UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Consumer Operated and Oriented Plan (CO-OP) Program

Advisory Board

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# A G E N D A

P R O C E E D I N G

MR. FEEZOR: ...I ask that you try to resist that temptation and stay on target in term of -- unless that's a contextual issue with respect to co-ops. I would ask if you have a question to sort of turn your card up. We're going to ask that each of the panelists make their comments and hold questions for the entire panel after they have completed. We're going to ask that, if you would, ask your first question and let other members of the Board ask any questions before you come back around on your second and third questions of that group.

If there are some issues that occur to you that you would like to that are particular salient that you'd like to have either staff or maybe be agendaed for one of our subsequent meetings, either write it down or say it orally, and we'll stick it on a parking lot sheet over here, and we'll get back to it this afternoon.

So those are sort of the order of the day. Does anybody have any questions in terms of the process? Barbara, any?

MS. STANLEY: Allen?

MR. FEEZOR: Yes.

MS. STANLEY: This is Margaret Stanley, and in the email I got it said that we could participate online, and I was wondering if there are going to be PowerPoints or anything like that. I haven't been able to get into the conference online. It said that it hadn't been activated, so any guidance on that would be helpful.

MR. FEEZOR: Okay. Margaret, we'll have somebody calling you directly on that.

MS. STANLEY: That'll be hard if I'm on the line.

MR. FEEZOR: Well, I'm trying. I'm looking over here. We will have -- we will email you exactly how to get on.

MS. STANLEY: Okay. Thank you.

MR. FEEZOR: Other questions? And Margaret, please -- I've never known you to be shy, but don't be shy because -- it's hard to see your card turned up when you want to ask a question.

(Laughter)

MS. STANLEY: All right.

MR. FEEZOR: I also would like to have our first panel to go ahead and come up to the table.

(Pause)

MR. FEEZOR: As they are making their way, the other thing that we will be dispensing with is going in any significant detail in terms of the credentials of our panelist. Take my word for it, all are seasoned experts and quite deep in the subjects that we've asked them to participate in.

Our first panel will be focusing on the concept of co-ops and their feasibility particularly with respect to co-ops in healthcare. We will start with a presentation from Sara Collins, who is an economist and in Vice President for Affordable Health Insurance at the Commonwealth.

We will then hear from Paul Hazen, who is President and CEO of the National Cooperative Business Association, and I note parenthetically has been a member of the Consumer Federation of America as well, wearing a couple of hat.

And then John Bertko, who is a Senior Fellow

at the LMI Center for Health Reform and Adjunct Staff at RAND and Visiting Scholar at the Brookings Institution and a longtime friend and trusted actuary in term of a lot of his work.

And then by phone -- I hope, Jay, you're with us -- is Jay Ripps, who is the Chief Health Actuary for the California Department of Insurance. We're delighted to have Jay participating. It's awfully early out there. He is participating not as a representative of the Department of Insurance but rather for his own work and expertise in both co-ops and in solvency issues.

Sara, if you would, start off.

MS. SARA COLLINS: ...to speak about the CO-OP Program. Barbara asked me to provide a high-level perspective on the program, so I thought I'd start with about high as you can get, which is a global perspective.

And everyone is pretty familiar with the fact the United States spends more per capita on healthcare and more as a share of GDP than any other industrialized country, and that has been broadening

over time. But yet, we rank lowest or among the lowest on key measures of health system performance, quality, access, equity, and efficiency. Surveys of the U.S. public like the 2008 Commonwealth Fund survey indicates that patients experience very poorly coordinated healthcare, and U.S. adults report going to the emergency room for conditions that could have been treated in a hospital much more frequently than adults in other industrialized nations.

I'm going to skip some of the provision of the Affordable Care Act that I planned to talk about, but really the overarching goal of the law is to make fundamental change in both our coverage and delivery systems to achieve high-quality, effective, and safe care, the design of care delivery that's in the best interest of patients, the efficient use of resources.

The CO-OP Program if it's provided the necessary tools and flexibility has the potential to embody those goals and help move the system toward a higher level of performance.

Some of the most or the most successful regional healthcare cooperatives have had strong links

to integrated care systems;  Health Partners in Minnesota, Group Health Cooperative in Seattle, and Group Health Cooperative in Eau Claire, Wisconsin. These nonprofit, consumer-governed organizations serve members in broad geographic area.  In addition to insurance, they directly provide healthcare services through nonprofit integrated delivery system.  They own or contract with hospitals and clinics in contract with dedicated, multispecialists physician group.

Some of their keys to success have includes a consumer-focused mission and accountability resulting from a consumer-elected board, close links with care systems and provider networks, a regional focus that integrates a broad range of services, commitment to evidence-based care, informed patient engagement, efforts at care coordination, and a greater accountability for the total care of patients, and a culture of continuous improvement that has included aligning payment and other incentives for providers and patients with organizational goals.

Examples of similar nonprofit integrated delivery systems that aren’t consumer governed include

Geisinger Health Systems in Pennsylvania, Intermountain Health Care in Utah, Kaiser-Permanente.

The CO-OP Program could spread these successful models of nonprofit, integrated delivery. It will be a challenge for new cooperatives to become these sorts of systems initially, but the provisions of the law are really sufficient flexible to allow cooperatives to contract with a wide array of high-performing provider organizations that might achieve similar goals.

For example, co-ops could contract with existing integrated delivery care systems. Through such arrangement, the CO-OP Program could help replicate unique, nonprofit collaborative environment of Minnesota's Twin Cities market area. They are a leader in health delivery innovation. Minnesota actually ranks in the top five states in the Commonwealth Funds state scorecards on states with high-performing healthcare system.

In this way, the CO-OP Program has the potential to reinforce the culture and increase the collective market share of these mission-driven

organizations in regional markets.

In the absence of integrated delivery systems, co-ops could contract with multispecialty group practices, clinics and hospitals with the goal of integrating those systems. Marshfield Clinic, a nonprofit multispecialty group practice in rural Wisconsin, is an example. They have a regional ambulatory care system and affiliated health plan and related foundation supporting health research and education. It sponsors the Security Health Plan of Wisconsin, which provides coverage through a network of affiliated hospitals and providers including Marshfield Clinic. The plan is administratively and financially separated from Marshfield.

Co-ops could also contract with community health centers networks. Community health centers are linked through a common mission across the country, and also they're national organizations. They have a potential, therefore, to become multistate networks. The qualified health plans are required under the Affordable Care Act to include essential community providers in their networks. Community Care of North

Carolina, which is mentioned earlier, is an example of a high-performing, community-based system of care.

A significant challenge facing the new cooperatives is their ability to gain market share in highly concentrated insurance markets. There are only about three states in the country where the two largest health plans dominate less than 50 percent of the market. In most markets, large carriers and provider systems negotiate prices. Those prices reflect discounts off list prices that depend on volume. Prices can vary widely, and the lowest rates are usually not available to those health plans.

The new co-ops will, thus, be at somewhat of a disadvantage in obtaining favorable provider rates, and this will affect, obviously, their ability to compete in the exchanges and the insurance markets.

The key to the success of cooperatives and other industries has been their ability to purchase at favorable rates. Rural electric cooperatives are really good examples. They are able to buy electricity at cost from Federal dams.

For cooperatives healthcare to slow the growth

in healthcare cost, they'll need the authority to purchase care on favorable terms and the ability, obviously, to offer high-quality provider networks. Federal or state government could consider requiring providers to give health cooperatives the lowest prices they give to other private insurers. And national cooperative organizations could be given the authority to negotiate provider prices on behalf of customers.

I know we weren't supposed to talk about private purchasing councils, but I'll mention them here. They are one potential vehicle for co-ops to gain leverage in provider negotiation. The law does preclude them from setting payment rates for healthcare providers, but it's unclear whether the purchasing council might at least be able to negotiate provider rates on behalf of the co-ops.

The concept of health cooperatives envisions mission-driven health plans that are accountable to their members and the public interest for providing accessible high-quality and affordable care. The way this provision and other key aspect of the law that are related to it are implemented is important not only for

the long-term viability of co-ops, but the ability of health reform to move or current system of healthcare to a national system that has mission, values, capacity, operational systems, and strategies of systems like Health Partners, Group Health, Geisinger, Intermountain, and Kaiser-Permanente. Thank you.

MR. PAUL HAZEN: Good morning. It's an honor to be here to speak before the Advisory Board to the Consumer Operated and Oriented Plan and to offer the views of the National Cooperative Business Association on implementing the program, and I thank the Board for the opportunity.

Barbara asked me to do high-level review of cooperatives, one of my favorite topics to talk about, about how cooperatives literally change the lives of people in this country and around the world.

My organization, MCBA, as a membership association representing the nation's more than 29,000 cooperative business and has a mission to develop, advance, and protect cooperative enterprise. In 2009, MCBA entered into the national debate on healthcare advocating for the creation of healthcare cooperatives,

which would be owned by their consumer members. MCBA actively worked with Senator Conrad and others to ensure that the use of the term cooperative or co-op meant that real cooperatives would be established. The cooperative community is disappointed that this plan does not contain that requirement despite the CO-OP acronym.

Cooperatives are member owned and democratically controlled enterprises that provide services and products to their members. Cooperatives are successful and developed when certain market condition arise such as when the market is failing to meet a need based on either cost or access. Economies of scale will bring benefit. The value of ownership will help to ensure the success of business or social conditions warrant the creation of a community-owned business.

Cooperatives deliver value to their consumer members and communities because they respond to member needs and through their commitment to the cooperative principles and values. Cooperatives play a vital role in our economy and provide an advantage to their member

owners.

By operating at cost and returning the savings to the members, cooperatives are the most effective corporate structure to address both economic and social needs. In fact the cooperative business model is the best business model for economic and social progress. Co-ops offer members a hand-up rather than a handout. The model encourages self-reliance and gives members both rights and responsibilities. In addition, through collective ownership, risk is spread among the members of the cooperative, which ensures long-term stability.

By contrast, a nonprofit is a corporation in which there are no individual stockholders, and no part of the corporation's revenue is distributed to its members. As privately owned businesses that serve the needs of members, co-ops are a better way in contrast to either a government-led system or a for-profit business.

No area of our society or economy is in greater need of the value provided by cooperative enterprise than our nation's healthcare. According to a study by Kaiser-Permanente, 50 million Americans were

uninsured in 2009. With so many of our people lacking health insurance, this indicates the failure in the market and that cooperatives can play a role in helping to rectify this and represent a need that warrants the creation on community-owned and focused businesses.

MCBA strongly advocates that the nonprofits created through this Act operate as cooperatives because to do so will ensure great and sustainable benefit to the America public. Although the Act does not allow these entities to organize as cooperatives in the legal sense, they can and should function as cooperatives, follow the cooperative principles and values and have both bylaws and articles of incorporation that enable members to govern. Principles and practices matter and will ensure that the American public receive ongoing value from these entities.

Group health cooperatives stand out as an example of this type of entity. Although organized as a nonprofit, group health cooperative includes in its bylaw provisions that allow policy holders to become members and grants those members voting rights on certain governance issues including the election of

directors. However, because it's a nonprofit, policyholders do not have ownership rights. It is an imperative that any organization created under this plan is consumer-run and controlled. Any attempt to create provider or doctor-owned entities would be in direct violation of the Act.

In addition, two provisions in the Act suggest way that the public can receive benefit via cooperatives. First, the section stating that profits inure to the benefit of members provides a means by which the public can receive a value similar to that provide by cooperatives through their member economic participation.

And second, the Act calls for the establishment of private purchasing councils which enter into collective purchasing arrangements for items and services. These councils could be organized as cooperatives. Two such entities operate as purchasing cooperatives for health insurance and point the way for these councils: Thanexus Inc., a funeral practice management cooperative created by the New Jersey Funeral Directors Association, and the Farmers' Health

Cooperative of Wisconsin.

The introduction of cooperatives as a mechanism to provide more consumers with access to affordable health insurance is a positive development if implemented correctly. To ensure success MCBA recommends alleviating challenges that threaten the success of the cooperative startups. Among these is access to equity.

The Maryland Nonprofit Health Insurance co-op, which is currently conducting a study to determine the feasibility of forming a nonprofit health insurer, estimates that it would need $100 million to $150 million in reserves to start and to enroll 50,000 to 100,000 people to be economically viable. If every state required the same funds, we'd need over $7 billion. Although the Act encourages qualified insurers to seek funding from private sources, our experience is that this funding is just inadequate.

In addition, the Act prohibits any entity receiving funds via the CO-OP Program from using those funds for marketing. Although not defined in the Act, the term generally refers to the promotion,

distribution, and selling a product or service including market research and advertising. It's difficult to comprehend why the Federal Government would place such a restriction on these entities. MCBA suggest that the Advisory Board clarify this restriction and create a definition that would allow co-ops participants to compete effectively and gain economic viability.

MCBA believes that if implemented properly the CO-OP Program could create successful, sustainable organizations that will act in a manner consistent with cooperative principles and values. To achieve this outcome, MCBA suggests that the Secretary and Advisory Board do the following.

Number one, provide clear guidance as to the type of co-op entity that is eligible for the program including requirements for governance and its relationship to State insurance laws.

Two, offer technical assistance and outreach for those interested in developing cooperatives.

Three, ensure that the program has access to expertise in developing cooperatives that is needed and

provide guidance to Health and Human Services and States on legislative requirements.

Number four, create rules to protect against the conversion to for-profit status.

MCBA offers our expertise in the cooperative business model and cooperative development and looks forward to working with this group and others as this law becomes implemented.

Copies of my written testimony are available on the MCBA Web site at MCBA.coop. Thank you.

MR. FEEZOR: Paul, thank you, and be careful what you volunteer. We'll be back to you later.

(Laughter)

MR. FEEZOR: John.

MR. JOHN BERTKO: Good morning, and thank you for the invitation to come here. Allen's given some of my credentials, and I would just say that I'm also a retired chief actuary and have been an actuarial consultant in my past. Over the years as a consultant, worked for several consumer-governed health plans across the country and for several local community health plans, and I've had on-the-ground experience

with health insurance rate setting, establishing new lines of business, solvency requirements, and relations with departments of insurance.

The creation of a co-op program under the Affordable Care Act to foster nonprofit, member-run health insurance companies I think is one of the law's major provisions to provide greater health insurance value to consumers and to increase competition. At the same time, we've got to recognize that the development of new co-op insurance plans will take time and needs to proceed with care in order to provide consumers with products that have adequate premiums and will guarantee their solvency. Many States I think may benefit from have increased competition in their individual and small employer markets because they are dominated, as noted earlier, by a few larger insurers.

One of the questions or comments that Paul brought up was the size needed to have a successful co-op, and I've got two comments along the size lines. First, a co-op plan needs to have sufficient membership to be financially and operationally stable. From my experience, and this goes back about 10 years or so

ago, that level is reached at about 25,000 members although the first-year membership could be less than that. And at this level, a co-op can afford professional manager. It can afford the infrastructure and utilization management and a distribution network.

One of the concerns that I have on there, or one of the considerations rather, is that most of the infrastructure at the level be rented as opposed to be created or purchased. And you can ask questions about what that means if that's useful.

A second level of success in my mind might be measured when the co-op begins to have an impact on the overall state or regional insurance market, and this, again, is my rule of thumb in terms of moving into new markets. That's reached with about a 5 percent market share, and for a middle-size State might be around 250,000 members, but in a small state might be a little as 50,000 members. Keep in mind this is well short of the 50 percent market share of the dominant insurer in many markets, but it's at a point where the co-op plan is taken seriously, meaning that employers would recognize it as a stable alternative and that the co-op

can, as Sara noted, successfully negotiate with providers.

Neither of these levels needs to be reached immediately. With the financial support under the Affordable Care Act, a co-op with a good business plan can start small and then ramp up over time.

I would note that because we have exchanges opening on January 1, 2014, the co-op plans, in my opinion, ought to be ready to go on that particular point in order to take advantage of what I would call the land rush of new memberships. It's a unique opportunity.

As a chief actuary, I participated in a different land rush for Part D on 1/1/06, and there was one.

(Laughter)

A comment that might be useful to think about here is in comparison many of you are familiar with high-deductible health plans with savings accounts, and those went from essentially to no market presence in about 2000, just a tiny amounts, to a recent analyst report that said it has maybe 12 to 15 percent of the

privately insured market today. So a 10-year period of ramp up is certainly a possibility.

I would also offer some success factors for a new co-op plan. I've had experience with very well run co-ops, some of those that were mentioned earlier, and a couple that you learn lessons from let's just say.

First and foremost, I'd say is the need to use professional health insurance managers to run the co-op. Secondly, and I think this is a huge success factor, is maintaining a focus on low administrative cost, being frugal, and that can happen in any number of ways. The third is the development of community support, and I think this is one for provider contracting, support among employers, and then consumer trust to say this is the kind of plan we want to enroll in, and I would guess that Paul and his organization have developed that kind of support.

Another factor is the premiums have to be realistic. I've had the unfortunate success of trying to clean up plans where the premiums were, let's just say, out of financial synch with where they needed to be, and it's a mess. We don't want to go there. We'd

rather start at the right level.

