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March 14, 2011

Mr. Alan Feezor, Chair

Federal Advisory Board on CO-OPs

March 14, 2011 Meeting

Dear Mr. Chairman:

This testimony is provided to the Federal Advisory Board on the CO-OP Program in response to the Draft Report on the CO-OP Program, March 14, 2011**.** It is provided by ESOP Advisors, Inc. from the point of view of senior management and financial consultants with decades of experience in enterprise startup, cooperatives and health insurance cooperatives, and non-profit organizations. Our recommendations represent a reasonable point of view of the Board of Directors and management of a startup nonprofit issuer desiring to obtain federal funding, based on the experience that ESOP Advisors has gained by providing pro-bono technical support to several organizations exploring the development of a nonprofit member CO-OP issuer in their state, as well as a regional CO-OP intending to serve the Washington DC metropolitan area including Virginia, West Virginia, the District of Columbia and Maryland.

In addition, this testimony provides a corrected response to the Request for Comments on the CO-OP program issued by HHS in February 2011 which provides additional background on certain aspects of the testimony on the Draft Report, especially those aspects and recommendation in the Draft Report that concern the Finance area.

Testimony on the Draft Report

The Federal Advisory board has provided the Secretary of HHS with an excellent set of recommendations for the development of regulations governing the CO-OP program. It may also be possible for these excellent recommendations to be improved further in certain specific areas with a few modest revisions. This testimony provides recommendations for improvements in some of these areas. Recognizing that the Federal Advisory Board requires specific language in its recommendations, the recommendations in this testimony are discussed specifically and where possible , specific recommended language for revisions is also provided.

In the opinion of ESOP Advisors, the first opportunity for improvement in the recommendations is when the Board in its Summary of Recommendations on page 10 of the Draft Report , Recommendation 13 addresses the requirements for conversion. ESOP Advisors supports the recommendations on conversion for successful CO-OPs, but notes that there may be circumstances such as CO-OP failure, where such recommendations may not be able to be applied. These circumstances will occur when a historically viable CO-OP is no longer able to meet its insurance obligations to its members and its other financial obligations. In such circumstances, the CO-OP, its state insurance regulator, its members and its obligatees may be required to take actions either led by or approved by the state insurance regulator in order to meet its insurance obligations which may violate Recommendation 13.

The next opportunity for improvement occurs in the discussion of the Finance Committee recommendations concerning loans and grants. Given that that Advisory Board rightfully recommends that CO-OPs provide the Secretary with very substantial amounts of information that a CO-OP would consider proprietary, the full or partial release of which could greatly impair the CO-OPs ability to succeed in the marketplace, and open it to political, legal, financial and market challenges which may impair its ability to meet the terms of the loans and grants provided by the Secretary, the Advisory Board should recommend that HHS develop loan and grant application procedures which do not require the CO-OP to fully or partially publicly disclose such proprietary information. The Board should recommend that such applications should be treated as proprietary confidential information by HHS, and HHS should develop policies and procedures to safeguard CO-OP proprietary information.

The Board addresses specific requirements for applications on page 12 of the Draft Report. As contemplated in Recommendation 3 on that page, as desirable as it may be for CO-OPs to be able to provide the Secretary in conjunction with a planning loan application early fall 2011 details concerning its business strategy, its products, its proposed provider network, the insurance regulatory requirements associated with this strategy , the limits on the usefulness of this information to the Secretary as a practical matter have to realized. Most prospective CO-OPs in organization may have difficulty in meeting this requirement.

Certain prospective CO-OPs, very few in number, that have received substantial feasibility funding from non-federal parties may be in a position to provide initial representations on these matters. Even in these cases, the Secretary must recognize that representations made at the time of the planning loan application will be very preliminary, and certain operating requirements of the CO-OP will likely not have been specified including the specific requirements for covered benefits in a qualified health plan, and exchange requirements and these requirements will directly affect a CO-OP's representations . Such representations may through no fault of the prospective CO-OP not hold true as the CO-OP proceeds through the

detailed business planning process and different representations may be found in the completed business plan. Most CO-OPs, those that have not received any substantial feasibility funding, will likely find that they may not be able to provide more than general answers, and will in general not be on a position to provide this level of detail, prior to having undertaken a detailed business planning process, which is to be funded from the proceeds of the planning loan. ESOP Advisors, Inc recommends that the words "and a general discussion of the " be inserted in line three of Recommendation 3 on page 12 before the words "organizations mission", and that this general discussion requirement apply to all issues prior to the semicolon preceding " and a budget for the use of the loan,".

With respect to Recommendation 4, the primary field of expertise that any expert supporting HHS in evaluating applications should have is that of startup organizations, and providing support services to such organizations. The next most import criteria should be the experts capability in starting health plans specifically, and specific expertise in financing and funding startup organizations, and then the professional designations and other factors recommended by the Advisory Board..

With respect to the Infrastructure Recommendations, we recommend that the Advisory Board recognize that member non-profit health issuers will operate substantially differently than their competitors, and may not undertake comparable paid marketing efforts. As nonprofit member organizations, they will be required to undertake membership development and membership education efforts generally not required by their competitors. In recognition of these differences in operation that are required by the statute, ESOP Advisors recommends that the Advisory Board in ser the words "membership development and member education" directly after "community outreach and education" in the first sentence of its recommendation 1 on page 14 of the Draft Report, as well as strike the word "marketing" in Sentence 2 and insert "membership development".

Finally, with respect to the Criteria, Process and Compliance Recommendations, and especially the definition of private support, ESOP Advisors generally supports the recommended definition. We would recommend CO-OP applicants be credited with private support that has been demonstrated prior to the application as well as the period for which funding is contemplated in the application. Most consumer oriented CO-OPs currently in development of which ESOP Advisors is aware (not including those currently sponsored or contemplated by heath care provider organizations or organizations with insurance operations) exist today completely through the volunteer efforts of their organizers and pro-bono professional support, including funding of out of pocket costs such as travel and communications. The Advisory Board should recommend that the Secretary' s priority give credit to private support demonstrated by CO-OPs in undertaking preliminary efforts for organization, development, and

feasibility that occur prior to their applications for planning loans, by inserting the words "previously utilized and future" after the colon and prior to the words "committed support" in sentence 2 of Recommendation 1 on page 17.

Though the Board recommends that HHS approach national foundations concerning the funding of technical assistance, and ESOP Advisors supports such recommendations, in general such assistance or funding as contemplated in Recommendation 1 on Page 17 of the Draft Report has not been yet committed, may not be forthcoming in the future, and will almost certainly not be provided in amounts that will allow most CO-OPs to demonstrate such funding in their applications.

Therefore, with respect to stage 1 planning loans the Secretary should not require any commitment of non-federal private funding in order to achieve a high priority rank in the Secretary's funding of such planning loans from among various applicants within a state of for overall priority. An applicant for Development Loans should be able and be required to demonstrate a higher level of private support in order to qualify for priority in funding by the Secretary, but should not be required to demonstrate any committed non-federal financing or funding in order to receive startup funding for operations, and at this stage the level of private sector support required to be represented would include contracts with potential providers and service providers, as well as executive and operational staff. In the opinion of ESOP Advisors third party private sector funding will not be forthcoming for almost all CO-OPs until federal funding has been received, and any commitments for such funding such as working capital financing, venture leasing, facility leases as well as most program related investments will be contingent upon the receipt of appropriate staged federal funding.

