barbara, what's the -- because these are going to be working -- working documents. So ... It's a chicken and egg problem.

BARBARA: Yeah. I'll need to consult with FACA(ph) counsel to see to what extent the working documents for circulation prior to finalization are available for public display. And then I'll get back

to you. There is also, in terms of the use of your time, to the extent that you -- that we are able to display that publicly sooner, you would need to consider that you would need to have your work finished that much sooner so that staff could memorialize your work that much sooner, so that it could then be made available. So I just would like to point out that it puts a little more pressure on the next two weeks than perhaps you had anticipated.

MS. YONDORF: So we'll take into advisement and see what the legal issues are. Thanks.

And is that Mike and Bill?

DR. PRAMENKO: There's some comment letters out to actually some very large organizations and people that have put a lot of time in this outside of this Advisory Board. What's the interplay between those comment letters coming back in and the information and how available that will be to this full Advisory Board?

BARBARA: Okay. By the -- do you mean the requests for comments --

DR. PRAMENKO: Right.

BARBARA: -- that was issued by the Department?

DR. PRAMENKO: Yeah.

BARBARA: Okay. So the requests for comments was issued with a 30-day period of response. So my understanding is that that means that comments would come in on March 4th. And those comments are a matter of public record, and we would get them to the committee as soon as possible.

MS. YONDORF: Okay. Anything else?

All right. Thank you, Barbara.

Well, this has been a terrific meeting. I'd like to really thank everybody. I think there's a number of themes we've heard. I think this Advisory Board has done a great job and we've had superb expert testimony and just very thoughtful public comment. I really want to thank all of you who stayed here for the full day.

I think -- you know, some of the things I would just like us to emphasize and consider and themes that I heard throughout the day was, the number one thing about this is member owners are supposed to be in

charge of the process. And that's the most distinctive thing in the legislation that we want to take account of, that we are trying to get a level playing field. I think some of the comments we heard were don't set the bar too high, sort of higher than may be necessary. Someone said, oh, my God, the fast timelines, et cetera, so we'll try to be responsible to that. Another one was flexibility for HHS. We might need to give them some wriggle room where we can, while giving them direction. And particularly one of the things I heard today was the importance -- that we need to recognize that there's going to be a huge variety of models coming in. And so we need to keep that front and center as we're looking again at our recommendations. We talked about all sorts of different sorts of applicants, maybe ones we hadn't thought about before this meeting. And certainly all kinds of different provider arrangements. And so that we're just going to need to be really cognizant of that.

So with that, thank you very much. Thanks especially to the staff, to Annie, to Barbara, to

Cathy, to the other people from the staff who've done such a superb job for us. And to the Steelers and the Green Bay Packers for a really good, good game.

Thanks.

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We, Linda O'Brien and Patricia Destajo, do hereby certify that this transcript was prepared from audio to the best of our abilities

We are neither counsel for, nor party to this action nor are we interested in the outcome of this action.

Linda O'Brien

Patricia Destajo