I would point out that risk adjustment, which is in the new law and will apply across the board to all nongrandfathered plans, offers some protection because if there is a maldistribution of risk that is, it could happen that less healthy people decide that they like the co-op. Well, then there will be a movement of dollars from those plans that are doing maybe implicit risk selection or have books of business that have had healthier risks in them.

The transitional reinsurance program in the new law, operating in 2014, 2015, and 2016, also offers some protection there against the initial surge of people. I personally expect the sickest people to show up when there is no longer any underwriting, and that transitional reinsurance program is in the law to offer that kind of support and spread that risk.

Renting the infrastructure services to maintain that low administrative cost structure could include renting claims adjudications services or software, renting network, contracting utilization management, renting billing and enrollment systems.

You can always rent accountant and lawyers and a variety of other types of things there.

One of the big advantages I think that co-ops can have is they're starting fresh, and they don't have to worry about cannibalizing existing business, and so they can start with new and innovative products. They can start with working with delivery systems. I've personally been working on accountable care organizations and start with those rather than working with, say, every provider in a community. They can work with value-based insurance design, which is a buzz word, but it does have some important concepts that could be focused on.

And then lastly, I would suggest very strongly that the consumer board governing these co-ops needs to be business-like in its operations. It's got to realize, to me at least, that the greatest value by offering good consumer-oriented products at stable, solvent rates, and that's very important.

So with that, thank you for letting me address you, and I'd quite happy to answer any question you have afterward.

MR. FEEZOR: Thank you very much, John, and a great list of some characteristics that we should look for in potential applicants. So thank you.

Jay, I hope you're awake and alive and well out in California this morning.

MR. JAY RIPPS: Well, I am --

MR. FEEZOR: And then --

MR. RIPPS: -- sort of awake, but I'll do the best.

MR. FEEZOR: Yes. If you would, Jay, please go ahead.

MR. RIPPS: Thank you. My name is Jay Ripps, and I'm a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Oh, incidentally, how much time do I have?

MR. FEEZOR: Five to seven minutes.

MR. RIPPS: Okay. I was a coauthor of a 2009 report by those two actuarial organizations regarding capital requirements for co-ops. I'm also the chief health actuary of the State of California, Department of Insurance, but my testimony this morning reflects -- Pardon me?

(Pause)

MR. RIPPS: Are you there?

MR. FEEZOR: We're here. Go ahead, Jay, we're listening.

MR. RIPPS: My testimony this morning reflects only my personal opinions and shouldn't be construed in any way as the opinions or positions of the actuarial organizations of which I'm a member nor the California Department of Insurance.

I understand that the loans and grants authorized by the Affordable Care Act will be awarded by the Secretary of HHS taking into account the recommendations of this Board. The purpose of my testimony this morning is to sort of echo and reemphasize the importance of risk capital, as John spoke about, in assuring that co-ops are able to fulfill their implicit and explicit promises to their members.

Now risk capital is the capital held by a risk-bearing organization to help assure that the organization will be able to keep its promises to its customer, or in the case of co-ops to its members, even

under very adverse circumstances.

Insurance companies are generally required to meet minimum capital standards that have been defined by the National Association of Insurance Commissioners, the NAIC. These standards are calculated according to risk-based capital formulas that are intended to establish requirements reflective of the risk that an organization is taking on. The standards take into account the amount and quality of the company's assets, the volatility of its future financial commitments, and other company-specific risks.

For you own thinking as a general rule of thumb, you might keep in mind that minimum risk-based capital requirements are in the range of 10 to 15 percent of premium income.

Now where does a company or an organization that's taking risk where does it get it risk capital? There are two broad sources of risk capital. One is investor, and the other is net income, a portion of that income that is retained from operations.

In the case of co-ops, initial risk capital is going to be supplied by grants as provided by the Act

with the requirement that it be repaid within 15 years. Now additional requirement beyond initial capital will be required as the risk of the successful co-ops increase. The risk is in general measured in large part by premium volume, and successful co-ops will grow in terms of membership, and, therefore, their capital requirements will grow also. They may be able to obtain this growth capital through additional grants from the Federal Government, but that doesn't appear to be the intent of the Affordable Care Act, and it would seem to violate the general notion that co-ops be required to compete with other health insurance programs on a level playing field.

So the primary source of growth capital then for co-ops should probably be retained earnings or retained net income that is not otherwise used for purposes of lowering premiums or increasing benefits.

In a member-owned organization, there's often tension between the immediate distribution of all net income to membership and the retention of portion of that income to build infrastructure or to otherwise support growth. That tension is very likely to occur

in successful co-ops. And in fact it appears to be built in to the law because paragraph (c)(5) of Section 1322 says any profits made by the co-op are required to be used to lower premiums, to improve benefits or for other programs intended to improve the quality of healthcare delivered to its members. So there's a suggestion that any net income be used immediately for the benefit of the members.

On the other hand, paragraph (c)(5) requires co-ops to meet state solvency requirements, which includes these risk-based capital requirements. So where is the growth capital going to come from?

I suggest to you that this means that premium rates need to be set, as John suggested, so as to generate reasonable level of net income; premium rates need to be adequate. And if that occurs, if the rates are set at an appropriate level and experience turns out to be the way that was expected, there will pressure not to retain a portion of these net incomes and immediately distribute it in some form to members.

So in conclusion, I urge the Advisory Board to recommend to the Secretary of HHS a requirement that

any recipient of loans and grants under the CO-OP Program incorporate in its governing documents a policy that has a couple of aspects to it: One, that the government documents stipulate that premium rates will be set with the intention of generating net income. They'll be set with a margin. And number 2, that a portion of any net income be set aside to meet projected risk-capital requirements or any such net income is used to lower premiums, to improve benefits or other quality of care, or otherwise distributed to co-op members.

So that's really all I have to say to you this morning, and I appreciate the opportunity to testify, and welcome any questions or comments.

MR. FEEZOR: Jay, thank you very much both for your comments and for the extra effort to be with us this morning telephonically.

We are now turning to a period of questions of the panel including Jay, and again, as Dave has already done, those of you who have question, if you'll turn your card up, and that way I'll know sort of what the queue line in. Dave, you get the first shot.

MR. DAVE: Paul, I guess specifically, I mean to me everything starts with definitions, and you responded in written testimony and today about the difference between how you and your association view cooperative and how co-ops are consumer operated and oriented plan. I mean what specifically should we be thinking about within our recommendations to the Secretary to make sure it meets, at least in your mind, the spirit of what a co-op is? I mean can you give us -- I mean I sense the vagueness, but I'm not sure where the specificity of what you want from us.

MR. HAZEN: Well, cooperatives have been operating for over 160 years. It's a very distinct business model, and the major differences is on the governance where the members actually control the business versus outside stockholder, so that's a fundamentally difference, but then it's also how capital is treated. In a for-profit business, you try to maximize your return on your investment. That drives the business in a certain way. You don't have that need in the cooperatives because you're operating at cost. And as Jay was mentioning, you do get into

some tensions about how much do you retain and how much do you return back to the members.

In a nonprofit, there's just any requirement. There's not a mechanism there for that consumer ownership, which actually makes the business run better because the members have some skin in the game, and that's where you get the shared risk, but we don't have the opportunity. We advocated for that.

So making sure that there is mechanisms involved with that allow the economic benefits to flow to the members so they can see if this business is successful we're going to benefit because we're going to get better rates on our insurance, the quality is going to be better, whatever those things are that the members would decide.

MR. FEEZOR: Jeff.

MR. JEFF: Thank you. My question is for Sara, and you made a key point in terms of the prices that large insurers, those with great market share or volume, can get from providers. And I was just really curious if you had an opportunity to review the Justice Department case in Michigan against Blue Cross on that

very issue?

MS. COLLINS: I have not.

MR. JEFF: Okay. I was just...if you could have chance to look at it and get back to us I think -- because I think it directly addresses the issue that you raised. Is anyone else familiar on the panel?

MR. FEEZOR: Yes --

MR. MARK HALL: I am.

MR. FEEZOR: Mark, you want to make a comment on it or just give a two-line sentence on the case.

MR. HALL: Yes. The whole issue of most favorite nation is being challenged in the Michigan lawsuit. But if a State enacts a law, the States are permitted to override essentially Federal antitrust laws, so a State could do what Sara was suggesting by law. And in terms of legal advice, you get what you pay for.

(Laughter)

MR. FEEZOR: Mike.

DR. MICHAEL PRAMENKO: Question for Jay on the phone. You had a recommendation that we recommend to the Secretary of HHS that we provide funding or allow

funding for the risk capital. Will that require a change in the law?

MR. RIPPS: Well, I'm not a lawyer, and I don't think so, and my recommendation was not that you allow it but rather that you require it -- or rather that you recommend that the organizing documents of a grant recipient incorporate the notion that risk capital -- a portion of net income is to be retained for growth capital or meeting risk capital requirements.

So I don't think that you want to make this permissive. I think you want to make it required as part of the governing documents of the co-ops.

MR. FEEZOR: (Off microphone.)

MR. BERTKO: Yes. Allen, we have I believe some lawyer in the room. Is there anybody here with knowledge of that and whether or not that would require a change in the law?

MR. FEEZOR: Mark.

MR. HALL: Well, again, you get what you pay for, but I think that we can -- I would assume that we can specify conditions for the grants, and the

conditions can call for a number of things that are in the organizing and contractual documents as long as it doesn't somehow contradict what's in the law, so -- but --

MR. RIPPS: I don't think (telephone connection interrupted) in the law. You have two requirements in the law that say -- that appear to be -- generate some automatic tension. One is that any profits have to distributed to the members. The other is that -- (telephone connection interrupted) co-ops have to meet State requirements including in particular State solvency requirements. And the question is if you don't get risk capital as a successful co-op grows from retaining a portion of profits or retaining a portion of earnings, where is it going to come from.

And I think it would be very helpful advice if you guys were to advise the Secretary along those lines because if you allow this tension to go unresolved and unrecognized there is a high likelihood that successful co-ops could run into a capital adequacy problem and things go sour they could go insolvent. It doesn't help anybody. It certainly doesn't help the members.

MR. FEEZOR: Jay, a quick related follow-up that perhaps you or John or even Donna might speak to. The current risk-based capital formula was, I guess, worked on, I guess, 10 years ago, and it's been in existence and used by most regulators and the companies. Do you see that formula getting recalculated post 2014?

MR. RIPPS: But I will certainly defer to John and Ana (ph) and invite their comments, but those formulas are updated periodically, and they don't go into effect and sort of be static. So I don't know whether they'll be updated, but the NAIC tries to keep those formulas updated to recognize changes in basic conditions.

MR. BERTKO: This is John. Let me just add to that. First, there are several components of the risk-based capitals, some of which won't change under the new law such as the kinds of assets and the risk to those assets.

The one, Allen, that you're probably referring to would be the risk that you take enrolling new people; underwriting goes away. In the short run, you

could actually make the argument that you might need a little bit higher because they'll be unknown risk coming in. I would say from my observations -- and Donna should certainly add to this -- that the components today I would describe as a safe level and an appropriately safe level, so I would think we would want to maintain those rather than -- and not be recalculating them until we see what actually happens in 2014.

MR. FEEZOR: Donna.

MS. DONNA NOVAK: Actually, if I weren't here today, I'd be editing a letter that's going to the NAIC on changes to risk-based capital. It is going to be changing; if anything, it's going to be going up. The NAIC is looking at risks that possibly were not quantified at the time it was implemented over a decade ago. There are more risk to the healthcare industry right now than there were then, so if anything, it's going to go up. And because of risk-based capital, you cannot truly have a not-for-profit because as claims go up, which they will, you're going to have to increase you risk-based capital.

MR. BERTKO: And Allen, may I add one more thing, and this has been mentioned by several people. If we have innovative arrangements with provider organizations where they're willing to take on some risk, that actually can reduce the level of capital because then the co-op entity doesn't need to cover quite that amount of risk.

(Pause)

MR. TIM SIZE: Tim, a question. It's a little awkward looking at you and leaning back to the microphone -- and that is when you were talking about having State law be changed potentially to require a lower discount or higher discount, are you aware of any precedent for that right now in any State?

MS. COLLINS: I mean I'm really not. I mean the rural health cooperatives are one example of a Federal requirement that they be able to purchase power at cost, so that's really where that idea came from. And John may have...

MR. BERTKO: Yes. The only one I know of for certain is the Maryland hospital all payer requirement, which levels out the field among commercial payers, and

I believe there is a second level for governmental payers, but that does kind of addresses this issue.

MR. FEEZOR: Tim.

MR. SIZE: I'd like to follow up on that. Again, I come from somewhat a provider perspective. I'm more interested in a level playing field rather than as provider having more forced discounts when we're struggling to keep our heads above water, so.

A similar conversation you can look at it half full/half empty. The level playing field is from a provider perspective is a more comfortable piece of rhetoric.

MALE SPEAKER: Mark.

MR. HALL: Well, Allen said that we could only ask one question at a time, but since she called on me last, I'm going to do my --

(Laughter)

MR. HALL: -- law professor trick and ask four questions in one, so here's what I'm thinking. No law is easy to write, and this certainly this law was one of the most difficult in history, and I'm starting to hear sort of a number of things that people wish had

been put into the law or hadn't been put into the law; and quickly, the list is getting longer and longer. And so I don't know if it is part of our primary charge, but I think it would be helpful to get a sense of sort of which kinds of legal or quasi-legal measures would be helpful and who would deal with them rather it would be at the State level, HHS regulations, perhaps NAIC guidance, or -- God forbid -- have to go back to Congress.

So with that sort of broad framing in mind, I have one question for each panelist in terms of potential sort of legal clarifications.

So starting with Dr. Collins, you were mentioning this partnering essentially with the large integrated delivery systems, which I think is a wonderful idea, but going to sort of the critical mass problem that John was mentioning, one way that provider-based plans in the past -- I understand this is not a provider-based plan, but let's say a provider-partnered plan -- one way in the past they have gotten their critical mass is simply to take their own employees because they're a large system already and

put them in the plan.

And looking for sources of this kind of critical mass to kind of get up and running on day one that seems like a very -- and a way to partner and a way to have a kind of a stake in the enterprise. That seems like a very attractive model that has been used a fair amount before. So I'm wondering if you agree with me that, and, therefore, if you see as a problem the apparent restriction that the co-ops can only sell primarily to individuals and small groups?

(Pause)

MR. HALL: In other words, the co-ops can't sell to its own partner because it's not a small group.

MS. COLLINS: I see. You know, I'd really have to give that some more thought. I think that one key part of the law that sort of in terms of how the landscape is going to change quite a bit is the ability of small to large employers to be able to come into the insurance exchanges. So you potentially have more customers coming into the exchange that could help address that market issue, and I think John mentioned just the flood of new people coming in in 2014 that

don’t have coverage now and the ability of small employers to bring into the exchange. So it really gets to some of the larger issues about how all the exchanges actually are functioning and how well these co-ops will be able to do in terms of attracting new members.

MR. HALL: Okay. So I understand that there might be critical mass from these newly covered folks through the exchanges, but critical mass or not, I mean the issue that co-ops would appear to bump up against their restriction to individual and small groups if they tried to enroll employees of the very health system that they’re partnering with.

MS. COLLINS: I see.

MR. HALL: Does that strike you as problematic?

MS. COLLINS: I mean are they not able to enroll large --

MALE SPEAKER: It says substantial.

MR. HALL: It says --

MS. COLLINS: -- substantial all --

MR. HALL: -- substantial --

MS. COLLINS: -- their own --

MR. HALL: -- substantially all their business must be individuals and small groups.

MS. COLLINS: Individuals and small groups?

MR. HALL: Yes. Yes.

MR. FEEZOR: Jon.

(Pause)

MR. JON CHRISTIANSON: Having been involved with a few startup organizations, I think one would take the approach, which I think is reasonable, of having a pro forma that's says, "We're going to go from 5,000 members to 25,000 or to Paul's number of 50,000," and the startup shows 5,000 members coming from a single large provider organization, the 25,000 from the community including the small employers and individuals over that 3-year period, my interpretation as a number counter would be that that might have satisfied the spirit of the law and the intent, but I would offer to let you do that.

I will say that the precedent, Mark, that you asked about on accountable care organizations is in fact how one of them that I've been dealing with has

started up to get going because it's so much easier to plop in larger employer groups all at once, and then you have that instant credibility.

MR. HALL: So that was my first question.

(Laughter)

MR. FEEZOR: That's the second one, and we're going to the third.

MR. HALL: Okay. So just sort of making, again, a checklist of sort of quasi-legal problems, John, let me just come to you quickly. Do you think the co-ops should have sort of a grace period on meeting the mandatory medical-loss ratio?

MR. BERTKO: That's really an interesting question. I actually think that it's unlikely to work in the downward direction. I think that the -- at least -- I have been involved some startup organizations, and it usually in the other direction that the loss ratio hovers around a hundred percent in being frugal, and then as you add memberships, it comes down to where you ultimately would like it to be.

But certainly on a paid basis, which is not I think the question you asked, is could be low in the

short run as people get accustomed to the system.

So the answer there is, yes, but I believe my interpretation is certainly at very low levels, under 2,000 members, there is an exemption of sorts from the medical loss ratio.