Further background for ESOP Advisors recommendations can be found in the corrected Response to HHS request for Comments on the CO-OP Program directly below.

Corrected Response to the Request for Comments on the CO-OP program issued by HHS

Our response begins with Section K, which establishes a context for the comment and answers provided in the other Sections.

K. What other considerations should be addressed relating to the CO–OP program?

CO-OP Start-Up Risk

The process of CO-OP seed development and start-up is fraught with all of the risks generally associated with new enterprise development in the private sector. These include financial and market risk, inability to recruit and retain qualified staff and executive leadership as well as members of the Board of directors, and in this case the strategic risks inherent in entering mature markets with dominant players with access to financial and political resources and regulatory influence who can be expected to take concrete actions in the face of a competition.

In addition, CO-OPs will be subject to further risks caused by detailed federal regulation [in process]concerning their non-profit and insurance operations and must obtain a new federal tax exemption subject to future IRS rule making, as well as meet financial demands placed on them by federal requirements of PPACA including : 1) transitional reinsurance requirements in Sec. 1341, 2) Risk Corridors in Sec. 1342, and 3) Risk Adjustments in Sec. 1343 . Non-profit CO-OPs will face greater challenges in obtaining non-federal financing than for-profit private sector competitors. CO-OPs in formation are scrambling to fund even basic needs, and CO-OP organizers are covering out of pocket expenses such as travel by personal contributions. CO-OPs would not be potentially financially feasible without the rapid access to federal loans and grants afforded by PPACA, which will provide start-up capital and insurance regulatory capital in the form of loans.

CO-OPs will have several additional risk factors that will have to be addressed in their initial development and subsequent business planning. CO-OPs are entering a mature oligopolistic industry, and will face entrenched and dominant for-profit and non-profit competitors that in general have successfully beaten back market challenges [with several notable exceptions across the US] by health insurance pools, ERISA plans, and HMO's and restricted successful competitors to regional markets within a state. Research previously conducted by a member of the HHS CO-OP Advisory Board demonstrates convincingly that past attempts at formation of health insurance purchasing cooperatives and pools have had no effect on competition in insurance markets and have had poor business results, leading many to cease operations. CO-OP's ability to implement integrated health care models is constrained by the limited geographic coverage of current credible integrated provider organizations, so that CO-OPs will be faced with the challenge of supporting the development of integrated provider networks while also undertaking the startup of insurance operations.

CO-OPs will have to be successful operating primarily in a completely new insurance market place of the exchanges. These exchanges have yet to be operationally defined or developed,

(except for enabling legislation which has been introduced in several states and is yet to be enacted) and will spring in to operation coincident with the initiation of CO-OP health insurance operations so that a CO-OP will have to "hit the ground running". Some of this enabling legislation, if enacted as currently proposed, could greatly impact a CO-OPs ability to reach prospective member customers in a cost effective manner by mandating the involvement of insurance brokers and market intermediaries at a substantial cost and creating barriers to approval for new CO-OP insurers to utilize the exchange. CO-OPs must provide guaranteed issue coverage of a mandated health care benefit package which has yet to be defined by HHS except in outline form. Substantially all of their activities must consist of serving the individual and small business market segments, which are the most volatile in terms of customer turnover and insurance risk. Some data suggest that recent market entry health insurers operating in the large employer market as well as the individual and small business markets [in today's marketplace defined by medical underwriting to reduce insurance risk] are still showing medical loss ratios over the last two years that exceed 100%.

Congress recognized this risk environment in crafting the PPACA, and created the $6 billion in federal financing for the startup and solvency capital needs of CO-OPs to foster the development of CO-OPs in this risk environment, and HHS is tasked to develop rules and regulations for the funding of CO-OPs and certain aspects of CO-OP operations [that are not the province of state law and regulation] that will also foster the creation and successful operation of CO-OPs that are legitimate non-profit consumer driven organizations.

Therefore, HHS must develop and implement rules and regulations that are not neutral, but which lean forward to "foster" the development and successful operation of CO-OPs, and foster is generally defined as "promote, further, advance, cultivate, or encourage" CO-OPs.

The CO-OP funding and financing is there to foster the development, startup and operation of CO-OPs because Congress recognized that CO-OPs would not be feasible and able to develop absent federal funding. This federal funding should be regarded as risk funding, that is financing or funding provided with the recognition that it is at risk, and that such financing should not be expected to be fully recovered from all non-profit startup organizations to which funding is distributed under PPACA in the form of principal and interest payments on startup 5 year debt and 15 year repayable grants. HHS must recognize that CO-OPs are non-profit organizations will have very few alternatives to source private sector financing, and that the third party financing that will be available to them directly will be in the form of additional debt, whether in the form of working capital financing or patient capital program related investments, and that this debt will not be forthcoming until third party financiers are assured that federal risk financing is in place.

CO-OP Feasibility

Contrary to conventional thinking, the proper approach to the issue of CO-OP feasibility is not one of assessing a potential CO-OPs business approach and strategy against a known successful strategy and approach to health insurance company start-up, development and operation in the risk environment faced by CO-OPs. Such a known successful approach does not exist. The proper approach to CO-OP feasibility in this risk environment is to understand that the challenge for potential CO-OP social entrepreneurs and start-up leaders is to innovate and develop a "home grown" state or regional business strategy and approach to development that provides a path to feasibility in 2011 in this high risk environment. This path to feasibility can be further developed, documented in a business plan and demonstrated in 2012 and 2013 supported by federal startup loans consonant with the further definition of the exchanges which will be its primary market and the mandated health benefits that will primarily define its insurance operation.

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

1. What is your assessment of the types of groups or organizations that would meet the criteria outlined above, and be successful in establishing durable qualified plans in the individual and small group markets? Do any organizations currently exist that would satisfy these statutory eligibility criteria for receiving a loan or grant under the CO-OP program? To what extent, and in what way, do funding needs of qualified nonprofit issuers that have already been established differ from the needs of those that have not been? How might funding needs differ for other groups or organizations that do not currently exist, but would be successful in establishing durable qualified plans in the individual and small group markets? How would such differences be considered in determining appropriate financing terms for Federal loans or grants?

No response

2. What skills, background, and expertise should be required of the loan or grant applicant? What skills, background and expertise should be required of the management team of the qualified nonprofit issuer once the entity is operational (e.g. experience in providing coverage?) What factors are most likely to lead to the successful operation and sustainability of a CO-OP?

No Response

3. What relationship with CO-OP enrollees would promote initial and continued enrollment, e.g. service to a geographic community, a strong provider network, its health care mission, etc.?

No response

4. What issues might a qualified nonprofit issuer face in developing provider networks in rural or other medical shortage areas?

No response.

5. How much time would a new qualified non-profit issuer need to establish a plan, become operational, begin to accept enrollment and provide health insurance coverage? What factors may affect the timeline necessary to become operational, and how?

