The Office of Consumer Information and Insurance Oversight (OCIIO)

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

January 13, 2011

Meeting Convened at 8:00am

Committee members in attendance:

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

Executive Summary/Minutes

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

Panelist Reommendations

Consumer Operated and Oriented Plans: Concept and Feasibility

Panelists discussed the importance of risk capital derived from investors and from a portion of the net income retained from operations. In the case of co-ops, initial risk capital will be provided by grants to be repaid within 15 years. Successful co-ops will grow in terms of membership, so risk capital will have to grow as well. It

was argued that retained net income should be the primary way to raise risk capital. One concern is that in Sec. 1322, it states that any profits made by co-ops are to be given back to its members, suggesting that any net income should be used immediately for the benefit of the members. Key recommendations: (1) Loan and grant recipients should incorporate a policy in which premium rates are set with intention of generating net income; (2) A portion of net income should be set aside to either meet risk capital or to lower premiums, improve care, or go back to the members; (3) Co-ops should have to meet rigorous fiscal solvency requirements; and (4) High level of regulatory oversight should be in place to prevent problems.

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

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

Starting-up New Nonprofit Health Plans

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

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

Some of the pathways that lead to success include having a mission focus and consumer governance; knowing your market; integrating care and coverage to assure absolute alignment of consumer interest; test, innovate, and redesign care delivery; keep administrative costs low; and ensure appropriate financial reserves. Key recommendations: (1) Co-op should be comprised of value driven partnerships with providers within community; (2) Co-ops should approach health care coverage

for members across their lifespan; (3) Co-ops should be held to same standards as other health insurance plans to ensure a level playing field, e.g., they should be accredited by National Committee on Quality Assurance; and (4) New co-ops should benefit from past and present experiences. Many co-ops throughout the country already exist; use these as examples of success.

New Nonprofit Health Insurers: Perspectives from State Regulators

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

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

I. GOVERNANCE and LOOKING AT APPLICANTS

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

II. FINANCIAL AND BUSINESS PLAN

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

III. INFRASTRUCTURE

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

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

Meeting was adjourned at 5:00pm.