MR. HALL: And also, I mean the concern on my mind is all these startup cost. Do they get expensed right away or can you capitalize them? Because if you can't amortize them, then your first year loss ratio gets hit with all these large startup costs. Is that correct?

MR. BERTKO: That would be a question for an accountant, but there certainly are ways to spread acquisition cost --

MR. HALL: Yes.

MR. BERTKO: -- among other things. And whether startup costs would be spread the same way is for somebody with a different kind of credential than me.

MR. HALL: All right.

MS. COLLINS: And just to follow-up --

MR. RIPPS: Let me get in here --

MS. COLLINS: -- I think there is --

MR. RIPPS: -- this is Jay --

MS. COLLINS: -- an exemption for the -- the minimum loss ratio requirement is below 75,000 members I believe. It's a phase -- it's a phase up I believe.

MR. FREEZOR: Jay, were you making a comment there?

MR. RIPPS: Yes. I'd just like to chime in here that I would suggest the direction not be to mess with the minimum loss ratio requirements but rather to address the problem through the appropriate accounting and treatment startup and acquisition expenses (telephone signal interrupted) capitalizing them and, therefore, not expensing them right away (telephone signal interrupted) trying to have exceptions to standards (telephone signal interrupted) you probably don't want to go, and there are better way to deal with that problem. It's a real problem, but I think the accounting treatment is the direction of the answer.

MR. HALL: My question relates to the risk capital that's been pointed out in different ways by different panel members; $6 billion may not really go

so far as one would think for our large country and all 50 States as, again, is part of the legislative direction and then the discussion of risk capital. So my question to all the panel members is there's only two sources, the grants and retained earnings, that were mentioned; but in the private sector, there are many ways that people raise and structure capital to grow their organizations.

So I'm wondering if you see any other sources of risk capital that these co-ops as structured by the law here, not traditional co-ops, would have access to or could legally use?

MR. RIPPS: What do you have in mind?

(Laughter)

MR. HALL: Well, there's -- you can have preferred equity -- I mean there's different kinds of equity, there's different kinds of debt structures that people have, those structured things that look like loans and that people can use as capital. There are many ways that people try to structure this. There's whole companies that's all they do, structure different forms of capital that mimic equity in the simple model,

right -- I started up a company, and I put in equity, and I go to the bank, and I sign over a personal guarantee. That's the very simple, small scale model, but there's plenty of other ways. I could send you some investment opportunities that you get in the mail all the time.

MR. RIPPS: Thank you. That would be good.

MR. HAZEN: I'd have a comment on that. Our experience has been if you really want a consumer-controlled business you cannot have outside investors because they're going to want some level of control. And so it's a dilemma: I'll seek outside investment, but then I probably need to give up some level of control. And that in our view has normally created a problem because over time the investors take more control than the consumer members. So I would caution about kind of trying to mix that.

There are very successful programs in the Federal Government provide ongoing low-interest loans for cooperatives, for electric cooperatives, housing co-ops, the farm credit systems. So there's lot of precedent in the Government for dealing with this

particular issue. After the initial program get started up, additional funding is added in order to provide long-term, low-interest loans that really function like quasi-capital.

MR. BERTKO: Can I make a comment.

MR. RIPPS: The thing here is that what's required for risk capital is surplus; that is, the excess of assets over liabilities. The problem with a loan of any sort, be it low interest or long term, is that that's a liability. And therefore, depending on the accounting treatment -- unless there's something pretty creative going on -- getting a loan doesn't increase your risk capital, which is a piece of your surplus. Is that (telephone signal interrupted)?

MR. BERTKO: Terry, I think you've identified what is sometime termed a very high-class problem. And so your --

(Laughter)

MR. BERTKO: -- implicit assumption there is that growth is astounding, and I would suggest that subject to your interpretation of one of the early questions about assigning part of your premiums to a

contribution to risk capital if you have that many enrollees to start with and the 15-year-payback period you may actually be able to grow the risk capital while also paying back because you've got so many members that you can accomplish both at the same time.

My personal belief is that in the short run, the next three to five years, the amounts available are probably, I'll use the word adequate, for the growth potential of this particular kind of product.

MR. FEEZOR: I'm going to, since we're running of time, I'm going to -- Dave started us off. I'm going to let him finish up, but before I do that, Dave, Barbara, if you've trying to raise a question, I have not heard you. Are you okay there?

(Pause)

MR. FEEZOR: I mean Margaret. Excuse me, I said Barbara. Margaret.

(Pause)

MR. FEEZOR: All right. Dave?

MR. DAVE: Two years ago when co-ops were being talked about, especially in Iowa with Senator Grassley, I went to a couple of insurance commissioners

and asked them about the advisability, and they were pretty negative about the whole process of co-ops. The question I have to John and Jay are how do you perceive the process of a co-op meeting the standard of the Federal Government and then having to meet the standards of the State government? Is there some advice of how to kind of do them in a relationship that they don't have to spend twice in order to meet both sets of expectations? I mean is there a way for us administratively to kind of allow things to kind of happen in unison or tandem or some kind of cooperation between the Federal Government and the individual State governments?

MR. BERTKO: Well, let me allow Jay to respond to this, but I think in many ways prior oversight at the State level has been -- let's see, I'll try to be at tactful as possible -- mixed bag with States like Jay's and many others being pretty active, other places not being so active. And many of you are aware of problems with BWAS (ph) and other things that kind of slipped through the cracks on regulations.

And so I would hope there would be, first of

all, very active level of oversight at the State level and then a combination of your oversight along with OCIO as being quite active in making sure these things happen because we are -- I can point out that, as most of you know and through this last big recession, insurance companies have been one of the few financial institutions being well-regulated that didn't come apart at the seams. And so regulation has succeed and better coordination, I think, in keeping up the oversight level will keep bad things from happening.

MR. FREEZOR: Jay, John, Paul, and Sara, thank you all much. And the one thing I would ask -- I'm following up on Paul's offer and then applying to all four of you -- is that in the weeks and months ahead that not only that this Board might not be able to call back on you in terms or your expertise on some specific additional information but also that you might serve as a potential technical assistance group or at least some names that we might put on technical assistance to help some of the folks who might be interested in starting co-ops.

Let's give the panel a very nice thank you and

welcome.

(Applause)

MR. FREEZOR: And if the panelist would go ahead and proceed to the table and Barbara will chair --

MALE SPEAKER: Mr. Chairman, a procedural question.

MR. FREEZOR: Bill.

MR. WILLIAM OEMICHEN: There were a number I would have liked to ask. I understand the timing. Is there an opportunity to ask the panel member in writing questions outside of the meeting today?

MR. FREEZOR: Yes. We will collect the questions -- and I'm looking back at staff in doing that -- but, yes, absolutely if you would. Whether you want to do that now or do it when you get back or do it on the plane and email them back, we'll get some follow-up. Good point, Bill. Thank you.

MS. BARBARA YONDORF: Hi, I'm very pleased to introduce the next panel, which is about consumers, which is actually in the name of the co-ops, and we've got two terrific people today who are colleagues of

mine. The three of us are actually among about 13 groups nationwide representing consumers who are sort of official representative to the National Association of Insurance Commissioners representing the consumer interest in those debates.

And I have to laugh because we were sort of smiling back and forth when we touched on the minimum loss ratio issue because we just went through that spirited discussion, and in part, the thought of opening up minimum loss ratio even though they didn't turn out perfectly from a consumer point of view is something we'd look at with great hesitation probably.

I also noted that Beth and Sabrina were sitting in the front row, and that's our job at the NAIC, to sit in the front row and let the commissioners know that the consumers are there.

So, again, I'll be brief. Beth is the Director of Administrative Advocacy at Health Access California, and was formerly the regional administrator of the Centers for Medicare and Medicaid services for California, Arizona, Nevada, Hawaii, and the Far Pacific.

Sabrina is a research professor at the Health Policy Institute at Georgetown University here in Washington, D.C., and she directs research on health insurance reform issues. Prior to joining the institute, she was director of health policy programs at The National Partnership for Women and Families. Thank you.

MS. ELIZABETH ABBOTT: Good morning, everyone. I'm glad I'm not participating like those from California. I'm very delighted to be here, and thank you so much for the invitation. Can you hear me all right?

(Pause)

MS. ABBOTT: I guess what I would say is our principal interests in this are the fundamental principles that consumers require and deserve the same consumer protection regardless of whether their coverage is provided by a cooperative or an insurer, and that is sort of baseline.

Our second fundamental premise is that co-ops are intended to be responsive to the members and that their governance must be dominated by consumers.

I guess what I would comment on initially is that co-ops run the danger of either succeeding or failing. And by that, I mean that if they fail and they as a result are unable to provide services to their members and cause financial hardship to consumers and providers, this is not a good thing for anybody. And if they succeed, they become a target of opportunity to be bought out by an insurance company or to be spun off and actually not serve as a cooperative.

So how is it that you're going to structure these health insurance cooperatives that you can assure strong consumer protections for the consumers who are relying on getting their coverage through co-ops. And I have in my written testimony some recommendations, which you will perhaps be able to take a look at, but here are a brief summary of what those are.

The first is that fiscal solvency is the ultimate consumer protection, so if you are granting to have exceptions made that would not require this of co-ops, my proposition was that that would be a mistake. Now I'm not necessarily saying that you might not want to have certain transitional opportunities and other

things that would make this more feasible because you're actually starting off from scratch, but in general, I would say cooperatives should be required to meet rigorous financial solvency standards that would ensure their ongoing ability to serve their customers and remain in the market.

The second recommendation is that cooperatives should have the same requirements and regulations that apply to other delivery mechanisms or the industry at large, and these include -- and this is what I do for a living. Actually, I work for Health Access half-time, which is true, but I work for the NAIC full-time. Only Barbara, Sabrina, and I would find that amusing. What a lot of work it is to be an NAIC consumer rep, and the pay is not great.

(Laughter)

MS. ABBOTT: It's like nonexistent. But consumer protections that we think should apply are those involving licensing, network adequacy, claims processing requirements, credentialing, timely access to care, cultural and linguistic access, access to care, reserve restrictions, internal controls, and

other financial and audit requirements.

As other people have mentioned, I'm actually quite hearten to hear other members of the panelist and the Board comment on these kinds of things implicit in your questions and in the testimony because I think they're very supportive of this, so sounds like you have the right people on this Board. Congratulations, and my good wishes to you because this is a big job you're doing.

Co-ops must have a sustained program of oversight, and this has to be including database monitoring such as tracking of enrollments and disenrollments, periodic assessment of adequacy of provider networks, tracking of consumer and provider complaints, the timeliness of claims payments to contracted providers and other vendors, which I would posit to you is sort of the canary in the coal mine for when you have financial difficulties in an entity that's ensuring risk, and the rate of appeals overturned by third-party adjudicators, etcetera.

The remaining recommendations I have I'll briefly summarize will have to do with the governance

of the cooperatives, so let me tell you what I think that should look like.

Consumer representatives should the majority of the governing board. I observe and actually sit on a few boards in California, not of cooperative but of other entities and state and quasi-state organizations, where there is one so-called consumer representative, and it is really a battle to have the consumer point of view to be not overshadowed by the professional representatives on the board, so it should be actually a substantial representation of consumers. And I urge you to set that up as a way to do that I've included in my testimony some model language from California law which might be of interest to you.

The expertise of the consumer representatives should be drawn from people who are not just charming amateurs but people who are drawn from knowledgeable sources who have their own credentials and expertise and can hold their own in debate on decisionmaking things that come before the board.

And California has -- there are many things we don't do right in California. You'll forgive me, Mr.

Ripps, for saying that, but there's some things we don't do perfectly in California. We're going to do them better I think shortly --

MR. RIPPS: (telephone signal interrupted).

MS. ABBOTT: -- but the statute in California actually specifies what areas of expertise that the consumer representative should hold, and they need to have expertise in two of those areas to be considered credentialed for board service. The governing board members must be held to standards to protect against conflicts of interest, and there have to clear and unambiguous standards that prevent them from profiting from serving on the board.

The standard in California is $250 within a 12-month retroactive and prospective period. There have to be protections against people taking advantage of their board service to make profits and gains. This could be providing counsel on valuation of assets as well as acquisitions and in turning things from nonprofit into for-profit entities, which many States have to deal with.

Consumer representatives must be accountable.

If they in turn are supposed to be representing a constituents subconstituency, there has to be a way for them to be accountable to that membership and for them to report back to and be removed if they are not performing their duties faithfully to their constituency, and there must be very high standards regarding openness, transparency, and accessibility for the deliberation decisionmaking by the board. And these I think are fairly common in many State laws, open meeting kinds of laws. We're at a FACA (ph) meeting now, which would meet several of those stipulations, but they have to be advanced notice of the timing of meetings, accessibility to the meeting location, no cumbersome application or registration for attendance, no fees or assessments as a prerequisite, and the time of publication of the proceedings of the meetings.

I want to tell you one last final anecdote. Before I became an NAIC consumer rep, I attended the NAIC meeting in San Francisco to sort of see how that took place, and they are open public meetings or so-called. And I attended the healthcare reform meeting

that the NAIC hosted in this huge hotel in San Francisco, and I was required to pay $650 to attend a 2-hour meeting, but I did get a cookie as a result.

(Laughter)

MS. ABBOTT: There was lots of information given, but that is a prohibition to a lot of people participating in a meeting, so you can't have stuff like that. And it is those things we don't really think about that are deterrence for people to participate.

I wish you great, good fortune and wisdom in the task you're undertaking, and I'll look forward to questions after Sabrina is done.

MS. SABRINA CORLETTE: Thank you, Beth, and thank you all for the opportunity to testify or talk to you all today. First and foremost, I want to thank you very much for your willingness to serve on this Advisory Board. As Beth said, you have a big job.

As envisioned certainly by the congressional authors, this provision of that ACA I believe as well holds great promise for consumers who are seeking better options for affordable coverage; but in order

for that promise to be realized, it's critical that you and your partners at HHS articulate principles, priorities, practices, governance rules, etcetera, to ensure that co-op plans do function in the best interest of consumers.

In my testimony today, I'm going to address, first, why consumers need viable alternatives to traditional insurance; second, what characteristics co-ops must have in order to be truly consumer operated and orientated; and third, what it means to be a consumer representative.

Co-ops provide us with an opportunity to bring new competition, choice, and accountability to insurance markets. Most individuals and small business owners purchasing coverage today face an insurance market that is simply not competitive. For example, the AMA found last year in a report that in 24 of 43 States surveyed the two largest insurers had a combined market share of 70 percent of more. The year before it had been 18 of 42 States, so in essence, the markets are becoming less not more competitive.

The lack of competition has many consequences,

but a major one is the lack of any incentive to control the growth of healthcare cost. Many of you may have seen the recent studies done by the Massachusetts attorney general that found that one of the biggest drivers of health insurance premium increases in that state was the fact that carriers were doing little or nothing to check reimbursement increases requested by providers. They were simply passing them on to purchasers without any real tough negotiations with providers.

One way to control cost, of course, which was discussed during the healthcare reform debate at length would be through a public plan option that would have sufficient capitalization and market clout to drive tough bargains with providers. But of course, that history has been written. The public option was dropped from the healthcare law, and the co-ops were essentially conceived as a compromise that would appease progressive because they would be consumer led and driven.

So now it’s time to implement and for co-ops to live up to their name and their promise. Certain

governance and operational requirements need to be put in place and need to be conditions of their receipt of any grants or loans from the Federal government. I'll just tick off a few, and a fuller list is in my written testimony, so I hope you'll take a look at that.

But certainly, I think that inclusion of consumer representatives in the planning and development of grant proposals for this program needs to be in place. There needs to be transparent, clear procedures for consumers to become members of the co-op. There needs to be transparent written bylaws that facilitate the involvement of consumer representatives in co-op governance including strong conflict of interest rules, open meeting, rules for the selection and election of board members including requirements for a balance between consumer representatives and substance experts.

And I'll just pause and say for a minute that I completely agree with John and, I believe it also, Jay who mentioned the need to have insurance experts running the plan and focus on making it a sustainable and stable business; that that is, of course, the best

way to help consumers. There also needs to be opportunities for consumer representatives to participate in governing or advisory committees as well.

It's important that there be written descriptions of staff roles that include clear expectations for member service, consumer assistance and support, and compensation structures that reward timely and effective consumer service and support.

I'd also like to say a word about what it means to be a consumer representative, and Beth has mentioned this as well. I do believe this term needs to be clearly defined because it's a term that often misinterpreted. After all, whether you're a doctor, a broker, a drug manufacturer, or an insurance industry executive, we are all at one point in our lives a healthcare consumer.

Essentially, a true consumer representative is someone who works for a mission-driven nonprofit, represents a constituency of consumers or patients. A consumer representative is focused on the needs of consumers and patients, lacks financial stake in the

healthcare system, makes decision independent of industry needs, and is part or an organization that is publicly recognized for advancing the interest of consumers. Examples would be the American Cancer Society, U.S. Perv (ph), AARP, the American Diabetes Association. Those are all examples of consumer representatives.

I also agree with Beth, however, that you can't just pull somebody off the street and ask them to serve. These folks need to have credentials on their own and substance expertise. Many of the organizations I just mentioned, of which there are a myriad around the country, have that kind of expertise on tap and should be utilized in this program.