No response

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

HHS should not require any CO-OP to undertake any specific course of action in developing a feasible business, governance and operational approach for CO-OP startup operations, but instead should encourage and foster the development of a diversity of approaches and strategies designed to respond to the particular conditions and issues that concern CO-OP development and operation in a state or region. In making application for a Stage 1 startup loan[as contemplated by the HHS CO-OP Advisory Board] to fund detailed business planning efforts, an applicant needs to present evidence that they are making progress toward becoming incorporated as a non-profit member organization in a state, that they have formed a steering committee or other organizing body to guide their efforts, and can present a cogent written document that describes the approach that they will employ to develop a feasible business strategy and detailed business plan including reasonable cost estimates for all components as outlined in our response to Question 12. Such applications should be treated as proprietary confidential information by HHS, and HHS should develop policies and procedures to safeguard CO-OP proprietary information as described in our response to Question 11 below.

CO-OPs that have received Stage 1 loan funds should be expected to present the results of their business planning efforts and other efforts to qualify for state regulatory approval as a health insurer as a condition of receiving Stage 2 startup loans to plan for and commence operations. CO-OP Stage 2 applications containing such business plans and information as well as discussion

of other efforts including regulatory activities should be treated as proprietary confidential information by HHS, and HHS should develop policies and procedures to safeguard CO-OP proprietary information as described in our response to Question 11 below. CO-OP grant applications should contain information sufficient for HHS to be able to verify that the CO-OP applicant is applying for grant funding sufficient to meet the specific operational, capital, surplus, solvency and other financial requirements that will be required by the state(s) in which it desires to operate, as well as federal 1) transitional reinsurance requirements in Sec. 1341, 2) Risk Corridors in Sec. 1342, and 3) Risk Adjustments in Sec. 1343 .

Non-profit member organizations operating as CO-OPs should be expected to devote substantial resources to membership development and member communication including communication with prospective members, and to providing information required by insurance exchanges, as opposed to marketing efforts. CO-OPs should not be asked to divulge their business or membership strategy in any public manner, as discussed below in our response to Question 11 in this Section.

7. What level of investment would be required by a qualified nonprofit issuer to develop sufficient administrative and claims processing information technology (IT) systems? Is there a minimal level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, geographic location, or other factors, and by how much? Are funding needs for this purpose different for any qualified nonprofit issuers that may already be in existence, and if so, in what way?

It is not possible at this time to provide HHS with an estimate of costs or required investment by a CO-OP in information technology (IT) required to support administrative and claims processing systems, or the IT required to support membership relations and governance. A CO-OP will be faced with a strategic "make or buy" decision regarding the form and structure of its required information technology support, and such decisions are not mutually exclusive and may vary across CO-OP business functions. A CO-OP choosing a "buy" strategy for initial operations that requires a smaller upfront startup investment overseen by a small cadre of experienced staff professionals and consultants may transition to a "make" approach over time as transaction volumes grow and revenues allow for greater development investments.

8. What level of investment would be required by a qualified nonprofit issuer to develop sufficient health information technology systems necessary to operate a health plan in the health insurance Exchange market, including the use of electronic health records? Is there a minimum level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, enrollee characteristics, or other factors, and by

how much? Are funding needs for this purpose different for any qualified nonprofit issuers that may already be in existence?

It is not possible at this time to provide HHS with a useful estimate of costs or required investment by a CO-OP in information technology (IT) required to support its operations in the contemplated health insurance exchange market or to utilize electronic health records (EHR). The form and structure of future health exchanges has not been sufficiently defined to allow for projection of the requirements that exchanges will develop in the information technology area, or for the potential for CO-OP utilization of EHR that is being developed and implemented in health care provider and clinical settings. As discussed above in Question 7, CO-OPs will have to make a strategic "make or buy" decision regarding the form and structure of its required information technology support in these areas, and this decision will greatly affect the amount, form and timing of the investment and costs that the CO-OP must make to support exchange operations and EHR

9. What is the range of funding necessary to capitalize and fund the establishment of a new qualified nonprofit issuer? How much of that amount can be raised privately, or funded through non-Federal government support? What factors should be considered in determining the appropriate amount of Federal loans and/or grants that would be needed to support the establishment of a new nonprofit health insurance issuer? To what extent do the fund needed to capitalize a qualified nonprofit issuer, and the degree of Federal support necessary likely to vary across issuers?

The range of startup funding to capitalize and establish a new qualified non-profit health insurance issuer (a CO-OP) is approximately $20 -100 million over the development, startup period and first five years of operation, not including the 15 year repayable grant funding required for solvency and to meet other insurance capital requirements. . Very little of this money can be raised from the private sector, given the non-profit structure of the health insurance issuer. Very few opportunities are available for funding from the private non-profit sector in general. Establishment of a non-profit health insurer in general would not be seen as a charitable purpose, and non-profit CO-OPs in general will not be charitable organizations. Most foundations and other grant giving organizations limit their funding to charitable organizations.

In order to clarify funding requirements, it is helpful to distinguish funding needs over the expected timeline for CO-OPs which includes 1) initial development efforts including initial organizing and feasibility development, including planning, strategic development and organization required to achieve federal funding for business planning efforts, 2) Business Planning efforts, 3) initial startup operations on the basis of the business plan and other efforts required to achieve state licensures as an insurance company resulting in the application of the non-profit state member organization to HHS for solvency grants and including achieving

federal 501 (c) 29 tax exempt status , 4) intermediate stage startup operations as a non-profit member CO-OP once solvency funds have been obtained and the insurance license process is completed, 5) Startup insurance operations that would commence in late 2013, including capital required to fund operations prior to the receipt of premiums as well as capital required to provide for funding any operational shortfalls in the first five years of operations, as these may occur for a host of reasons even if premiums are set at correct actuarial levels designed to recover all costs and provide an operating surplus.

One CO-OP in development in Maryland has obtained grant funding to support the development of a feasible approach to CO-OP establishment in a manner that can serve currently underserved populations, i.e. this funding is based on developing the potential of the CO-OP to serve current medically underserved populations in that state and increase access to medical services for those populations qualifying for and requiring access to insurance subsidies. One current member organization has received a grant to explore expanded insurance operations as a CO-OP or CO-OPs. Such feasibility funding will not in general be available for development of feasible approaches to serve the general population. To the knowledge of this respondent, no other CO-OPs in formation or development have to date received any funding from third parties, and all utilize volunteer efforts and personal funding of out of pocket expenses. Federal funding is crucial in all stages of development, startup and operation; and CO-OPs are not feasible absent federal funding.

The American College of Actuaries has prepared a report containing estimates of the startup and capital and reserve funding on a nationwide basis required for CO-OPs. They estimate that $750 million in funding will be required for startup costs nationwide, and between $1.6 - 15.6 billion will be required for capital and reserve funding to meet state solvency requirements depending on the success of CO-OP insurers in the marketplace. Therefore, on average, each state would require approximately $15 million in startup funding in the period from 2011-2012 prior to the commencement of insurance operations and participation in the exchanges. CO-OPs in States with large populations, and large geographical coverage will require initial business planning funding startup funding well in excess of the average amount , perhaps up to $50 million.

CO-OPs should not be expected to provide matching funds in consideration of the receipt of a federal loan or grant. As a practical matter, it will be very difficult for a new non-profit CO-OP to fund raise or finance from private sector sources that are not parties interested in and standing to benefit from the operations of the CO-OP prior to the time that it begins to produce revenues or accounts receivable. A requirement for matching funds in the context of federal funding would likely result in the CO-OPs having to enter into business arrangements with potential providers, consultants and vendors that could limit the CO-OPs ability to develop and

implement a successful consumer driven and controlled business strategy. It is possible that in the future certain foundations may desire to make program related investments in CO-OPs that could be used to supplement federal grants for capital and solvency purposes that would be required to meet near future needs based on the projected success of the CO-OP in the marketplace, as well as to fund expenses that may be defined as marketing expenses for the purposes of PPACA. It is likely that such foundations would require the CO-OP to have received full federal funding before their investment were to be made in order to reduce their risk profile on the investment. The Ford Foundation, generally regarded as the largest participant in program related investments, does not participate in the health care arena.

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

Investment in the startup stage for appropriate fiduciary management for CO-OPs can be defined as appropriate financial management and control, auditing and review, and validation and review [including actuarial development and review] of financial processes, assumptions, and operating requirements such as premium setting will require funding of staff, engagement of consultants such as actuaries, accountants, corporate financial advisors, legal counsel with experience in insurance regulation, and would be in the range of $2-5 million for an average CO-OP over a two year startup period.

11. Are you aware of any State laws that could create opportunities for or barriers to the formation of qualified nonprofit issuers? Do you think States are likely to create or amend licensure laws to accommodate the formation of qualified nonprofit issuers? Under what circumstances could regional qualified nonprofit issuers serving multiple states be formed? Is there a role for a federation of qualified nonprofit issuers to serve more than one state or region, with risk shared among issuers? Would this approach be desirable for specific types of communities? How would such a federation be organized? How would it be capitalized? What are the advantages and disadvantages of a regional qualified nonprofit issuer or a regional federation of issuers? What barriers would need to be overcome? What would be the advantages of, and barriers to, serving a metropolitan area that crosses State lines

Insurance regulation is in almost all circumstances a state matter. There are many circumstances under which a "regional" CO-OP insurer serving multiple states could be formed. For example, a CO-OP or CO-OPs could find it advantageous to serve a multi-state metropolitan area in order to be able to provide insurance services to individuals who may reside in several states through the Federal Employee Health Benefit plan, or to provide insurance services to existing or future markets organized by current or future insurance intermediaries as discussed

below in response to Question 12, as well as to respond to business opportunities that may arise from Sections 1333 (b) or 1334 of PPACA. Additionally, a CO-OP and its associated member non-profit organization may organize itself to provide insurance coverage in multiple states in order to assist the Secretary in encouraging a CO-OP in a state that does not have a qualified non-profit issuer as is contemplated in Section C; Question 2.

CO-OPs must be free to develop and operate in the most effective manner, including multi-state insurance operation or provision of insurance services. HHS should not in its rule making contemplate, develop or impose any rules or regulations in addition to those insurance rules and regulations promulgated by the states which govern the potential formation and operation of insurers and other organizations that provide insurance services in multiple states. HHS should not develop or impose any rule or regulation that would define, constrain or limit the ability of CO-OPs to form and operate a "federation" or any other form of organization or operation that will advance the successful operation of CO-OPs, based on the CO-OPs own judgment and analysis of the barriers and advantages of various business strategies. CO-OPs in development, startup and operation should not be required to present to HHS any discussion, justification, or analysis of business or operating strategy by the CO-OP, or CO-OPs participating jointly that is not required for HHS to reach a positive conclusion for startup and solvency funding, or that the CO-OP is operating within the requirements of the PPACA with respect to those areas such as consumer control and operation, non-profit operation and other requirements such as providing qualified health plans.

HHS should promulgate rules and processes for qualifying for and receiving federal funding and satisfying the other requirements of PPACA that do not require a CO-OP to publicly disclose or in any limited form outside of HHS [and other federal parties to CO-OP regulation such as the IRS] disclose its development and operating strategy, and the costs, risks and potential results of such development and operating strategies, as such disclosure would negatively impact the CO-OPs ability to compete and succeed in the insurance marketplace. HHS should develop adequate internal processes and controls to ensure that such information that must be disclosed to HHS and other federal parties remains confidential.

12. While "substantially all" of a qualified nonprofit issuer's activities must be in the individual and small group markets, what other markets or product lines, if any, would be desirable for qualified nonprofit issuers to participate? For instance, could they participate in Medicaid or the Children's Health Insurance Program (CHIP) and still satisfy the statutory criteria for being a qualified nonprofit issuer? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the small group market? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the individual market? To

what extent would participation in other markets affect the viability of new qualified nonprofit issuers or their ability to satisfy the statutory criteria for being a qualified nonprofit issuer? What type of startup costs are necessary and reasonable for establishing a qualifying CO-OP? What startup costs might be associated with establishing a private purchasing council?

CO-OPs should be free to develop and implement a business strategy in other markets and product lines in which its Board and members find to be advantageous, without restriction as long as the CO-OP meets the "substantially all… activities" test.

Insurance experts and executives recognize that the individual and small business (2-50 insured's) health insurance markets are the riskiest and most variable and volatile market segments, in turns of customer churn, claims experience or medical loss ratios, and fraud and misrepresentation. The entrance of millions of currently uninsured individuals and small business employees into this potential market via exchanges is not expected to alleviate these risks. A CO-OP may want to consider the potential strategic business importance of building a relatively stable block of business in other market segments, such as:

1. the currently insured small business group market served by brokers and other intermediaries such as:
    - Small Business Organizations currently offering coverage to their members
    - Health Insurance Purchasing pools [both cooperatively organized and other pools]
    - Employer pools formed under federal ERISA regulations
    - Association group plans where small businesses can obtain health insurance coverage as a member benefit
2. the large group market
3. the Individual market served by Association group plans where individuals can obtain health insurance coverage as a member benefit

These blocks of business could be important as a counterweight to the initial variability in insurance risk and financial results that may be expected from early customer acquisition efforts and claims experience on the exchanges.