You have before you the critical task of defining what it means to be consumer operated and oriented in order to ensure that these new entities live up to their promise of providing the viable alternative option for consumers and small business owners. Thank you for taking on the challenge, and thank you for inviting me to talk with you today. I look forward to the questions.

MS. YONDORF: Thank you very much. I'm going to start at this end of the table and work around, and I'm not -- I don't want to call on these lawyers who might ask four-part questions.

(Laughter)

MS. YONDORF: No. I'm teasing you, but start with Tim.

MR. SIZE: Thank you for your comments. I'm assuming -- and this question is coming from a rural perspective, a setup question. I'm assuming that most co-ops through the statewide, regional nature will be a mix of communities that are both urban and rural; so, therefore, they would have probably consumers that represent those communities. But probably usually the vast majority of the consumer representatives on the board would be from urban communities.

And my interest is how do we assure that we protect the rural minority interest in that context and particularly around issues of network adequacy where you get some tensions between -- I mean the most urban point of view is "Well, they can just travel into the center." And obviously, the rural point of view is

“No, you need to develop a more robust provider network in the rural area.” So from a consumer rep balance on the board, how do we deal with that?

MS. CORLETTE: Well, I’ll let Beth address this as well, but certainly in terms of balance, if it is a plan that serves members in rural and urban areas, I think one thing you’d want to see, for example, is when they have meeting they’re not just in the major urban centers, that perhaps they have field meetings where they go out to the communities that they serve that are more rural. And certainly, you could have a requirement that the Board has some geographic balance to it so that the representatives are from the communities that they serve.

And I should say that while many of the consumer organizations and patient organizations might have their offices in an urban area, they often have representatives that live in the communities that are less urban. So I would just encourage those plans to make sure that they have geographic diversity.

MR. SIZE: That’s important. My question assumes that diversity. My problem is essentially

consumers themselves can have different interests, and I'm assuming that on most boards that unless it specifically kind of a rural market, and I think that may be the minority of such co-op plans, is how do we assure that the minority of rural consumers that their interests that are different around access standards perhaps and around network adequacy that they're protected?

(Pause)

MR. SIZE: I don't know the answer to this question by the way. It's an honest question.

MS. ABBOTT: I don't think I know the answer either. I think it involves some pretty careful recruitment of people to be on the board. I have been surprised the number of consumer organizations that have sprung up in rural areas or span small communities in rural areas that actually bring a rural focus, and there are, as Sabrina says, a number of organizations that have as their mission nonprofit consumer advocacy that have branch office and field stations and outreach centers and affiliates that have been very successful in bringing that. We're a coalition-based

organization, and we have tapped into a lot of faith-based organizations that are really excellent spokespeople and often represent broad geographic diversity and rural points of view, and they have been wonderful members or our coalition and have in turn spoken out on behalf of this.

I think it is often that you find that you want some who has a little experience being a consumer advocate, and in the rural areas, they often are found through these kinds of networks, so I think it takes a little effort, and I think it's worthwhile and bring a much better quality of advice and counsel and governance if you are able to do that.

MR. SIZE: Thank you.

MALE SPEAKER: Thank you for your testimony. One of the advantages of having nonprofit and the whole idea of the co-ops is it provides a better level of trust when decisions are made about maintaining viability of an insurance company and also our system as a whole. I mean one of the things we're facing is cost containment and really wasn't addressed all that well in the bill. It's one of the things that

deficient.

My question is as we move forward on viability whether it's the co-op for our long-term sustainability delivering healthcare in this county as consumers -- and I'm certainly in favor of having consumer-driven co-ops -- but what is the danger or do you see it viable that we would engage in value-based benefit design? And as consumer advocates would you support here today the necessity of seeing how we need to drive that direction if we're really going to sustain these systems with value-base benefit design?

MS. ABBOTT: Well, I don't want to speak necessarily to the merits of value-based benefit design. I certainly think there are ways to do it that will inure to the benefit of consumers, and there are ways to do it that may be more problematic. However, I do think that if you have a plan that is truly consumer oriented and operated the willingness of the community to take on some of those cost containment issues, looking at comparative effectiveness, and covering treatments that are shown to be effective, when that's coming from a plan that everybody recognizes it's

consumer led and driven there might be more willingness to say, “Oh, yeah, you know, comparative effectiveness, value-based benefit design, we are willing to work with that plan.” Whereas when it’s sort of us versus them kind of dynamic with the traditional insurance, sometimes they’re just seen as the, you know, the green eye shades, and they’re only doing it out of cold hearted greed. So I think that is -- gives me great hope for the future of co-ops being able to take on some of these delivery system issues more effectively.

MR. SIZE: I guess what I’m trying to get at is do you see a problem with a majority running the board in conflict with being able to do value-based benefit design?

MS. ABBOTT: I do not inherently. I think it’s all in sort of the way it’s done, the way it’s communicated, how it appears to people, the level of trust that it engenders. So I don’t think inherently it’s a conflict. Part of my CMS background is coming out, and when I say this and the confluence of that and advocacy that I think we do have to do it. We’re spending a bloody fortune for healthcare, and we need

to do it much more effectively and much value for that. And we have to -- we cannot superimpose that on patients and their families. We have to be able to make people realize that, so I think it's both arts and science in doing that.

MALE SPEAKER: Ms. Abbott, you made a comment very early in your testimony I just would like to explore a little bit further with you. And let me make a quick --

MS. ABBOTT: Mistake. I didn't say that.

(Laughter)

MALE SPEAKER: Let me quick make a contextual statement. I agree with Mr. Hazen that we're using the work co-op quite a bit because that's the acronym used in the statute, but the entities here may or may not be cooperatives, and that goes to my question to you. You said that these entities whether they're co-ops are not should meet the same standards everybody else has to live with. In Minnesota and Wisconsin law it's very well-settled how to form a co-op, how it has to be designed from a governance perspective, it's very prescriptive. Because of that,

because they're member owned, member led, then Wisconsin, Minnesota law gives quite a few exemptions to cooperatives that are not available to noncooperatives businesses. Some are in healthcare, but they're in lots of other areas. Does it make a difference to you if, for example, the governance recommendation we made to the Secretary we said to the extent that this entity is formed under State cooperative law and fully complies with that cooperative law that if may not have to meet the same requirements that you might say would have to apply for nonprofits that do not meet that State's cooperative statute.

Is there a valid distinction there in your mind or not? And Ms. Corlette, certainly, feel free to respond to that as well.

MS. ABBOTT: I think that my general testimony was framed by my experience in California where financial solvency standards were clearly not met, and exceptions were granted which I would say were wholesale, and they did not approximate statutory regulation that anyone would like or admire or see in

retrospect as valuable to the financial viability and sustainability of an entity providing risk-based care.

I can't -- I'm certainly not an expert on what the requirements are in the States that you mentioned. I think there can be -- I think there are lots of challenges in getting co-ops up and running, and I think when you're starting fresh, which is both an advantage in how you do the benefit design, it is also hard to start without playing Little League to start sort of in the World Series or the playoff.

And so I think there may have to be some acknowledgement of standards or lessening our transitional aspects of it, but I do not think they should get a free pass, nor do I believe that's what you're suggesting. And I think there have to be clear standards that people meet that everybody understands that helps build the public trust that these are organizations that are not here today gone tomorrow. And it sounds like, particularly in several Midwestern States, those standards have been enunciated and have been protective of consumers, and I think you probably are a better judge of that than I.

MS. CORLETTE: The only thing that I'd add is in my view there is nothing particularly magical about being called a co-op in the ACA provision. The fundamental problem is the lack of competition in most health insurance markets today, and to the extent we can think of ways to engender more and greater competition in these markets and if -- I don't know what rules might need to be bent or, as Beth observed, transitional rules need to be put in place. I would say that's true of almost any startup plan that's trying to break into a new market that is highly concentrated; that regulators need to think about how we can encourage competition while balancing that with the necessary consumer protection.

MS. YONDORF: Just a comment. We've got one, two, three, four more questions, which is great, and you can have an opportunity to ask all that. I would just request that we keep the questions succinct and the answers, and recall that if there are more questions you have we're going to take those, and ask you to respond to them in writing. So, next, Pat.

MS. PATRICIA HAUGEN: My question is to both of

you, but I'll start with directing to Ms. Abbott. In your comments, you have suggested that oversight of the consumer that the focus should be on their competency, the experience, the credentials of those individuals in order to contribute appropriately. And as I listen to Ms. Corlette, you seem to focus on that individuals should actually work for a specific organization.

And I guess I'll direct to Ms. Abbott to give us some of your experience relating that because there is some diversity out there that working is not necessarily the competence credentialing that requirement for successful oversight on the part of the consumer. So if you can comment to that question.

MS. ABBOTT: I think there are sort of two models, and one of them is sort of an expertise pattern or standard, and one is membership or affiliation with a particular organization. I don't know necessarily that you can insist on both for you consumer representative, but I think having -- I have not been but I have observed the California State Board of Pharmacy that has one consumer rep, and that person is not a pharmacist, and it's senior who's very interested

and articulate, but he does not have any professional background that particularly qualifies him. Everyone else is a chained pharmacy member or a pharmacist. I know this is different than what you all are charged with, but the consumer voice on that board is completely overshadowed.

So I think -- what I'm trying to express is that there needs to be -- which ever model you pick, someone has to be able to hold their own in the debate, and how you fashion that I think can follow a couple of models. But I think the outcome has to be the same.

MALE SPEAKER: My question was rhetorical, so I was thinking about passing, but maybe I'll just make my point and not in the form of a question just sort of a comment in terms of what I'm hearing and learning.

Up until about a week ago, I thought I knew what a co-op was; but in the process of preparing for this meeting, I'm realizing that I'm much confused. And think there's sort of this "you know it when you see it" sort of phenomenon. We're looking for the sort of ineffable attributes of consumer oriented and member

oriented, and to that extent, I think your testimony and the suggestions in your written materials are very, very helpful.

But I guess I'm skeptical of sort of trying to define that in any sort of kind of corporate organizational way because we're hearing about organizing as an official co-op or mutual insurance company or -- the statute uses the phrase "nonprofit member corporation," which are sort of legal words of art. Even the question of what's a member I think is sort of fuzzy. I mean we're talking about consumers, members, policyholder, purchasers. Is the employer a member? Are all policyholders members? Is the family unit a member? Or the does the agency cover life of the member? [1:37:22] All these things I think are sort of could be done in different ways.

So I guess at the end of the day I'm thinking that kind of a diversity of approaches makes sense in terms of the governing and corporate structure. So I'll just say that in terms of a comment and see if there's any sort of fundamental disagreement with that philosophy.

(Pause)

MALE SPEAKER: No?

MS. ABBOTT: No.

MALE SPEAKER: All right.

MS. YONDORF: Dave.

DR. DAVID CARLYLE: Thank you for your comments. I appreciate the essential voice of consumers in the planning, maintenance, and governing of the organization but have a concern about what I think is a bit of a conundrum. In FQHCs, they have that same requirement of the 51-percent rule, which is often just great. But given some of the varying needs of the organization that change from time to time, having a mandated representation of a membership not based on specifics skills that may be needed and given the changes that would take place within the first few years of a co-op makes me a little bit uncomfortable.

And I wondered if there are other models that we could look to for getting that essential voice of the consumer yet also getting the skill set that we need for solvency?

MS. CORLETTE: Well, you might have hit on a

little bit of a disagreement between Beth and myself, and I'll have Beth jump in and clarify if there's not a disagreement.

In my testimony, I talk about the need for a balance between consumer representatives and substance experts on the board, and I think that is important. This plan needs to be run by people who know what they're doing.

So it may not be possible in some communities to have a majority of the board be "consumer representatives." What I do think is absolutely critical is clear conflict of interest rules, and I think the legislation already has a provision barring insurance industry involvement in the governance. But I think particularly if this entity is going to pursue innovative delivery system models you need to be very careful about provider participation in the board and capturing of the governance. So I actually am not wedded to necessarily requiring a majority be "consumer representative."

MS. ABBOTT: I think what I mostly wanted to say in my testimony is I do not think that the consumer

orientation and operation provision is met by having a sole consumer rep that is a token, that is easily overwhelmed, and serves no one's interest. So I actually am a great believer in competency. I guess I would argue that the consumer representatives would have to have a competency all of their own, but I don't disagree with how Sabrina has framed this and the subtext of your question.

DR. CARLYLE: Thank you for the remarks. In rural Iowa growing up, we had grain co-ops and part and parcel of member involvement was also member responsibility. What's your sense of mission-oriented requirements of a co-op member? Is that possible at all? If it is, is there nuances that seem understandable? Obviously, you can go too far, but at least in a pure sense if you take the diversity, it appears that the co-ops there was some kind of give and take, a two-way street.

MS. CORLETTE: Yes. I think one of the previous panels mentioned that one of the things that make co-ops, co-ops is that the members have skin in the game. And this also goes a little bit Mark's

question about what's a member. Is it every covered life? Or is it folks who sort of voluntarily take on that role and meet certain requirement. In my testimony, I say there needs -- to the extent that's the case, there needs to be clear requirements as far as what it means to be a member. And I'd be happy to do more thinking about what those requirements might be, but I'm not necessarily thinking that every covered life needs to be a member, but you may want to have some rules and parameters around that. But whatever they are, they need to be transparent.

MS. YONDORF: Thank you very much, and we really appreciate it, and thank you.

(Applause)

MS. YONDORF: And can I ask both of you the same question we're going to ask all the panelists? I'm going to phrase it as this: You don't have any problem if we call on you --

(Laughter)

MS. YONDORF: -- for more advice and counsel do you?

(No audible response.)

MS. YONDORF: Thank you. We --

MS. ABBOTT: It is a coupon without expiration.

(Laughter)

MS. YONDORF: Yes. And we will give you a cookie.

(Laughter)

MS. YONDORF: We're going to try to reconvene promptly at 10:30 so we stay on our agenda.

(Break)

(Off the record)

(On the record)

MR. FREEZOR: ...I think our panel increasingly more important some the task that his Board -- some of the answers or suggestion, recommendations that this Board is going to have to come up with.

And the panel that we have in front of us and by phone are going to focus in on some of the issues that new nonprofit plans face in starting up. So we think Mark will be very familiar with what we're all about.

We have four panelists, one participating by phone. We will hear, and I think in this order, lined up this way is Cindy Palmer, who is the CEO of Colorado Choice Health Plans, which is a not-for-profit health plan serving rural communities in southern Colorado. She's previously served as CEO and associate administrator for a multispecialty medical group practice in Southern California.

Next we will hear from Mary Dewane who served as vice president for Medicare and Medicaid program for the Schaller Anderson, which is a healthcare/management consulting firm that many of us probably have had the pleasure of working with on a variety of issues.

We will then hear from Mark Reynolds. He's the Chief Executive Officer of the Neighborhood Health Plan of Rhode Island, a 78,000 member HMO that is a fairly recent startup, but is going quite successfully.

And then our last speaker and I think somewhat unique but I think will have some very insights is Amit Bouri, and I hope I came close on that, who is Director of Strategy and Development at the Global Impact Investment. He works with a lot of international

foundations and -- this is my layman's term, so you can correct me a little later -- in terms of how private foundations, international foundations, and government programs might complement each other to advance social programs and social issues.

So that is the lineup. Cindy, if you would lead off, you're welcome.

MS. CINDY PALMER: Thank you, and I appreciate the opportunity to (inaudible) and speak to you today. As was stated, I am the CEO of Colorado Choice Health Plans, a nonprofit oriented organization that has been serving rural Colorado, southern Colorado, for over 35 years. It is a co-op. It got its start in the early '70s under a Federal program. It had a Federal grant and a Federal loan to help it get organized, and in 1990 when it made its last payment on that loan, it was one of only three of those plans in that program that was still in existence.

The plan was started in the San Luis Valley region of Colorado. The San Luis Valley is a geographically isolated area in south central Colorado. It's surrounded by mountains and comprise of six

counties. All of those counties are designated either rural or frontier. Those six counties have a population of now about 46,000 lives. Three of those counties are in the 10 poorest counties in the state, and we're in what has generally been known for a lot years as one of the most economically depressed areas of the State of Colorado. So it's in a tough road.

The plan was started by the community to provide services to this underserved rural area. It originally operated as both an insurer with an HMO license and actually as a CHC and had clinics in some of the most isolated rural communities that it served.

It moved away from that model when a local community took on an FQHC designation and took over that program.

The plan was self-managed in those early years, but due to the need to implement new technologies and broader service, it entered into a management contract with a larger insurer in the state of Colorado that did not compete in the same service area, and it stayed under that model until 1998 when it moved away from that model.

It moved away because the plan felt that the company that was providing all of the management services really did not always have the best interest of this plan in place, but it was doing a lot of the function, the administrative functions, that it did by rote. The plan did keep -- it had its own executive director, and it had its own sales force. And it continued to be governed by the community board, but it felt that it really needed to grow to be able to continue to be a viable, sustainable health plan going into the future and that the best place for that focus to come from was really within the plan itself and its community board, and so it took all the operations back in house.

Where it got into some trouble was even though the executive director, even the community board had had some long-term players on the board, the executive director had been the executive director of the plan for eight years. They did not understand what it really took to manage the operations of health plan. And so within 18 months of separating from that contract during which time it needed to put its own

infrastructure place and find a viable system, a lot of bad decisions were made, and it really was prepping for this when it was unwinding the contract.