HHS should expect CO-OPs to present applications for startup loans for business planning purposes that include funding for:

- Organizational Expenses for the State member Non-profit organization

- Non-Profit Board of Directors Operations
- Lean Non-Profit Staff Operations
    - CEO
    - CFO
    - COO of Non-Profit Operations
    - Chief Membership & Governance Officer
    - COO of Insurance Operations
    - Chief Care Officer
    - Chief Medical Officer
    - CTO
    - Chief Compliance Officer
    - Executive Support
- Legal Support
    - Non-Profit Organization Counsel
    - Health Care Operations Counsel
    - Insurance Regulatory Counsel
    - IRS counsel
- Accounting Support
- Consultants
    - Management Consulting
    - Actuarial
    - Consumer Advocate
    - Membership Development & Communication
    - Staffing and Recruitment
    - Corporate finance
    - Information Technology
    - Insurance Operations
    - Health Care and Provider Operations
    - Membership & Governance
- Data and Information Acquisition on insurance markets
- Other Cost of Non-Profit Operation & Business Planning
    - Facilities & Equipment
    - Communications
    - Travel Expenses

In the initial start up stage of CO-OP development, startup operations on the basis of the business plan would be initiated and other efforts required to achieve state licensure as an insurance company resulting in the application of the non-profit state member organization to HHS for solvency grants and including achieving federal 501 (c) 29 tax exempt status would b undertaken. At this stage, HHS should expect CO-OPs to present applications for startup loans for initial operating purposes that include funding for non-profit and insurance corporate level operations including membership development and communication as well as all of the operational function areas identified in Attachment 1: Administrative Service Responsibility, page 8 of the testimony presented by Mary K. Dewane to the HHS CO-OP Advisory Board on January 13, 2011.

CO-OPs should be free to enter into any legal arrangements to form a purchasing council as captioned under the PPACA without regulation or scrutiny by HHS, as long as these business arrangements do not and will not cause the CO-OP entity regulated by HHS to be in violation of PPACA or any rule or regulation established by HHS or terms , or the conditions or covenants of the federal grants and loans made to the CO-OP and the requirements of section 501 (c)29 of the IRS code. If HHS is in a position to offer funding or financing in the form of loans or grants to a purchasing council as contemplated in PPACA, then it would be appropriate for HHS to establish a process for making such funding available and requirements for such funding that would require any organization or group wishing to form such an entity to estimate and describe the startup costs that might be associated with establishing it.

13. Are there other considerations that should inform what costs would be eligible for a CO-OP loan? Should there be limited time periods for which Federal loans for start-up costs may be available? Are there any start-up costs that would be incurred after the qualified nonprofit issuer begins to provide coverage under one or more plans?

All costs borne by a CO-OP in development and startup operation, including past costs borne in feasibility development by CO-OP organizers that may be in the form of out of pocket costs borne without reimbursement, loans, and services provided in consideration of future payment, should be eligible for funding through a CO-OP loan. The only exceptions would be costs for marketing [strictly defined so as not to include non-profit membership development and communication and costs associated with providing information needed to qualify for and operate on an insurance exchange] and costs for activities that would clearly contravene the governance requirements discussed in Section H of the request for comments.

As a practical matter, the time period that a prospective CO-OP could apply for a startup loan for business planning [Stage 1 loan as proposed by the HHS CO-OP Advisory Board] and initial operations [Stage 2 loan] is limited by the business milestones that it must accomplish in order to meet the statutory deadline for the disbursement of CO-OP loans and grants in July 2013. HHS and CO-OPs should anticipate that HHS will require a minimum 30 day period for evaluating grant applications and disbursement of loans and grants, and that this period may increase as the statutory deadline nears. A CO-OP will generally require an absolute minimum of six months of business planning efforts in order to define a business case that will be sufficient to receive state insurance regulatory approval and allow the determination of the appropriate level of risk based capital required for solvency and the determination of other capital requirements that may be required to meet standards for guarantee funds, risk pools, temporary reinsurance, exchange funding and other requirements. Therefore, a CO-OP must begin business planning efforts no later than the last quarter of 2012 in order to complete development of its business case that includes definitive estimates of capital required for satisfaction of all state capital and contribution requirements and make application to HHS for capital and solvency grants to meet these requirements in a timeframe that ensures completion of the HHS grant funding process prior to the statutory deadline. Therefore, HHS should keep open the "loan window" for startup loans through 2012.

A CO-OP should be able to apply to HHS for startup loans that include funding for startup costs that may occur coincident with or after the CO-OP begins insurance operations, as long as such costs can be reasonably estimated and substantiated. A CO-OPs application for Stage 2 startup loans should include current costs of initial startup operations on the basis of the business plan and other efforts required to achieve state licensure as an insurance company resulting in the application of the non-profit state member organization to HHS for solvency grants and including achieving federal 501 (c) 29 tax exempt status , and to fund future intermediate stage startup operations as a non-profit member CO-OP once solvency funds have been obtained and the insurance license process is completed, and to fund Startup insurance operations would commence in late 2013, and to fund future operations prior to the receipt of premiums, and in any period where enrollment or premium production estimates are not fulfilled well as future capital required to provide for funding any operational shortfalls in the first five years of operations.

14. What market factors would most likely affect a qualified nonprofit issuer's durability in the market? What factors should be considered in determining which issuers are likely to be viable in the long-term?

No response.

15. In evaluating applications for loans and grants, what actuarial and minimum plan enrollment criteria should be considered? What is the effect, if any, if providers are anticipated to bear risk? How would such criteria affect the financial soundness of the qualified issuer?

Actuarial and minimum plan enrollment criteria should be considered differently for loans than for grants, and differently for Stage1 and Stage 2 startup loans. No such criteria are appropriate or should be applied to evaluate an application for Stage 1 to fund business planning efforts. Stage 2 loans to fund initial operations should consider and apply these criteria in a very limited manner that reflects the specific circumstances of the particular CO-OP, and HHS should presume that a CO-OP that has achieved state regulatory signoff on its business plan meets HHS actuarial criteria and has provided in its business plan actuarial estimates and financial projections based on an enrollment level that is sufficient to provide the state regulators with comfort that the CO-OP has the ability to become financially sustainable meets HHS criteria. Actuarial and plan enrollment criteria can be applied to evaluating grant applications, and in this case the appropriate use would be to verify that the grant application is supported by actuarial analysis performed by professionals with a track record of such analysis, and valid financial estimates based on estimated enrollment that provide a reasonable forecast of capital required by the CO-OP to be funded by the grant. HHS should not substitute its business judgment for that of the CO-OP applicant, or utilize any absolute enrollment standard or any inflexible actuarial criteria in its evaluation of CO-OP applications for loans and grants.

Insurance experts familiar with the economics of certain health insurance plan market segments and companies that have recently started operations indicate that a CO-OP following a particular business strategy in certain markets could potentially achieve sustainable operations with fewer than 10,000 enrollees, and results of recent startup companies [including testimony before the HHS CO-OP Advisory Board] indicate current successful operations on the basis of approximately 23,000 enrollees. The American Academy of Actuaries estimated in 2009 that CO-OPs on a nationwide basis could enroll 2 million insureds, or approximately 40,000 enrollees average in a state. HHS should not presume that a CO-OP must meet any set criteria for absolute numbers of enrollees or percentage of penetration in any particular insurance market, or that a CO-OP loan application based on higher enrollment estimates should be evaluated to be superior to a CO-OP that presents lower enrollment estimates. Experience with the previous development and operation of HMO's suggests that HMO's that began operation with a smaller service base of customers and expanded over a period of years have a track record of sustainable operation over time that exceeds HMO's that began operation with larger service areas and customer bases and expanded quickly.

Any risk bearing by providers contemplated by the CO-OP applicant will be already be adequately reflected in the business plan presented by the CO-OP which will include actuarial analysis and financial estimates based on the insurance risk assumed by CO-OP operations. HHS should make no presumption in its loan or grant evaluation process that any mechanism of risk bearing by providers positively or negatively effects a CO-OPs prospects for financial and operational sustainability, and evaluate each application on their ability to present a valid business strategy and business case based on whatever provider risk sharing and compensation arrangements they believe to be appropriate.

16. What types of technical assistance, if any, should the Secretary provide to grantees? How should such technical assistance be structured?

The Secretary should provide startup loan funds to prospective CO-OPs sufficient for them to be able to access the technical assistance that they require. Prior to the time that CO-OPs are able to apply for startup loans, the Secretary should make available basic legal, financial, insurance and non-profit operations technical assistance to CO-OPs in development to support their efforts to deliver to HHS a complete and valid application for Stage 1 Startup loan funds. Such technical assistance can be obtained from professional sources engaged under contract to the Secretary, and make available to prospective CO-OP applicants that request it.

17. In what geographic areas are qualified nonprofit issuers most likely to be successful (e.g., rural or metropolitan areas or certain regions of the country)?

No response

18. How can qualified nonprofit issuers build provider networks? What strategies have proven effective?

No response.

19. What is the extent of interest in forming qualified nonprofit issuers under Section 1322 of the Affordable Care Act? In what State(s) or geographic region are these entities likely to be established?

No response

B. Section 1322(b) of the Affordable Care Act Section 1322(b) of the Affordable Care Act

1. How should the term ''integrated care model'' be defined in the context of section 1322? How should the degree of integration and the degree to which integrated care is used be measured? Should qualified nonprofit issuers formed by primary care networks, even if they

contract with secondary and tertiary providers, also be given priority for the award of a grant or loan? To what degree should priority be based on whether providers share risk?

CO-OPs should be free to propose to HHS their individual, specific approach to development of an "integrated care model" that meets the definition of Section 1322. It should be remembered that at the time a prospective CO-OP makes an application for Stage 1 Startup financing that they will not necessarily have any approach or strategy for development and operation of a provider network, much less any possibility of documenting the degree of integration that may be achieved by this future provider network. A CO-OPs approach to the development of an integrated provider network will be one of the areas for specification in the business planning effort funded by Stage 1 loans as discussed above in Section A, Question 12. It is very likely that at least some CO-OPs may develop and propose new and innovative approaches to "integrated care models" that extend the definition of health care and care provider in ways that have not been contemplated or implemented in the US, but which build upon best practices utilized by successful international integrated health care and health insurance cooperatives. These innovative integrated care models may integrate self care, volunteer community member support, integrative and complementary providers and other care modalities than current allopathic medical care approaches, and may provide for the delivery of care in formats and locations that are not typically supported by current care health models and payors. The form, structure and operation of these new models may in all likelihood defy reasonable and appropriate measurement by current standards, metrics or models developed to evaluate integration and other measures of quality that are applied to care models embodied in HMO's and community health center operations. Information on a CO-OP's approach to "integrated care models" should be treated as proprietary confidential business information by HHS.

How should "significant private support" be defined in this context ?:

"Significant private support" should not be defined as requiring any level of matching funding for the amounts of loans and grants applied for by CO-OPs. A CO-OP applicant will have demonstrated significant private support by its success in undertaking initial organizational and feasibility development prior to its application to HHS for federal funding, and such support can be documented in its application. HHS should encourage and foster the development of a diversity of approaches and strategies designed to respond to the particular conditions and issues that concern CO-OP development and operation in a state or region, including demonstrating significant private support. A CO-OP Stage 1 loan applicant should present evidence that CO-OP organizers are making progress toward becoming incorporated as a non-profit member organization in a state, that they have formed a steering committee or other

organizing body to guide their efforts, and can present a cogent written document that describes the approach that they will employ to develop a feasible business strategy and detailed business plan including private support of any form being provided to the prospective CO-OP in their initial development and feasibility without receipt of consideration. A Stage 2 CO-OP loan applicant should be able to document to HHS the forms of private support that they have received in the business planning process, to include volunteer efforts, pro-bono professional assistance, technical and operational support, and engagement with providers. In the context of a grant application for capital and solvency funding, a CO-OP applicant will be able to demonstrate private support for its strategy and implementation plan in the form of "buy-in" by provider organizations, and other private sector entities that will be providing operational support to the CO-OP and seeking to operationalize other aspects of PPACA, and allied organizations including various service cooperatives, credit unions, health reform support organizations, labor unions and progressive business organizations.

What options for private support should qualified nonprofit issuers be able to pursue while maintaining nonprofit status? How can such support be structured to avoid inurnment to the benefit of non-members and protect the independence of consumer governance?

Qualified non-profit issuers must be able to pursue and accept any and all forms of private sector support that are legally acceptable in the state in which the non-profit member organization is incorporated and which do not contravene the federal requirements of new section 501 c 29 of the IRS code. There is no basis to conclude now that any form of private sector support discussed above in response to Question 2 will likely call into question the state nonprofit or federal tax exempt status of an issuer, or inure to the benefit of non-members or impair the independence of consumer governance. A CO-OP should be required to disclose to HHS in their funding application(s) all sources of material private sector support, and to make an affirmative statement that such private support does not in all likelihood call into question the state nonprofit or federal tax exempt status of an issuer, or inure to the benefit of non-members or impair the independence of consumer governance with respect to the terms and conditions of such private sector support. To the extent that the terms and conditions of private support cannot be so categorically affirmed, then the CO-OP must present an approach and plan to mitigate the possibility of such private sector support causing such issues.

HHS should not propose or implement rules and regulations with respect to CO-OP federal funding, such as matching funds requirements or other requirements for private sector financial support. Such requirements could result in the CO-OPs entering into business arrangements with potential funders, financiers, health care providers, consultants and vendors and other parties at interest that could limit the CO-OPs ability to develop and implement a successful consumer driven and controlled business strategy, and could under certain adverse

circumstances lead to business impacts that could call into question the state nonprofit or federal tax exempt status of an issuer, or cause inurnment to the benefit of non-members or impair the independence of consumer governance.

C Section 1322(b)(2)(a)(iii) of the Affordable Care Act

1. How can the Secretary best ensure sufficient funding to establish at least one qualified nonprofit issuer in each State?

The Secretary should ensure that a minimum of $15 million in startup loan funds are made available to establish a CO-OP nonprofit issuer in each state and the District of Columbia. To accomplish this, and to encourage the establishment of a CO-OP in a state that has not had a qualified nonprofit issuer applicant approach HHS for funding by the June 2012; HHS should fully fund the qualified startup loan applications that it receives from every state by June 2012, and then should also identify an amount of additional startup loan funds for near term future distribution that should be held back from the $6 billion total federal funding for allocation and distribution to CO-OPs in the form of grants. The amount of additional startup loans may be sufficient if it provides provide a minimum of $15 million in startup loans to potential CO-OPs for each state and the District of Columbia that has not made application to HHS. This amount of startup funds is consistent with the findings of the American Academy of Actuaries and this may be sufficient to foster the establishment of at least one CO-OP in each state and the District.