They brought a system that didn't meet their needs. They really did not understand the magnitude of what they were undertaking, and I think while I'm under the heading of new startup, this obviously is not a new startup, but everything that we went through, that the plan went through during that timeframe is very similar to what a new startup would have to go through.

I actually came to the plan when it was in that situation. It had fallen to statutory net worth reserve of $250,000 when the State of Colorado had a $1 million minimum requirement. And the Division of Insurance had put it under supervisory order, and I actually came into the plan consulting one day off of when the supervisors were appointed by insurance commissioner came in. So he and I worked hand in hand over several months to really figure out if it made sense for this plan to continue running and what they needed to do in order to continue to operate.

And I've deviated a lot from my written

testimony it -- when I got there, what we did was we started looking at everything, and he had an actuarial background; I had more of a finance and operations background. And we looked at every aspect of the company and said, “You know, what’s not working? How do we really” -- the Division of Insurance had given the plan time to try and turn around. But you had to say, “Okay, what does it really take to turn this thing around?” And we started looking at every aspect of the company.

It became very apparent that they had made a bad decision on the system. It wasn’t meeting their needs. They were struggling to get claims paid; accounts receivable hadn’t been reconciled in month; their enrollment was not reconciled; it was in poor shape. Basically, every place we looked it was broken. The provider community -- our local rural provider community had stayed very committed to the plan, and I think that’s the value of being community oriented. But being rural, 50 percent of our care is delivered on what we call the front range, Pueblo, Colorado Springs, Denver area, and those providers were not so

understanding.

And so when I came onboard, the biggest hospital system had either canceled their contracts or were threatening to cancel their contract. A lot of the specialists were in the same boat, so you're looking at a company that has a system that doesn't work, operations are out of control, its network is falling apart, and it's in financial distress.

And we were able to go through the company and work with all the different aspects. We had good personnel. There were good staff people, but there was not good management. And the people that have talked before have talked about the need to have people who truly understand the industry and what it takes to operate, and that's exactly what happened to this company. You had people who if you gave them a good system, by golly, they could pay claims; but if you gave them a poor system, they couldn't make it work.

And so the staff was basically hampered by the decisions that had been made by an executive director who had eight-year experience, but it was relevant experience. And we were able to turn the company

around.

One of the first things that I did as consultant was an RFP to go to another management company, and said, “Okay, this isn’t working, you know, the first thing you need to do is to look at -- to do this” -- two things. Number one, determine whether or not it makes sense to try and save this health plan or does it make sense just to sell these members to another health plan and let it go. Number two, then, if we decided that it make sense to save this health plan, we need to go out to another management company because there is not management in place here that can do it.

And we went through an extensive exercise with the board, with the provider community in our area, and the decision was made that this entity created value for the consumers in our area that they felt that another health insurer would not.

So in order to bring the statutory net worth back up to a more reasonable area -- and you had talked about are there financing mechanisms. One mechanism that is available is the ventures, and the providers

stepped up to the plate and put the ventures in place to bring the statutory net worth up to $750,000. And as the ventures could not be paid back without the approval of the Division of Insurance and until there was enough funding in the company for the company to be financially viable. Then the providers could get their loan repayment or their venture repayments back.

The ventures brought it up to $750,000, and we were able to turn the organization around. We've now been in -- we're 10 years down the road from that, but think the most critical thing to really take away from this story is that you have to have people who understand what it takes to operate the business. And it maybe isn't necessary always wisest to rent all of your infrastructure, to really hang onto some of your own operations and that commitment to your community. Thank you.

MS. MARY DEWANE: Thank you, and good morning. I appreciate the opportunity to be here. I was asked to talk about starting up a large public Medicaid managed care program, CalOptima, one that shares certain characteristics with the cooperative,

and I'll let to briefly describe CalOptima and highlight some of our experience that I think are relevant to the co-ops.

First of all, I'm here because I was the startup CEO for this managed care entity. I was hired by the board of directors in 1994 to start up a program, and it went live in October of 1995. CalOptima is a government entity that provides Medicaid coverage services to virtually all Medicaid eligibles in Orange County California.

Starting in 1995, it operates under a Congressional designation known as a health-ensuring organization, which among other things means CalOptima is the single healthcare authority for administrating the Medicaid program in Orange County. CalOptima operates under the contract with the California State Department of Health Services. CalOptima's board is appointed by the Orange County Board of Supervisors, but other than this, the program operates completely independent of the county.

Today CalOptima serves 350,000 Medicaid-eligible individuals and competes with other health

plans to serve the CHIP and dual-eligible population in that county.

There are important features of CalOptima that are relevant to the co-op model that I would like to elaborate on. First of all, the provider network development. We looked at various ways to contract with providers to ensure the care would be coordinated, and we ended up with rather unique model: We contracted with at-risk, independent physicians associations to provide the physician-care component, and at-risk hospitals provide the hospital-care component and all of the attendant services on both side.

In addition, we required each entity to enter into a risk-sharing agreement with each other to incentivize high-quality, low-cost care. The IPAs and the hospitals were required to sign MOUs to ensure mutual coordination and cooperation and provide the covered services to members in a quality manner. We call these entities physician-hospital consortia, PHCs, or health networks.

Of note is that over time many of the PHCs

ended up not reaching critical mass of enrollment to remain financially viable and mostly consolidated with other health networks. At least the providers and the hospitals were consolidated in with the other networks as well as our paying particular attention to keep the physician relationship intact. But I think that has something of relevance here today.

Consumer and marketing issues. Early on, we recognized the importance of social services workers, cultural centers, physicians, and office staff as sources to provide information to enrollees as well as the important of the patient-physician relationship in maintaining continuity of care. The patient-physician relationship also assisted our PHCs health networks in obtaining market share and maintaining viability in the changing market. The importance of physician recruitment should not be underestimated by the co-ops.

On financing. Co-ops need to be financed for both startup and operations periods. Delays in startup or failure to attract sufficient number of enrollees based on (inaudible) estimates will create serious financial issues and co-op failures. The exchanges

will be new too, and the co-ops will be dependent on them to run smoothly. If any part of the system is delayed, it will be very costly to the co-ops because they will be ramping up for enrollment on whatever chosen date you have.

Medical management. Co-ops will need to hire a disciplined medical director to oversee management of members across the continuum of care and to detect high-cost, high-need patients. High-cost members are a relatively small subset of the population but a very important one to manage. The last healthcare company I worked for, for example, which was Schaller Anderson found that just 2 percent of the population of a commercial customer of their drove 50 percent of the cost, and this is not unusual, and this is -- we pretty well see this across all populations. Creative approaches to identify high-cost members such as health survey questionnaire or use of pharmacy data to identify high cost is very important.

Financial management issues. Most importantly, and I reiterate here, co-op rates need to be risk adjusted. Our experience is that high-cost

patients gravitate to certain health plan due to certain provider networks and programs such as centers of excellence, university hospitals, children's hospital, etcetera.

The exchanges or State should also consider limiting, I believe, the med loss ratio, the medical loss ratio to 85 percent. This meant that 85 percent of the premiums would go to providing healthcare, and no more than 15 percent to administration and profit. I know this is contentious. We've put this into play at CalOptima for our health plans and networks that we put at risk, and ultimately, the State of California has adopted this for all the health plans.

Anticipate higher frontend cost for persons who are uninsured prior to coverage. Experience has shown that people will delay care that is medically necessary but not emergent.

Information Systems. I stress that IT will be the backbone of the co-op and central to running all aspects of the program. Select your contractor very carefully. IT support is critical during the development and startup phase for all of the co-op

operations and will need a vendor's undivided attention. On the buy-or-build argument, I would lean toward buying it not building it yourself from somebody else at least for the short timeframe.

Human resources. John Bertko and Beth Abbott both mentioned this, and I'd like to reiterate it. The skill set of the board is critical. It should be composed of active and well-respected members of the community and their professions who have strong financial and managed care background and strong local connections. I can't stress the financial backgrounds of the board and their experiences enough.

The staffing. As Cindy just mentioned, hiring the right people at the right time is important in any business, but startup situations are complex through the intersection of bringing up an organization and bring up staff, training them, and starting business operations. In addition, the skill set needed in a startup mode may be a little bit different than those needed in ongoing operations. At startup, decisions need to be made very quickly, and mistakes must be recognized and fixed. There is no time to dwell on the

perfect.

Timeline. There's never enough time for implementation, never. Start with the date of implementation of the program and work backward; calculate the time necessary to develop the critical aspects of the program. If there are slippages, there needs to be the ability to implement backup and alternative plans right away.

And finally, as a footnote -- and John Bertko had mentioned this -- you can rent infrastructure. The last company I worked for that was their business. They built administrative services organizations. There were ASOs for commercial as well as Medicaid managed care programs across the country.

And it's worthy of note that it's an alternative to building all this infrastructure with its significant cost and time, particularly in the startup mode, administrative services organizations contract with employers and provider-sponsored healthcare to provide most services needed to run the co-op. The co-op could hire a small staff and contract with an ASO for operations.

And in the attachment to the paper you received, there is -- it's really a matrix of all the services that any operating organization, whether you do them yourself of somebody else need, this is the basis for which then you can pick and choose as to which services you might want to buy and which services you might want to provide yourself. So I just hand that out in case you're interested. I did write a paper on this, so for any of you in the audience, if you'd like, give me your card, I can email it to you. Thank you.

MR. FREEZOR: Mary, thank you very much, and I think we may have some interesting follow-up for you and Cindy talk about that you can get up and going faster if you rent a lot of your infrastructure and yet the importance of staying in touch and making sure that infrastructure matches what you need and what your functions are, so we can come back to that.

Mark, I hope you're on and not snowed in in Rhode Island?

MR. MARK REYNOLDS: Yes, on (telephone signal interrupted) been there (telephone signal interrupted)

I’m not sure if I know the context of what (telephone signal interrupted).

MR. FREEZOR: Mark, we’re going to try to get you to start again here in a second. You’re cutting out on use a little bit, so start over if you would.

MR. REYNOLDS: Well, I’m Mark Reynolds. I’m the CEO of Neighborhood Health Plan of Rhode Island. Neighborhood is a community health center based health plan, so it many ways has a similar background to what co-ops are likely to be in that it’s really developed by community-based organizations. And all the community health centers have boards where a majority of the individuals are actually served by those community health centers. And those community health centers so then represents the majority of our board.

We were founded in 1993, started serving people in 1995. Today we are serve 69 percent of the people in Medicaid managed care in Rhode Island, and we’re the largest health plan in the Medicaid world in Rhode Island although we are generally quite small; we have 90,00 members.

I’ve also since its inception been on the

board of another small nonprofit health plan in Massachusetts, the Commonwealth Care Alliance, so I also have some direct experience in the development of that health plan.

For what I can tell you about Neighborhood is Neighborhood really had a very difficult first six years of existence at least from the beginning on enrollment of individuals in 1995 through about 2001, and since then, it's really sort of gotten over that initial period and been able to succeed.

But I've tried to layout four key areas that the commission should focus on and indeed co-ops should focus on. And the first has to do with building adequate reserve levels. The Federal statute provides for money that can effectively be borrowed from the Federal Government in order to provide for some reserve coverage. But I also think it's likely important -- it's likely going to be difficult for co-ops to pay back the startup money that they'll need to pay back within five years and even to pay back monies that they're going to borrow for reserves even after potentially 15 years. It is not so easy to earn enough

money in the insurance industry, despite what you have heard about United Health Plan, etcetera, to necessarily make high profit margins. And I think co-ops are going to have a fair amount of difficulty making significant profit margin particularly in their first few years of existence.

Startup costs are going to be relatively high, and earning enough to be able to pay that off fast enough will not be easy, and so it may require co-ops. I'd say more likely than not just have some alternative source of capital or to develop that alternative source of capital, something which isn't generally easy in the nonprofit world.

In the Neighborhood experience, it was founded with some capital invested by the State's community health centers with additional capital coming from Neighborhood Hospital Plan of Massachusetts, a parallel company that ended up having both contributing capital and having the management services contract initially to run Neighborhood of Rhode Island.

After a period of time, the program was also able to get additional capital from the Rhode Island

Foundation, a community foundation, in the way of subsidiary loans, which are able to count toward reserve requirements although they are a loan. And in my experience with Commonwealth Care Alliance, in that program, we have also been able to contract for a line of credit, which is considered a subsidiary line of credit and likewise has been counted by the State of Massachusetts as counting toward reserve requirement because it would be paid off after any claims to providers or others.

But one way or another, I think co-ops are going to need access to alternative capital and won't be able to rely, for the most part, on the Federal loans that are -- grants and loans that are available.

And I'd advise the commission to recommend that in terms of trying to decide which co-ops to fund that they would focus on co-ops that can demonstrate a plan for being able to raise additional capital.

I'd also advise the commissioner to try to think about the most flexible way of starting the repayment clock, perhaps only starting that clock once enrollees are actually enrolled in each co-op instead

of earlier to maximize the amount of time co-ops would have to pay back those loans.

The second I'd say is infrastructure. The last two scholars, Mary and Cathy, spoke about that, and I think that infrastructure is critical. Really having the management talent and also having they systems in place and processes in place, policies and procedures, is critical to actually running a health plan. Whether or not you're a co-op or a for-profit, they are some basic processes that need to be put in place. They're not processes that are easy to develop from scratch.

Given the short time clock that people are going to experience, I'm fairly certain that people are going to then need to really rent those services. I think it's really a question of make buy decisions, and for the most part, people are going to have to buy those services from venders in order to be able to develop sufficient infrastructure quickly; and not just in order to start serving people in 2014 but also to demonstrate to regulators, healthcare providers, and consumers that you have that infrastructure in place.

Providers aren't going to sign up if they don't think they're going to get their claims paid in a timely way. And likewise, consumers aren't going to sign up if providers aren't invested in this program. So infrastructure is going to be critical.

And my advice generally would be that co-ops are going to need to have senior leadership demonstrate infrastructure in addition to be able to meet cash flow, have policies and procedures in place. And the CO-OP Program should find some way to also be able to assist new co-ops in building this infrastructure.

My third area of recommendation is market affinity. And this really is about being able to get sufficient enrollment in the health plan. And the question is how to accomplish that. For Neighborhood, it was our affiliation with the health centers that really provided our initial enrollment. Because the health centers were invested in us, because they were deeply involved in having this program succeed, they encouraged people they served to sign up with our health plan. And I think some form of affiliation with providers is going to be critical for drawing

enrollment into co-ops.

Secondly, at Neighborhood, we also developed very strong relationships with the consumer advocacy community, something that most health plans aren't able to pull off, but we focused a lot on making sure that we showed consumer organizations that we had the same mission as they and we were intent on providing quality of care to the members we served, and so we've developed very strong relationships which have helped encourage others enrollment.

And then on top of that, we developed some very clear processes for letting the member voice, consumer voice, be a strong part of the work we do. We have member advisory committees for each of our product lines, and we have an ombudsman who can jump over hoops in order to make things work for members. I think all of those things are going to be very important particularly for co-ops because co-ops marketing advantage in theory will be that they are more directly tied to consumer needs, so they're going to have focus very hard on consumer needs and getting the support of people in the advocacy community.

So my recommendation is that co-op programs should really require a general market analysis to be done by co-ops, to have a clear marketing plan which distinguishes a potential co-op from competitors, that they work very hard on how they're going to remain -- be member centered as an organization and create the infrastructure to be so, the policies and procedures in order to do so; and that they also develop some clear relationships and commitments from providers in order to assure that they're going to be able to have some significant enrollment in order to be able to take off.

And finally, my last point was on creating high-quality health plans. Co-ops really do need to develop the infrastructure to meet quality standards and deliver appropriate member care. In Neighborhood's history, this has been an important part of our success, being forced to actually go after NCQA accreditation by the State, and I'm not sure it was totally forced, but it was required, created a focus for the organization and for the organization's infrastructure and policies/procedure development which allowed us to really commit to what needed to be done

and created really an organizational focus that has allowed us to be successful. It's given us very high rankings nationally in terms of the NCQA consumer reports rankings, and it really pushed us to do what needed to be done and gave us a reputation in the consumer community that has allowed us to be successful.

And I would recommend that the CO-OP Program also require co-ops to meet national accreditation standards and have detailed quality management plans but also that new co-ops be given additional time to meet accreditation standards because it's very difficult to really within say a couple of year be ready to meet those standards. And the CO-OP Program should also help assist plans in terms of technical assistance in meeting those accreditation standards. That is my quick summary.

MR. FREEZOR: Mark, thank you very much. And now changing our focus a little bit, Amit is going to talk about some efforts to in fact -- some other, let's just say, financing opportunities and ideas that might come out. Amit.

MR. AMIT BOURI: Thank you. My name is Amit Bouri. I'm the Director of the Global Impact Investment Network, and I want to thank all of you for the opportunity to contribute to these discussions today.

The Global Impact Investment Network or, The GIN, for short, is a nonprofit organization. We're dedicated to increasing the scale and effectiveness of impact investments, which is the use of for-profit investment to have a positive social impact, and I'll give more information about that shortly.