2. How might the Secretary encourage the establishment of a CO-OP in a state without a qualified nonprofit issuer

The Secretary can best encourage the establishment of a CO-OP in a state that does not have a prospective qualified non-profit applicant for federal startup funding by June 30, 2012 by communicating to previous nonprofit issuer applicants that have received federal funding that there is the opportunity for them to apply within 60 days for federal funding to establish a CO-OP in such states, and that the Secretary would welcome additional new applications by these funded applicants. These new applications should provide a basis for the Secretary to determine that the currently funded applicant has the ability to undertake CO-OP development and startup activities in the new, additional state or states and provide a legal and operational approach for achieving regulatory approval in the new state. If the Secretary has not received an application for funding from a CO-OP in formation intending to operate in every state and the District of Columbia within the 60 day period, then the Secretary should immediately undertake direct outreach efforts over a period of thirty days to potential CO-OP organizers in

such states to encourage them to make applications. If such direct outreach efforts do not bear fruit, and sufficient new applications from existing funded applicants are not forthcoming, then the only other feasible option may be for the Secretary to contract with the private sector entity to provide services to take the actions necessary to jump start the development of a CO-OP in a particular state, realizing that such efforts to seed and incubate a CO-OP will be inherently risky. Private sector non-profit organizations and for profit consulting entities have health care practice units and provide support to federal operations and have proven capability embodied in respected professionals including some with direct expertise on health insurance CO-OPs.

D. Section 1322(b)(C)(ii) of the Affordable Care Act

1. How should the restriction on the use of federal funds for marketing be applied?

Non-profit member organization CO-OPs in operation and development should have the capability to undertake membership development and membership communication activities required to develop membership in the non-profit and develop communication materials as may be required by the Exchanges without restriction, utilizing federal funding. Such activities are not marketing, but are inherently bound up with the required legal, operational and governance structure of the non-profit member CO-OP, and the requirement that these member non-profits offer coverage via the exchanges. Additionally, a CO-OP should be able to utilize federal funds to make required payments to exchanges or exchange operators that may be utilized to defray the cost of exchange operation.

Further, a member non-profit CO-OP should be able to utilize federal funding to engage in public relations activities including responding to press inquiries and participating in and sponsoring events in any forum or format that will offer the CO-OP the ability to educate the public about the CO-OP's mission of consumer oriented and operated health insurance and how members can participate in the operation and governance of the CO-OP.

CO-OPs should be restricted from utilizing federal funds for paid media opportunities and sponsored brand awareness campaigns focused solely on the health insurance benefits provided by the nonprofit qualified issuer.

2. What other sources of financing for marketing would be available to qualified nonprofit issuers?

All funds developed from operations or received by the CO-OP from any non-federal party, or federal party not in the form of grants and loans under PPACA can be utilized for marketing purposes. These include but are not restricted to premium income, other income, grants, loans, in-kind contributions, donations, sponsorship income, program related investments, etc.

3. What accounting standards and metrics should be used to determine the sources of funding for marketing activities? If qualified nonprofit issuers did engage in these activities using nonfederal funding, what rules should be in place to ensure federal funds are not used?

A CO-OP or CO-OP in development or formation can establish a separate Bank account from which all prohibited marketing activities, if any, can be funded. The CO-OP can develop financial processes and management controls that assure that federal grant and loan funds from HHS are not deposited in this account, as well as developing other methods to achieve the same result in conjunction with their accounting support entity. The accounting firm or other entity utilized by the CO-OP to support its required financial reporting for insurance, governance and non-profit purposes will then have the ability to make an affirmative statement that the financial control and processes of the CO-OP are sufficient to prevent any use of prohibited federal funds for marketing purposes, and that it's tests and analytical procedures as applied to the operation of such processes, controls and procedures have not revealed any prohibited use of federal grant and loan funds.

E. Section 1322(b)(2)(D) of the Affordable Care Act

1. To what extent is it necessary for new qualified nonprofit issuers to be operational by 2014 in order to be successful? How soon should grants or loans be distributed to establish qualified nonprofit issuers that can be operational in 2014?

New qualified nonprofit issuers should be operational no later than January 1, 2014. Health Insurance Exchanges will be implemented in 2014 and will operate as a primary market access for qualified nonprofit issuers. CO-OPs will generally rely on the Exchange to build their membership in their first few years of operation. If CO-OPs are not operational by 2014, they will miss out on a key marketing and exposure opportunity through the Exchanges, given that it is likely that the Exchange, States, and Federal government will engage in a public awareness campaign to ensure that individuals and small businesses understand that the Exchange is an opportunity and alternative to purchase health insurance.

The distribution of startup loans should begin no later than the last quarter of 2011. HHS should be prepared to begin accepting applications for CO-OP grants no later than the first

quarter of 2012, as certain CO-OPs in organization may have made enough progress in their business planning process by that time. HHS should be prepared to begin distributing grants no later than the beginning of the third quarter of 2012.

2. How might funds be best allocated and, to what extent should distribution of loan funds be front-loaded to meet the statute's goal of establishing a CO–OP in each state?

HHS should be prepared to allocate startup loan funds from its $6 billion authorization so as to fully fund every qualified Stage 1 and Stage 2 loan application, as well as allocating loan funds to encourage CO-OP establishment in states where it does not receive a qualified application as discussed in the response to Section C, Questions 1 & 2 above.

HHS should be prepared to begin distribution of the loan funds as soon as possible after completing the processes required to finalize regulations in this area. HHS should develop a simplified and expedited process of accepting and evaluating loan applications that should take no more than 30 days. It should be possible for HHS to begin accepting applications in August or early September 2011, and to begin distribution of loan funds by September 1, 2011.

Distribution of loans and grants should be entirely front loaded, and the total amounts should available for distribution on the approval date, and not subject to any staging, phasing or other extended funding period or mechanism. A mechanism for meeting the statues goal of establishing a CO-OP in each state and the District of Columbia is addressed in the response to Section C, Questions 1 & 2 above.

3. Given the limited funding for this program, how long should draw down on grants and loans be permitted after the award date if loans and grants are not being utilized?

HHS should be prepared for prospective non-profit issuers to draw down the total amounts of funds in their Stage 1 and Stage 2 loan applications within thirty days of approval, and should not impose any extended or staged draw down period or interim reporting requirements, unless a CO-OP applicant proposes and justifies such an extended draw down period in their application. HHS should expect and be prepared for startup CO-OPs to apply for grant funds based on their estimated requirements for capital and solvency requirements developed on the basis of consultation with state insurance regulators and internal financial projections as early as the last quarter of 2012 and draw down grant funds immediately upon approval. Approval of any loan funds not drawn down within 90 days from loan application approval should be suspended, subject to reinstatement within 30 days based on justification to HHS from the prospective CO-OP, unless a CO-OP applicant proposes and justifies such an extended draw down period in their loan application. Suspended approved loan funds whose approval is not reinstated within 30 days should be available to be distributed to other CO-OP applicants. CO-OPs should be able to draw down approved grant funds until the end of 2013, and given the business imperatives discussed in response to Question 1 directly above should be required to

draw down such grant funds, unless they present justification for a later draw down in their grant application.

F. Section 1322(b)(3) of the Affordable Care Act

1. When developing a repayment schedule, how should HHS take into consideration state reserve requirements?

Stage 1 Startup Loans provided to prospective non-profit issuers to fund business planning efforts and Stage 2 loans to fund startup operations should be structured as unsecured totally subordinated notes, without recourse to any entities other than the new non-profit member organization created to pursue CO-OP business planning and startup activities, and without recourse to any private sector entity, or persons, individuals or that are associated or involved with the development, creation, governance, and operations of this entity. In the event that such an entity is not the applicant or has not yet been created as could be the case with Stage 1 loan applications, then the unsecured totally subordinated note should not have recourse to any private sector entity, or persons, individuals or that are associated with or involved with the application unless the application is fraudulently constructed and presented for the primary benefit of these entities, persons or individuals.

These unsecured totally subordinated notes should be in each case and in every term and condition, including a contemplated repayment schedule, subordinate to any and all other liabilities including contingent liabilities and any and all other financial obligations of the non-profit issuer, including those imposed by state reserve requirements, solvency requirements, risk based capital requirements or other insurance related capital or funding requirements, including funding required to meet requirements for guarantee funds, risk pools, temporary reinsurance, exchange funding and other requirements. It is likely that state insurance regulators will require nonprofit issuer CO-OPs to obtain approval of any contemplated repayment schedule of any loan liability originally taken on or assumed by the non-profit, and to approve in advance each and every repayment contemplated. It should be assumed that state regulators will not approve any contemplated repayment schedule or repayment itself if such schedules or repayments will in any manner impair the [then] current and projected future financial ability of the issuer to meet its insurance obligations including maintaining and increasing reserve requirements as well as all other valid obligations of the issuer such as employee compensation and tax liabilities.

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2. What factors will determine the ability of qualified nonprofit issuers to generate sufficient revenues to repay the loans and grants? How and when will such issuers likely develop sufficient revenues to start the repayment of grants provided to fund reserves?

The market success of qualified nonprofit issuers is the only factor that will determine the ability to generate funds for loans and grants. If a qualified nonprofit issuer is successful in the marketplace, then state regulators will require that such issuer increase its capital and reserves, and potentially increase other insurance related capital or funding requirements, including funding required to meet requirements for guarantee funds, risk pools, temporary reinsurance, exchange funding and other regulatory or operational requirements consonant with its success in the marketplace. Only if and when a qualified nonprofit issuer satisfies these requirements to the satisfaction of regulators will the issuer be able to seek approval for establishing a start date and mechanism for repayment of grants under the surplus notes arrangements.

3. What interim benchmarks after initial funding should the Secretary use to determine an issuer's ongoing likelihood of success and whether corrective actions, or other protective measures might be necessary with respect to loan and grant funds?

The staging of loan applications and approvals and the subsequent application and approval process of grants to qualified nonprofit issuers as contemplated by the HHS CO-OP Advisory Board and discussed above in response to Section A will provide the Secretary with adequate information that can be used to determine an issuer's ongoing likelihood of success and whether corrective actions, or other protective measures might be necessary with respect to loan and grant funds. No other interim benchmarks or performance standards should be imposed on prospective or operational qualified nonprofit issuers, except those milestones, benchmarks or performance measures proposed by an applicant. Even in the case that an applicant proposes such measures, HHS should realize that the process of startup and initial operations of any new private sector business operation, including qualified nonprofit issuers operating as CO-OPs, is subject to a high degree of risk and variability, and the fact that that a qualified nonprofit issuer does not meet or fully accomplish milestones, benchmarks or performance measures in the timeframe proposed does not indicate that corrective actions on the part of HHS are required. However, if an applicant has proposed to become operational and begin to offer coverage on Exchanges in January 2014, and does not become operational at that time or does not appear in the last quarter of 2013 to be prepared to become operational, then the Secretary should be prepared to take corrective action.

4. What data are available about the potential success and failure rate of nonprofit health plans who may apply for grants and loans? If data are not available, what proxy data would be useful to inform benchmarks, or other performance standards?

No data on comparable nonprofit health insurance issuers is available according to the knowledge of this respondent. It is generally believed and supported that over 50% of private sector for profit startups fail within five years. The Secretary does not need to rely on proxy

data, but should utilize the direct information and data furnished by applicants in the staged loan and grant process including business plans, timelines, etc. to inform its oversight measures with respect to funded applicants. Additionally, the Secretary should engage in comprehensive due diligence efforts to ensure that representations made by applicants are valid, For example, the Secretary should carry put due diligence efforts with state insurance regulators to ensure representations made by applicants with respect to their engagement with state regulators, and the results of these engagements in terms of risk based capital requirements and other regulatory requirements are correct and valid.

Section G: No response

Section F: no response

Section H: No response

I. Section 1322(c)(4) of the Affordable Care Act

1. ***How could the governance structure and type of organization help ensure that excess revenues are used for the benefit of members? What accounting standards and metrics should be used to determine how such funds are applied? Should such funds in one year be used to lower premiums in a subsequent year? What types of benefits might be considered? Should excess funds be used to prepay loans or grants, to allow for greater revenues/benefits to the members over time? Is this preferable to giving refunds to members for the year in which the profit was earned?***

The term "excess revenues" is not a defined term utilized by professionals who provide corporate financial advice or services or accounting services to nonprofit organizations, nor is the term profit associated with nonprofit organizations. It is hopefully possible, and desirable that a member nonprofit issuer may generate more premium and other revenues in a year of operation than it has direct and indirect operating costs in that year. However, the NAIC has presented information to the HHS CO-OP Advisory Board that suggests, along with an examination of insurance regulations in the several states that an insurance company will have many other required and desirable uses of funds, and that any revenues above operational costs must first be devoted to meeting these requirements and uses, including developing internal reserves for future claims liabilities and other forecast liabilities. The form and general forecasts of the amounts of several of these liabilities is briefly discussed in the American Academy of Actuaries report cited earlier. It is highly unlikely that any "excess revenues" or "profits" will be forthcoming from the full accounting of the financial results of operations of a CO-OP in its first years of operation. In the first five years of operation, it is likely that any "surplus" available after the full accounting of the financial results of operations but prior to required or optional funding of unsecured, subordinated liabilities such as those represented

by startup loans from the federal government, will be applied to the funding of these liabilities. After the period in which these federal loan liabilities and other optional but highly desirable uses of funds have been satisfied including those associated with expanding the market success of the CO-OP and funding the liabilities associated with expansion, then it is likely that insurance regulators will require any "surplus" to be applied to building up capital and reserves to replace capital currently supplied by "surplus notes" as well as diminishing the contingent liability represented by these surplus notes. At such time as all of these required and desirable uses of surplus have been satisfied, then a CO-OP should be free to decide with the input of its members how to utilize a surplus to inure to the benefit of its members in the manner prescribed by the statue, i.e. to lower premiums, to improve benefits, and for other programs intended to improve the quality of health care delivered to its members.

2. How should programs intended to improve the quality of care be defined and measured in this context?

No response.

Section J: No response

Section K: response provided at the beginning.