It's important to know that we are not investors ourselves, and so we don't represent the self-interest of any organization that would potentially benefit from opportunities emerging from these discussions, but we do absolutely care about the increase use of investment capital to produce a positive social benefit.

I'll also provide the disclaimer that I'm not an expert in healthcare issues or (inaudible), which would probably not have taken you very long to figure out.

(Laughter)

MR. BOURI: But hopefully -- but what we can contribute is the perspective of a diverse set of investors. We are actively deploying billions of dollars with the intention of having a positive impact.

So for my remarks, I'll just briefly give some background on impact investing, a few short examples, and then some recommendations for your consideration for this initiative.

So a conventional investor will seek to maximize financial profit given a certain level of risk. Impact investing is referring to a specific type of investor who's also seeking to make a financial profit but is actively trying to have a positive impact with their investments. This includes investors you hear about in many different poverty alleviations, access to basic services like healthcare, housing, and healthy food as well as those you hear about climate change.

So impact investors are actively investing in businesses that are developing affordable housing units and for capitalizing small companies that are providing

healthy food for school lunches as well as investing in renewable energy projects. It's a very diverse set of activities.

When I say impact investors includes a diverse set of institutions, so many major foundations are complementing their grantmaking activity with investments that are aligned with their missions. So this includes many foundations that are familiar to you such as the Robert Wood Johnson Foundation in the healthcare space as well as Gates, Rockefeller, Kellogg, and Annie and Casey Foundations as well as many prominent financial services companies including banks, pension funds, investment funds, and also high net worth individuals who are seeking to invest in a way that aligned with their values.

Now one thing that's important to know about these investors is that they do care a lot about the impact, and many of them may focus on tracking the social or environmental performance of the metrics. So this could include for our discussion today things like the average income level of the people served by these co-ops; issues like the number of previously uninsured

who are now insured and other dimensions that would help motivate these investors to support such efforts.

Impact investors have been active for a long time although the term is a relatively new one to capture this type of activity, and they've been active both in supporting things like increasing access to health insurance as well as cooperatives, focus on a broad set of activities. Two small examples. A number of organizations in the Northeast came together to support the freelancers union to increase affordable healthcare to their members through the creation of an insurance company. So this included the Ford Foundation, the New York Health Foundation as well as Prudential through their social investors program.

Similarly, a prominent example of a co-op, the Evergreen Cooperative in Cleveland was supported by the Cleveland Foundation, local government, and other investors who were seeking to help this cooperative develop local sustainable businesses that have been active in that community.

Now given the stipulation in this program, a nonprofit will only be able to access through intensive

capital, so investors will not be in a position to provide equity or the higher tranches of capital as you heard from some of the testimony in the first panel today. However, many investors do have experience giving loans to nonprofits, and this could be a role that investors could play in this initiative, particularly as it pertains to helping to expand coverage and extension activities after those kinds of some stable activities are in place.

There's a surge of interest from private investors and trying to make impact investment, and this is certainly a relevant growth capital free to explore as part of these efforts.

I'm going to have three recommendations for you in consideration of these opportunities. One, it would be critical to clearly and consistently demonstrate the positive impact of these investments. By definition -- in fact investors are seeking to have an impact and will care very much about how these cooperatives will expand coverage or target specific populations that are underserved.

Second, as any of investor would care about

any of these issues, it is important to design these businesses so they have stable and consistent cash flows. Just like a lender would want you to have a stable paycheck before giving you a loan. And impact investor will care about these structures and being able to provide a consistent stream of revenue and income by which they could pay back the loans.

Third, I would think about -- given the structure of these as nonprofits, it would be important to think about the significant resources that the Government has to support these efforts as to how they can particularly entice investors to participate. And what I mean by that is that there may be specific mechanisms in terms of the design that can draw investment capital. This could take the form of capitalizing the risk -- capital needs for these entities, providing loan guarantees for investors, or other types of mechanisms that will help draw investors into what may be very viable businesses; but the grand landscape of investment opportunities, these will look relatively unorthodox at least initially.

And so I'd encourage you to think about ways

that the financing that we can provide can help leverage much greater capital for private investors. And this is something that the Government has done in a variety of ways both in international development initiatives as well as in community development financing

So in closing, I would actively encourage you to -- if this is of interest, and free to explore, design an effective policy that engages impact investors will also engage them in its creation, and we're certainly -- we're willing to support you both as a steward of the industry as well as an organization that has deep connections with many of the leading impact investors in helping to design this policy. So thank you.

MR. FREEZOR: Amit, thank you very much, and your testimony that you submitted has some interesting ways and some creative ways for-profit entities actually helping to get some financing into some nonprofits, so if any of my colleagues have not read it, I urge you to do so.

Questions and answers. We're going to start

this time from my right to left. Mr. Curtis.

MR. CURTIS: Several of you emphasized the importance of, particularly Cindy and Mary and Mark, relationships -- I'll just use the elusive term -- partnerships with providers with blind incentives. There are two points of emphasis in the law here. One is statewide and the other is partnerships -- I can't remember the exact wording -- with integrated systems of care. It strikes me that there is probably a tension between these two objectives, and, of course, an overriding objective that everybody on this panel would like is to see that these things be viable over time rather than just noble efforts that disappear.

So I would like Cindy's, Mary's, and Mark's reactions to this. In states that are not just a single county or the city-state of Rhode Island where there are varied environments, and you have to -- and I know Mary Dewane used to run a similar program for the State of Wisconsin; for those of you don't know, she does have rural as well as urban areas.

If OCIO applications, it needs to choose between approaches that start with an area where there

are good constructive alignment with providers but it's not statewide, and sort of pushing to meet the statewideness requirement which way do you think that should cut.

MS. PALMER: I think that's a -- that's a really good question, and when I look at the statewide issue, I think it's critical for a co-op to grow to have enough mass to support its infrastructure; but when you look at the -- looking at integrated providers, you look at the state of Colorado, we don't have a lot of integrated systems in the state of Colorado.

And so I really think you're going to need to look at the geography -- each geography separately. And we started out in six counties; we've now expanded into 23, but expansion is slow, and the key to that expansion and how fast we can expand is the provider relationships. And like I said, where there aren't a lot of integrated systems, it's pretty tough, so I think that's going to be a challenge. You're going to have to say -- maybe you start with an organization that starts with -- like we did -- a smaller geography

where you can get up and get your feet under you and start running with a goal of expanding as there's capital to expand, and I think you're going to really have to be a little flexible of that with maybe a long-term goal being that you get to be statewide.

MS. DEWANE: I would certainly agree with what Cindy said about statewideness. I think that it would be very difficult for a new health plan coming up and becoming statewide from a state like Wisconsin, more rural, which shows a lot of geography to thinking about California, it would be really impossible. So I think that if co-ops had a goal of reaching statewideness that that would suffice.

In terms of the provider involvement, I think that providers can be consumers too in a health plan, and I think that providers are very key to running a successful health plan and co-op. So I don't think there should be a particular fear about including providers who are knowledgeable, and can help you build and develop networks or make affiliations. To leave them out of the mix, I don't think it's really necessarily helpful, so I just also throw that out.

In terms of partnerships, if there are not-for-profit hospitals or others who have similar kinds of thinking around how to provide healthcare, I think that they would make very good partners.

MR. FREEZOR: Mark, and comments on Rick's question?

MR. REYNOLDS: First of all, I think if (telephone signal interrupted) but I'm not (telephone signal interrupted) is something that's impossible to overcome. I agree with Cindy and Mary that a strict requirement that a co-op but completely statewide day one is going to be a virtually impossible task in larger states. But I think even in areas of rural -- with significant rural communities putting together a network is possible, not necessarily with integrated providers but with providers as long as they have, again, some interest in the existence of co-op and seeing that as an alternative path to coverage which is currently provided through other organizations, so I (telephone signal interrupted).

MR. FREEZOR: Thank you. Dave, next question.

MR. DAVE: This is to Cindy, Mark, and Mary.

In 2014, Medicaid will be in existence for the population under 133 percent, so I guess my sense is the co-op's prime target will be above 133 percent individuals and small group area. The other thing to say is that with this huge influx of Medicaid population I think the community health centers are going to be overwhelmed to a certain extent because they got a lot more folks able to have health access. How do you with your startup experience look at a -- to me that's a little bit different population, that 133 percent and higher population. Is there nuances in how you think things will play out in 2014 with that population versus the population you three had to work with although I realize you worked with above 133 percent also, but it just seems like there might be some differences that you might be able to expound on. Thanks

MR. REYNOLDS: This is Mark. I'd say I think they're definitely going to be some differences between Medicaid population and the exchange population, and that's true in terms of Medicaid today as well as Medicaid tomorrow, which will now include adults who

aren't parenting, aren't disabled, aren't elderly up to 133 percent FPL.

And I'd say the way in which the population will be different are, one, that the exchange population a lot of choices is going to be made on price. I think there is a certain expectation that exchanges when they operate well will monetize health insurance so that often people will be selecting exchanges based on the lowest price possible perhaps even more so than quality of care or customer service. And think exchanges will have to be very aware of that.

In the Medicaid world, we have to be less aware of that because often we're working on a fixed price, a price was bid ahead of time or a price which was mandated ahead of time in order to win the contract. So there's very little consumer cost-sharing in the Medicaid environment. It's going to look very different in the exchange environment.

The second area I think the populations will different has to do with your level of social service need. People at the lower end of the income spectrum need a great deal of hands-on assistance with

connecting with social service needs, trying to help people deal with their social problems so that they have an opportunity to finally think about their medical problems. That need declines as people go up the income spectrum. But I do think there will be a number of people who are above 133 percent of Federal poverty up to the 200 percent level, which will still need some significant assistance with their social service needs.

And finally, I think there'll be clinical differences between Medicaid populations and the exchange populations. I think particularly this new Medicaid population below 133 percent is going to have significant unexpressed disabilities; people who haven't been disabled enough to qualify for SSI but will have substantial needs much more so than people higher up the income spectrum. Although if you look at the Massachusetts experience of people that enrolled in subsidized healthcare up to 300 percent of Federal poverty level, it's also true that that group has a much higher incidence of behavioral health and substance abuse presentation than a standard commercial

population. So I think new networks focusing on the exchange are going to have to work very hard to make sure that they have the right behavioral services in place.

MR. FREEZOR: Cindy or Mary, any additional comments to those that Mark made.

MS. DEWANE: I just have two. I agree with Mark. My experience, I was chief operating officer for the University of Wisconsin's HMO in Madison, Wisconsin, Dane County. We enrolled the indigent population in our HMO, and the costs were incredibly high. There were a lot of mental health issues, substance abuse issues, so that can be noted.

And also -- and this is maybe part of warning to the co-ops. Initially, my experience both in Wisconsin as well as in Orange County contracts with Blue Cross, United, Kaiser for the Medicaid population. And quality by some people is really enrolling in a health plan that has a name that that they've heard about and they finally get an opportunity to do that; never mind that it was run completely different, it had the name but not the same of anything else in the

health plan offer. But people did initially choose the names and ultimately gravitated toward others. So that's just another piece of it.

MR. FREEZOR: The chair will observe five tents up and about maybe another seven minutes, so, hopefully, concise questions and succinct answers. Terry.

MR. TERRY GARDINER: For any of the panelists, how would you in your startup organization attract employers who pay the bill?

MS. PALMER: We are a commercial carrier, so that's something that we deal with, and I think to Mary's comment that it's a little tough when you're competing against the Uniteds, the Blue Crosses. I think the co-ops are going to struggle. I think it's another reason why it might make sense for co-ops to start off in small geographies where they can really start to build some reputation, and it's going to take -- that sales effort is going to be critical because they are going to be competing against the big carriers, and they're going to have to build some credibility, and that's going to take a little bit of

time. That's not an easy game when you're competing against the big carriers.

MR. FREEZOR: Cindy, do you use agents?

MS. PALMER: We do use agents. That's also an issue with agents. They're a little reluctant to -- they say, "Well, now who are you?" We found that our growth as we've expanded into additional counties has been working directly with the employer groups both small and large, really talking to them about how we're different, about our community orientation. And then it starts to spread a little by word of mouth.

MALE SPEAKER: I'm curious to hear the thoughts from Mary and Mark in particular about the potential for co-ops to collaborate with safety net providers, particularly those that may be organized around Medicaid managed care plans.

And one potential that occurs to me is that I know there's discussion about whether Medicaid managed care plans can start selling through exchanges and some of the difficulties that that would present in terms of meeting the regulatory standards, and I wonder if you see any potential for basically using a co-op type

structure as a way of sort of building onto an existing safety net provider network in a fashion that would allow marketing to a commercial marketplace?

MS. DEWANE: Mark, you want to start?

MR. REYNOLDS: Sure. Can you hear me? I guess two thoughts. One, I think that co-ops should definitely try to focus on safety net providers. I think it's an ideal group of providers to be communicating with. Those providers are oriented in the same way that co-ops are. And again, at least in our experience is having that type provider commitment which will help drive enrollment, and I think that's even true in the individual and perhaps in a small group market. If you can then find the employers that are smaller employers who's population is already traditionally been seeing safety net providers such as health centers, I think it's definitely a population that you should try to -- a group of providers that you should try to pursue.

In terms of Medicaid, we as a health plan, for example, have thought about whether or not -- we can't create a co-op structure given the Federal statute. We

may be entering an exchange environment on our own. We have also at least thought about whether or not if we elect not to if there is a co-op that's developed in our geography whether or not we would -- or even in another geography -- if we'd be willing to provide the administrative support to such an entity to be able to help an entity start up and have a partner which has the same ethos and cares about consumers in the same way that a co-op will need to.

MS. DEWANE: I agree with Mark. I'd just like to add that the safety net providers are probably many of the providers that are serving this population now. And so by reaching out, it the co-ops reached out to them, they would have that critical patient-provider relationship.

Secondly, I think that there are many organizations who serve only the Medicaid population that could easily begin serving other populations. The Medicaid population is very difficult to serve, and there's a lot of good infrastructure there that can be used with the other populations as well.

My particular -- the HMO that I started,

CalOptima, with the challenge it is a governmental, as I pointed out, so it wouldn't be eligible as I understand it, but they certainly now have the infrastructure, having run 15 years to be able to help out.

MALE SPEAKER: So do any of you see any problem with your current organization serving as a TPA or administrative services contractor for a co-op?

MS. DEWANE: Not at all. I think it's critical to note that sometimes TPA is thought about as paying claims. It's not. The major part of a claims processing systems supports the critical medical management and utilization and review, and that is essential to the successful operation of a co-op or any health plan.

MR. REYNOLDS: (telephone signal interrupted)

FEMALE SPEAKER: I want to thank the panel because it's been very informative. And I have a more complicated and I'll submit in writing, and I'm hoping that you'll take some time to answer it.

But I have a quick question for, Mr. Bouri. If you heard earlier, the co-ops are going to have to

raise capital and will have the capital that does not have an associated liability with is. So the impact investor from your experience would they be willing to supply the capital that is very restricted as far as repayment even payment of interest where the insurance commissioner would have to approve that other funding requirements would have to be met before anything was paid back?

MR. BOURI: I think there's quite a bit of diversity among the impact investors community. Some will expect things that are -- seems closer to commercial returns or any kind of conventional investment product. However, there is also a segment of the investment space, or landscape, that it, it will take on different types of (inaudible) debt structures, particularly those that come from philanthropic groups, so those foundations and high net worth individuals may be interested in supporting businesses because the impact comes first for them, and they see the investment part as an alternative vehicle to complement their grantmaking.

However, depending on the nature of

investment, I think it is also important to note that they do need to be viable investments. So if the terms look so unfavorable such that they actually would not be -- seem like they had a reasonable chance of producing a return, then that would probably not be appealing to many investors.

MALE SPEAKER: Thank you, Mr. Chair. I'll ask the question not expecting an answer necessarily today because I'd like some detail on this. But the Act provides for loans for startup costs. What were the startup costs that you experienced at the formation of your various entities? And what types of things with your startup -- basically, what did you pay for actuarial assistance? What did you pay for legal cost? What did you pay to rent networks? All those types of things. And to the extent you can provide an estimate of what it might cost today. If I can just pose that question and ask for a response. And I know that's a tall challenge, so I apologize for that.

MR. FREEZOR: Put it in writing so...

(Laughter)

MALE SPEAKER: Thanks. I have a series of

questions I'll put in writing, but the one I want to ask now: There's sometime the tendency, as least I've experienced, where Federal programs be overly prescriptive. I've heard some of that today. I understand why some prescription is needed. But where in your judgment you think we need to be most careful not to stifle the entrepreneurship, which I associate with the success of a startup?

MS. DEWANE: I'd love to answer that. I'm one of the few people I know that has worked at the Federal, the state, and local level. I think that -- I would hope that at all levels they would approach the co-ops in regulations through contract and not just lay in layers and layers and more layers of new things to do. I think that Mark had some really good ideas about the structure and where there needed to be some regulation, and all that can be put in a contract.

MS. PALMER: I think one of the areas that they're going to struggle with is one that we struggled with is really on building your (inaudible) your risk-based capital. And the biggest dollars -- when you look at buy versus build, I think there are some things

you could easily buy; there are other things that you need to have in house. Most of what you can buy you can buy on a PMPM basic, a per member-per month basis; but in a lot of cases, they have a minimum amount. And we struggled with that given the size of our organization, the few things that we do outsource. When you look at the minimums that they require and then a PMPM, that's a struggle.

So I think if the systems are going to be one of your biggest cost and contracting your network. And when you talk about going out and renting a network, everyone knows that rental networks are not near as cost effective, the contracts are not near as good as a direct contracted network. And it's going to be critical that the co-ops be able to compete on their premium structure with the carriers that are out there, so I think network development and systems are going to be your two biggest issues.

There was a lot of discussion around the risk-based capital, and we have returned money to our members. We did a turnaround that we've had some good years where were able to return to reduce premiums to

our members, but we did not do that until we had reached a certain risk-based capital. And we had to do that to satisfy the division of insurance that we were going to continue to be in existence to serve those members. And again, I don't know how much room there is in the regulation, but I think to really allow them to take a part of their profit and put that toward risk-based capital is going to be critical because you have to build risk-based capital, and that is not growth capital.

So you have to remember there are different steps here, and to really give the co-ops enough leeway to be able to build some of their own reserves as well as look to what other sources of capital might be out there, I think is going to be very important.

MR. FREEZOR: Indeed thank you, and thank all of our panelists. Mark, thank you. And going to give you these folks, would you please express your appreciation for their work.

(Applause)

MR. FREEZOR: And again, as Barbara said, we hope we'll have the opportunity to further pick this

group's expertise in some of our later deliberations and as a resource for co-op operators.

If our next panel would come up, and just for my colleagues on the Board here, we still are hopeful of adjourning pretty close to our planned time, so we'll have about an hour, hour and fifteen for lunch, and we don't have too far to travel for lunch, so we should be able to do so.

Our next panel will focus on some perspectives, lessons learned in member-run nonprofit plans, and we have three panelists to hear from. The first will start, and I guess we'll be ungentlemanly, Peter, and let you go first and let the ladies wait.

Peter Farrow is the CEO and General Manager of Group Health Cooperative of Eau Claire, Wisconsin. I would note the only blight on his record is that he was an assistant deputy commissioner of insurance, something several of us have had to endure, but, obviously, he overcame it quite well.

Our second panelist is Andrea M. Walsh who is the Executive Vice President and Chief Marketing Officer of HealthPartners of Minneapolis, and I would

note that she started part of her career practicing law and as assistant commissioner for health in Minnesota, and say something about -- maybe I do note that co-ops you can't have been a former government employee or a government employee. I don't know what that says, but anyway.

And then our final panelist is Diana Rakow who is the Executive Director of The Public Policy Group Health Cooperative of Puget Sound and previously spent some time on Capitol Hill advising some of the members of the Senate and particularly Senator Baucus, who has been for probably 25 or 30 years very active in insurance and insurance regulation. For people who think he just came alive in the health reform debate, he was one of the earliest senators to take on the leadership in trying to regulate insurance.

Peter, start of off.

MR. PETER FARROW: Thank you, Mr. Chairman, and the members of the Board that have taken the commitment, time, and the investment of your energy and expertise to try and tackle a incredible complicated issue.

You have my written comments, and I've rewritten my verbal comments about four times in the last few hours just trying to respond and not be redundant to what's been said already but to kind of highlight a couple of points.

When at started at Group Health Cooperative 11 years ago, we have 22,000 members, and we now have about 85,000 members in 35 counties about, basically, the western geographic half of Wisconsin, served by 10,000 providers and 40 hospital, a very broad network. I was intrigued Mark Reynolds's comment when he said that the first six years of the startup were kind of rough. Knowing their predecessor very well, I'd say the first 30 years or so of the cooperative have been pretty rough, and I may have had one smooth year in the middle there. I'm not sure.

What I was struck by with all of the comments and I think the plan on Tim's last question of where do you put the focus of the requirements and where do you allow for flexibility. I think the greatest challenge the Board has is recognizing that we have very different regional cultures in the United States, and

from an insurance perspective, from a provider perspective especially, there are different challenges and different strengths and weakness in different parts of the country, and your challenge is going to be to try and incorporate that in some way and recognize that the different models may have different opportunities and strength in different parts of the country.

And I think Mary's comment made just a few minutes ago about that and maybe putting some of these requirements more in contrast with the individual plans rather than bring prescriptive, overarching requirement might be appropriate.

One thing that I might suggest, while we all seem to be former insurance department employees -- or maybe too many of us -- is it might be an opportunity to, again, as ACA (ph) does in many ways, reach out to the insurance department and have them very actively involved in the sponsorship or the approval of some of these plans. It's not uncommon for commissioners to write orders on individual plans and make both allowances and special requirements for individual plans, and this may be a great opportunity for that.

I think when we look back at Wisconsin's history and the strength that Wisconsin had in the growth of managed care that started with the State pushing State employees in managed care in the early 1980s purposely to create a public policy to support the (inaudible). And it was done with the very active role of the insurance commissioner in wanting these fledging plans, of which we were a small one at that point -- and difference allowances for different plans to create different opportunities.

And my comments are -- except for a couple of years when I was in Washington, a decidedly cheesehead and Wisconsin focused, and I recognized that there are different cultures. I think that along that line of being prescriptive or balanced in figuring out where to write that, I would caution that the most important thing might be focused on the strength of the mission of the organization and the passion of the individuals that are starting it. I think that a mission can trump a lot of other weaknesses, and an organization that has a core group of people that are really focused in the right areas doesn't need the same level of some

conscription as other.

I was struck by the comments of the need for a professional consumer representative. It is something that my board would blanch at. I have 15 members. None of our staff are allowed to serve on the board. Our bylaws allow one provider to serve on the board. Otherwise, they are members covered by the plan, and I think that is one of the -- and this is going to really betray my cooperative roots -- but I think that that's a huge part of this that should be considered is more than anything a majority of the board members should be covered by the organization or at least the prospect of being covered in a startup situation. But there is something to be said for making you bed and having to lie in it.

And I think that my last comment would be how strongly supportive I think I am of this program. I do not believe that we are going to see significant reform in healthcare without real engagement from consumers, and this is one way that consumer can be brought into the healthcare reform debate and get them literally on the frontline and engaged in the process. And I think

that while some people view this provision of the law as a throw-in or a compromise or whatnot, I think it is a very key component of the law and one that could hold real promise. It doesn't take a significant portion of the market to be represented by these types of plan to have real market disruption and change the way the market delivers product. It just needs to be -- the comment of 5 to 10 percent is enough to get notice, I think that's right. And I think that that clearly is an opportunity. Thank you.

MR. FEEZOR: Thank you, Peter. Andrea.

MS. ANDREA WALSH: Thank you, Chairman Feezor, and members of the Advisory Committee. I appreciate the opportunity to testify today. As mentioned, I'm Andrea Walsh, Executive Vice President and Chief Marketing Officer at HealthPartners. HealthPartners is an existing nonprofit, consumer-governed plan. We serve about 1.3 million and dental members predominantly in Minnesota and Wisconsin but have membership coast to coast by virtue of the fact that our Minnesota companies have everywhere.

I was asked to comment on what are the

pathways to success for consumer-oriented plans, and in my written testimony, I laid out for key factors, and I thought I would just briefly highlight them for you today.

The first factor -- and I think you'll hear a lot of common themes probably across this entire panel. First and foremost, I couldn't agree more with Peter that a mission focus and consumer governance is absolute key. From our vantage point, the only way you achieve a mission of health improvement, which is what our mission is, is through consumer governance. Our consumer board ensures that we're focused on population health, that there is an accountability by the healthcare system to consumers, and that ultimately we're focused on how do you keep care affordable because at the end of the day if we've got great healthcare quality but nobody can afford it, the game is up.

So I think that the consumer perspective has been incredibly important for us as an organization. And our 15-member board, 13 of them are consumer elected from among those who carry HealthPartners

cards, those we provide coverage to either fully insured or self-insured.

The second attribute is community and consumer focused, and I supposed you can ask what do I mean by that? I think I'm picking up on Peter's comment about how important it is to know your market. Knowing your market in Minnesota means you need to have as a consumer-oriented organization a full range of products and services that are demanded by consumers both individuals and seniors, by group purchasers both small and large as well as the government purchasers as well.

And so I think as you focus on consumer-oriented plans that would focus in the individual and small group market the most important attributes that we see in our marketplace by individuals and small group purchasers is absolute flexibility in product design. It changes year over year, so not being too prescriptive about benefits, designs, and offerings so that the co-op is able to have product innovation over time and affordability. The products that our individuals and small group customers purchase look

very different than the products that our larger and government groups purchase. So I think that flexibility is important in terms of marketplace success. It also though is important as you look at what administrative systems you need to be able to have in place to be able to administer really a very diverse product offering.

In our marketplace, we're not dominated by any single carrier; and I think, frankly, the existence of consumer-governed plans in the Minnesota marketplace is part of what has kept us competitive and what's kept the marketplace competitive. So that would be the second factor.

The third factor is a factor that's been mentioned by earlier panelist as well, and that is the importance of care and coverage integration. Ideally from our vantage point, employing physicians and other caregivers assures absolute alignment of the interest of the consumers. We recognize that that would be a tall order, so I wouldn't view that as a mandate and the only way at it.

At HealthPartners, our integrated structure

has allowed us to test and innovate and redesign care delivery and then share those learnings across the broader community. About one-third of our members of the 1.3 million members get care from our own system; two-thirds of our members get care from the network that we directly contract with. And I would say virtually every provider in the state has become a partner with us in looking at how do you transform care, how do you make sure that those members of HealthPartners get care when they need it. And I think that the attribute of having employed physicians has allowed us to innovate and really move medical culture in ways that wouldn't happen were we not consumer governed.

Finally, a topic that I think each panel has pressed on, and that is the need for financial stability. From our vantage point, being nonprofit is key, and I think there are three parts of stability that I see as important for consumer long run.

The first is low administrative cost, really making sure that the vast majority of the dollar is spent on care, not on administrative systems, but

recognizing you need to have good administrative systems. Secondly, is appropriate financial reserves, and there has been quite a bit of time spent on that. And last but not least is the nonprofit mission, the commitment to low margins, the commitment to only having margins that sufficient to make sure that you have the capital you need to reinvest to make sure that you are able to keep programs and services in place to serve your members long pull.

So at the end of the day from our vantage point, those are the four key attributes to successful co-op. We believe long pull that both existing and new cooperatives should be eligible to participate in state-based exchanges. We'd like to see state required to have those cooperatives participate. That's not to say that we don't think others should participate in exchanges. We just believe that ultimately a competitive model is a good thing and ultimately consumer-governed organizations and a competitive model can thrive and succeed. Thank you.

MR. FEEZOR: Thank you, Andrea. Diana.

MS. DIANA BIRKETT RAKOW: Thank you. Thank

you for inviting Group Health to offer its perspective on consumer-operated and oriented plans. I'm going to tell you a little bit about Group Health's history, some of our success, and some of the things that we believe -- or recommendations for the new program.

And as mentioned, I'm Diana Birkett Rakow, Executive Director of Public Policy, Group Health. Group Health is a nonprofit, tax-exempt health system that provides both coverage and care. We offer coverage through Medicare, Medicaid, state and Federal employee programs, individual markets, small group, and large group and as well as self-funded. We pretty much run the gamut.

We cover 450,000 residents across Washington state and northern Idaho about two-thirds of whom receive care in one of 30 Group Health owned and operated medical clinics and are taken care of by one of our 1,000 physicians in our group practice. And we also contract with more than 6,000 physicians in 44 hospitals out in the community both inside and outside Group Health's four walls.

The Group Health Foundation, another part of

our organization, makes donations to increase childhood immunization rates and improve community health. And we also have the Group Health Research Institute, which conducts research in the public domain on healthcare systems design, treatment options, and comparatively effectiveness.

We're fairly unique in the healthcare market, or at least in our healthcare market, but certainly not among the organizations represented today. First, we provide healthcare directly to the majority of our members. Second, we're a regional plan serving Washington and northern Idaho subject to State regulation and responsive to the needs of our local community. And third, and of course, the primary reason I'm here today, we're consumer governed.

In 1947 when Group Health was founded, the idea of a consumer-governed prepaid medical coverage was a radical one, but the healthcare system left many people out of coverage and people in post-war Seattle didn't believe this was a sustainable situation.

The founders of Group Health came together, organized the first clinic, and chose to incorporate

under Washington State law as a cooperatively governed, not-for-profit corporation and were classified under the tax code as a 501(c)(3) organization.

Over the years, the structure and the consumer-governance infrastructure that was initiated over 40 years ago has endured. We have a member-elected board of trustees that are made up, as Peter mentioned, by the members of the cooperative themselves. And we've evolved from a single clinic organization into a large one that's serving members both inside and outside of our clinics and with very strong partnerships throughout the community.

We're regulated on a level playing field with other coverage providers operating in Washington subject to a set of rules and regulations that are in many cases more stringent than elsewhere around the country, and you'll hear from our commissioner in Washington state a little bit later today.

We have to keep our premiums in line with the market in order to stay competitive, and we have to be accountable and responsive to our members. So striking the right balance between those three factors,

regulation, our members, and the market, has sometimes been a challenge, but it actually is what makes us who we are.

Someone asked earlier about how to be competitive and market a new cooperative to large employers, and that's obviously a challenge for startup organizations. The way that we approach that -- not just to large employers but really to any member of Group Health -- is distinguishing ourselves both on member experience, on quality of care, and also on cost savings.

One highlight of our success in that area has been the patient-centered medical home, which reduced the number of patients seen by every physician, length and appointment times, scheduled time for phone calls and emails, and establish regular processes for preimposed appointment check-in. We're saving now $4 for every $1 invested in primary care staffing. We've seen emergency room visits go down 29 percent and hospitalizations go down 19 percent.

A similar program actually working outside of the Group Health clinic in community hospitals has

resulted in the reduction in Medicare readmission rates. That's fairly significant. While across the country the average rate is 20 percent, among Group Health Medicare members, the readmission rate is 14 percent.

The CO-OP Program provides the potential in a reform healthcare environment to support and expand this kind of patient-centered model of care with members and patients not just member of the cooperative and engaged in coverage decisions but also very engaged in care decisions.

We'd like to bring our own values and successes to other parts of the country and help inform this process. We can't participate as a new co-op, but I hope we can find a way to support the program, perhaps through innovative partnerships because there is a great value in learning what has come before.

I have a couple of specific recommendations, which are outlined a little bit further in my written testimony. First, I would recommend and Group Health would recommend that the CO-OP Program promotes systems that will deliver patient-centered care and coverage.

Through clinical integration which could be employing providers and actually having clinics, but could also be robust, sort of value-driven partnerships with providers in the community, also using value-based payments and value-based benefit design.

Second, we'd recommend that you look for organizations that would approach healthcare coverage for members across the continuum of their lives and experience, that will have an active community presence to promote broader public health through disease prevention and well-being. It's pretty remarkable to talk to Group Health members that were born at Group Health and are not seniors and getting their care, and they have a physician that has known them through a lot of different things in their lives both personal and medical. And I really believe that that enhances the quality of care that's delivered.

You might consider having co-ops serve Medicare and Medicaid beneficiaries in addition to members through the exchange, allowing for continuity of coverage across that spectrum of care and experience.

Third, ensure the co-ops are held to standards of regulation and quality on a level playing field with other organizations. While co-ops will benefit from upfront grants and loans, they should be required to be licensed under State regulation and accredited by a major independent, quality-assurance organization such as the National Committee on Quality Assurance.

Fourth, look for organizations that are prepared to build a structured set of opportunities for consumer engagement as my colleague Sara also talked about. The member engagement piece doesn't just happen on its own. There have to be specific meeting and engagement opportunities both at the organizational-wide level and, more specifically, at either the clinic level or the community level.

Finally, find a way to benefit from past and present successes to build on the experiences and lesson learned by organizations such as those of us sitting here today and also others. There's Group Health Cooperative of South Central Wisconsin I know really wanted to be here today, and there are many other cooperative throughout the country.

Possibilities for partnership could exist from consulting or technical assistance to shared networks, other innovative partnerships, and expertise.

So thanks for the opportunity to offer some perspective, and I welcome your questions.

MR. FEEZOR: Thank you, Diana. As we get ready to let Tim ask the second question -- the Chair is going to jump in here on one -- all three of your spoke about consumer voting on the board. I'd like a little more clarity behind that. I've been in enough organizations that it's indirectly done or it's the same folks that get reelected every time, sort of like the old mutual insurance games, so a little bit of specificity if you will on how your board is -- who they're drawn from, how they're nominated, vetted, and any limitations on terms.

MR. FARROW: Our board is limited to 3-year terms, so they can serve a maximum of 9 year. They are selected by a nominating committee of board members, and they're elected by the membership, the commercial membership on an annual basis, so there are staggered 3-year terms.

And as it turns out, I would say the average tenure of our board member is probably about four of five years, maybe six, somewhere in that range. They don't typically term limit out very often.

MR. FEEZOR: ...not bound by Sarbanes-Oxley if there's anything sort of that sordid piece of corporate history suggests to us is making certain that boards have the expertise that they need on there. How does your organization also assure that? Is that part of the criteria that the nominating committee goes afterward? And I guess if each of you will speak to that issue as well.

MR. FARROW: They don't have formal standard on the board, but the board typically tries to balance. We have a large public employee and private employee makeup of our commercial block, so they try and get a balance for that. They try and get a balance of financial experts, accountants, and things like that that would qualify under the financial expert criteria of Sabs-Ox so that our fiscal committee is made up of a majority of experts that would meet that standard.

MS. WALSH: At HealthPartners, our board,

like Peter's, has three three-year terms as the term limit. Most of our board members do serve out all three terms, not all of them, but we've had great board continuity. The terms are staggered so that we're not left with all board members ending their terms at the same time.

We have a governance committee of the board that's accountable to the full board for coming forward with candidates. They have a fairly robust process where they look at expertise needed on the board across multiple dynamics. We have a strong commitment to having a diverse board.

In addition to board governance, we also look out for opportunities for members and nonmembers to serve on board committees to fill the compensation and finance committees. We have external experts to the extent the board wants that. And then beyond that, we have a number of other opportunities. For members who may be interested in serving the organization but may not be able to serve as board members, the serve on our patients' advisory council and a number of other opportunities for member and patient engagement outside

of just board service.

MR. FEEZOR: (off microphone).

MS. WALSH: Exactly.

MS. BIRKETT RAKOW: So we have actually a formal set of criteria for board selection, and there's actually a lot of material on our Web site, and I'm happy to send them to you, but it goes through executive experience, financial experience, actuarial experience, positions nurses, sort of to get that broad breadth of perspective on both managing a company and also the healthcare system.

And any member can apply for the board, and they go through likewise a standing nominating committee process not made up of board members, but other members of the organization -- other members of the cooperative, and get vetted. And then the voting process is actually by mail. Since we're such a large organization, it's hard to get everybody to the annual meeting. So people vote by mail. Some people do vote in person, and that happens on an annual basis.

The other thing that I'll just mention is in addition to the board, there are likewise a lot of

different committees, and each medical center has a medical center council, their community-based councils. So there's a very complex terp (ph), but there's a lot of different ways that issues can get served up to the board.

MALE SPEAKER: I have a quick -- a point a clarification for Diana. Your board members is there a requirement that they be members --

MS. BIRKETT RAKOW: Yes.

MALE SPEAKER: Okay.

MR. FEEZOR: Thank you all for those responses, and thank my colleagues on the Board for letting me ask that question. Tim, you're up.

MR. SIZE: I totally agree. I think it's well-said that new co-op plans success will definitely depend on the ability to create robust relationship with providers whether they be freestanding or networks. I realize the nuances in those differences.

I'm curious, what do you think may either hurt or help that potential and that requirement as we see another Federal initiative get going, accountable care organizations, and we have regs forthcoming, and you

can comment on that or even more broadly recognizing the initial set of regs is kind of focused on Medicare, but I think the movement is broader. And I can see pros and cons even in the discussions we haven't brought that up.

MS. BIRKETT RAKOW: From HealthPartners's vantage point, we look at ACOs and the attributes of an ACO and really find ourselves in a position of we're acting as an accountable care organization today, and so I think many of the attributes in the CO-OP Program likewise will have application to ACOs, and so I think there's an opportunity for co-ops to partner with either have an ACO and utilize it or to partner with other ACOs as a way to deliver and network to smaller group in (inaudible).

It may actually facilitate that transition toward integration as there are more existing integrated entities out there in the community that you could do a direct contract with. We sort of think of ourselves as inherently an ACO, but we're also given that there are areas that we don't reach in that way, and we just have sort of the one-off docs, the rural

area that we serve.

We've begun a trend of reaching out to some likeminded providers that try to do coordinated care now and develop either risk-based or semi-capitated or some kind of payments structure so that our payments rates to those providers are modeling the kind of care that we want them to deliver and that they want to deliver to their patients (inaudible), and that may be an opportunity for the co-op as well.

MR. FARROW: I think that -- and I commented a bit about this in my written comments, but I think that Eliot Fischer (ph) probably has laid out the best kind of model for a virtual integration in an ACO, and I think that from that standpoint it's -- and I said it -- and I said it for a reason. I think the consumer role is very important. I've challenged my staff to give me any other market that's been reformed from the supply side. Markets are reformed from the demand side, and in order for a market to be effectively reformed, the consumers have to be engaged, and this is one vehicle to very effectively engage consumers.

I think also that hospitals and physicians

should be represented in an ACO but not necessarily by the same organization. They still have different interests, and they can have shared interest, but they will have different interests. I think it's very complementary to an ACO structure and may facilitate it.

MR. SIZE: Here's the follow up. I agree with everything he said. There's an intuitive voice in me that says it also means in some but not all communities it becomes a competitive issue. With the provider networks working to develop an ACO, it's not too much further just to make that an insurance entity, and so you have a provider driven versus consumer driven. Further thoughts on that will be welcome. Not necessarily right now.

(Laughter)

MALE SPEAKER: We've heard -- there's some testimony about the important of marketing and name recognition as far as where people sign up. And Andrea, since you wear one of the hat on marketing and we're discussing the importance of whether or not the co-ops can use money to market, can you comment on the

importance of that and name recognition and what that will take to keep these programs viable?

MS. WALSH: I definitely think there is a lot to be said for co-op needing to establish a value proposition that resonates with the market and then become known in the market, so marketing is going to be key. I think it's key for consumers. From an awareness standpoint, we definitely see in our marketplace and beyond our marketplace -- I'm sure my colleagues would agree that the consumers want to know and trust the entity that provides their healthcare and their healthcare coverage. And so figuring out way to market is important.

I don't know that that necessarily means that needs to be advertising dollars per se. I think often times the best marketing is word of mouth, and next to word of mouth and right alongside of word of mouth is the value in what you deliver to your members. So more than anything, I think it's important that the co-ops deliver on a promise of great experience and great stability, and that will help, but you're going to need marketing.

MS. BIRKETT RAKOW: This sort of relates more to the exchange issue than to the co-op issue, but we've thought about ways that exchanges could help highlight high-quality plans and have an open market but try to makes sure that consumers are making informed decisions. And one thing that an exchange could do is to make sure that consumers are aware that there is a co-op being offered in the state, and that could be as simple as setting up the Web site the right way so that that comes us as an option. But those simple things can be relevant too.

MR. FARROW: The psychology of how members choice a health plan is fascinating, and the comments earlier that a lot of time they go for the name recognition even if they don't know if the quality or even if the quality might not be as good. And that's true. There are a lot of hurdles to overcome from that sense, and the exchanges are going to face that, whether people pay enough attention to quality data once it's really available.

It's certainly something that needs to be focused and aware of, and I think it speaks, again, to

the very local aspect of a co-op and the nature of making it very local so that you have coalition and support in the community that drive to a critical mass initially.

MALE SPEAKER: I think this is a quick question. Do you have a history of and do you offer the possibility of contested board elections?

MS. WALSH: At HealthPartners, its' a matter of board philosophy. Our elections are contested.

MR. FARROW: I've tried it several times in the past. My board members don't like it, and --

(Laughter)

MR. FARROW: -- and it's kind of a hit and miss thing. We do have contested elections, but they're not required.

MR. FEEZOR: (Off microphone.)

FEMALE SPEAKER: Thank you. This is so instructive, and I'm just struck with the fact you all each (inaudible) to our ACOs, medical homes, and co-ops in that basically what I see is people kind of rushing to imitate you, but it's not called the group health law. It's called the co-op law --

(Laughter)

FEMALE SPEAKER: -- so a question that keeping going through my mind -- and I'm very much a consumer representative -- are these terms member and consumer. So if you can expand on that a little bit, and in particular reforming co-op the initial members by definition initially probably are individual, for the most part, individual and small group. I mean that's the focus. But under the legislation if a small group employer is going to change from the definition of 50 to 100, and then it's going to open things up.

So one question is if you want consumer members on but you know what you're going toward do you consider saying, "We just can't focus on small employer and individuals and people who are current members." So if you have thoughts about that.

A second area is you could have people who represent consumers -- and we've talked about this -- who aren't necessarily members, and that's because you're a larger organization initially, you've got 60 members who represent 300,000 consumers across the state because you're the major consumer advocacy group

in the state -- so I don’t know what to do about that.

And the final piece, definitional piece, is when you define the word “member” does that include I am a small employer or an employer or a self-insured employer and I’m a member? Or do you mean the individual patient. So if you can clear up those terms or offer advice, that would be really helpful.

MR. FARROW: Our bylaws define a voting member as anyone 19-years or older that is covered by the plan, so it’s not at the group level; it’s at the individual level, yes.

MS. BIRKETT RAKOW: Ours is at the individual also, and to your second question, I think the perspective I’d offer is -- partly because we started as mostly and HMO-driven organization, we equated patients and members, and that has evolved, so you don’t necessarily have to be a group patient to be a group health member.

But there’s still something in that philosophy of having a stake in the care and coverage that you are getting as -- I think that brings a different perspective to sort of how you think about

the organization and where you want it to go and what your values are than you would if you were just looking at this organization from the outside. So we still hold true to that model of “you are part of the organization if you’re a member.”

MS. WALSH: Similarly, for us, a member is somebody who has their coverage from HealthPartners in some form or fashion. With respect to a small group, our expectation would be the small group business owner or the small group person who would to us -- the people who sit on our board are both members and some of them also are the decisionmakers for coverage, and so you can wear many hats as a member.

We consciously talk about consumer governance from the vantage point of our mission is health improvement, and our belief is patients are what you become when you’re not healthy, and so we use the term “consumer” to really capture the fact that we take care of patients and we take care of consumers; part of your journey is when you’re healthy and part of it is when you’re not, and we really want to be there across that continuum.

MR. FEEZOR: (Off microphone.)

MALE SPEAKER: Do you have any training programs for your board members especially board members with especially financial?

MR. FARROW: My board members typically say that they don't have a clue what's going on the first term that they serve, and after about three years they feel like they're up to speed because they're not insurance experts, and they rely on the kind of goal of having a smooth transition to board members. We do give them orientation. We walk them through financial. We walk them through a lot of it, and they're all very local, so we do this quite a bit. We also have a local attorney that kind of does the rules of the board and does a couple hours' briefing of kind of their role in the organization and their responsibilities, obligations, and potential liabilities.

MS. BIRKETT RAKOW: We have a fairly parallel structure, and periodically actually we'll do sort of a more deep dive in board development and thinking about how is the board functioning, how can the board function better, what are the needs of the

organization, how can the board speak to that. And that's a process that's goes on in a lot of nonprofit organizations around the country not just healthcare organizations. So that would be something that co-ops could consider and maybe something that the grant or loan could contribute toward.

MS. WALSH: Our board has published the principles of governance that we've got on our Web site and has a formal board orientation process of new board members come in. In addition, we're committed to board education and have a requirement that board members who serve on our board have a certain number of educational hours each year, and we keep track of that. The governance committee then on an annual basis reviews whether board members fulfill the education requirement and also conduct an annual survey of the board around board effectiveness.

MR. FEEZOR: (Off microphone.)

MALE SPEAKER: Thank you very much for your presentation. I had a question around the generalizability of your experience to the rest of the United States in terms of sociodemographic and rural

and urban because there may be some limitations that you'd like to tell us about.

MS. WALSH: From our vantage point, we serve both metro markets and rural markets. I think our care delivery system has been predominantly located in the Twins Cities metro area and in the first, second, and third ring suburbs of the metro area.

But with respect to plan coverage, our coverage is really statewide, and the partnership we have with contracted providers I believe has allowed us to fulfill on responsibility of maintaining consumer governance, of being able to deliver care in local communities, and I think it's easily replicable actually in many locations.

MS. BIRKETT RAKOW: I was going to say pretty much the same thing, and I would only just add that I think that there is a community-based nature to sort of starting these kinds of organizations. I mean 1947 Seattle was very different to communities today, but the concept of having labor organizations and physicians and groups with a real stake in the community that was one unique culture, but there is

also other unique cultures around the country with very similar types of groups that have an urge to serve something new whether it's greater consumer investment. So I can see that being very replicable.

MR. FARROW: I think that your question speaks to the strength of a true consumer-oriented board as opposed to a board that worries about consumers. And in an environment where you have a true consumer board, those issues don't necessarily come up. For example, my board is very comfortable in the idea that we don't market on the fringe of our provider network; we only market our products in areas where we know we have solid networks, and we got to expand a little bit beyond that because they have members that travel from those areas.

And those rural/urban issues, I think work themselves out if the board is structured the right was and the mission of the organization is structured the right way. They're going to be different; regionally they are going to be different, and I can't speak to how they should be different, but I think it's just more you have to recognize that you have to allow for

some differences in the structure.

MALE SPEAKER: So what you're saying is you feel like it's generalizability in all markets? I just want to...

MS. WALSH: There's just different challenges.

MR. FEEZOR: (Off microphone.)

MALE SPEAKER: Thank you all, and I have a lot of interest in what you've given today. You guys are living the dream, but you're also in the trenches --

(Laughter)

MALE SPEAKER: I hear that every day.

(Laughter)

MALE SPEAKER: -- you're living in the trenches, and you got to deal year in and year out with the costs conundrum. I mean we've talked about medical homes, which I'm very excited that you mentioned that. You talked about ACOs. Let me peer down a little bit into the horizon. Is there something else you guys, the three of you, have been thinking about as far as dealing with the cost? Because that's going to be what

all of us will be facing as a society, and there may not be an answer, but if you had one, I'd be interested.

MS. BIRKETT RAKOW: Well, the one thing that I'll just add to sort of the medical home and ACOs is we've been trying to think about how to get assets at a variety of different ways, and one is actually engaging the -- I mentioned value-based benefit design -- engaging the consumer in the incentives themselves and not just (inaudible) incentive.

So we have a new program called Total Health, which is the coverage program for our members -- sorry, our employees, and we're a very large employers in Washington state. And we partnered on this with the union that represents all of our nurses and others to develop a value-based benefit program, which means that you have lower copays for higher quality providers, you have zero to low copays for various preventative care services, and if you take the health-risk assessment and go to your primary care physician, have a relationship with the primary care physician, if you have all of these that the evidence has shown actually

keeps you healthier, then you have a lower premium. And so that sort of -- and it get lower every year if you kind of keep up these practices.

So that's another way of really, truly engaging the consumer in a different way and trying to drive down healthcare costs.

MR. FARROW: A few years ago we stopped calling our wellness programs wellness and started calling them health promotion programs. And about a third of our commercial block that engaged in what we would determine or define as a true health promotion program, which is an onsite, worksite based coaching and intervention and things like that where we actually have health coaches go that go out to the employer, another advantage of a very local organization. The experienced trend is half of what it is with the rest of our commercial block. And if you could hold your experience trends to -- and this has been sustained over three or four years with some of our larger groups -- if you can hold your experience trends down to 4.5 percent versus 9 or 10 percent, you're a lot closer to a sustainable equation than we are right now.

I think that -- and it was interesting -- I passed my comments out to a couple of people, and that was the one feedback that I got from a few board members and others is there should be a strong health promotion and wellness component to the efforts that any co-op is engaged in at the start up. I think that way of incorporating people into their own health has shown -- and we're not the only ones that have experience like that -- but has shown real promise.

MR. FEEZOR: We -- go ahead, Andrea.

MS. WALSH: I was going to say we also see health as sort of the next horizon is how do you figure that out. A fully 25 percent of healthcare costs are attributed to healthy behavior, what is it that you do to support members. And I think that hold a lot of promise in terms of impacting trends.

The two other places that we're working on to impact trends is really focusing on care models process, how care is delivered clinically and transitions of care in particular between primary care specialty in the hospital so that we really leverage the investments we've made in the electronic medical

records to make sure that care happens as efficiently as possible and produces the highest quality.

And then last but not least, our disruptive care development: How do you take care out of a clinic setting? So we've just introduced an online clinic, for instance, where 30 different conditions you can get care right online, or we think that will be something that not only will our members love but will lead to more affordable care along that.

MR. FEEZOR: Finally, I'd ask one last question, not seeing any tents up, and then, actually, and a dividend question, Pete, for you. The co-ops by legislative intent have to focus in the individual and small group. What percentage of your company's business falls into that category? And maybe even more to the point, in terms of your -- unless it's proprietary -- of your sort of strategic evaluation either in terms of stability of your enrollment or the ability to amortize your cost, how important that is? Is that segment of the market, in other words, is it something that you really count on holding your main clients, being the 500 life and above, and seeing what

you can do? Then this is for the marginal business or is it core business, and how do you distribute some of your overhead costs? So that's sort of the question for all three of you, and we'll start, Andrea, with you since you're in the marketing side.

Then, Pete, the last question for you, John Bertko started out this morning talking about some plans hitting the economies of scales around 25–30,000. We heard experts talk about the importance of good management. Putting aside, obviously, the representation of your management that's sitting in front of us, talk to us a little bit about your ability to attract being a relatively small player.

And I'm not asking these other two, they're (inaudible) giants in their own states, how are you able to compete in terms of the kind of talent that you need to run the plan that you have? Andrea, on the...

MS. WALSH: Sure. From our vantage point, the individual and small group markets are really important marketplaces for us right now and into the future. That being said, only about 125,000 of our members come from those market segments. So from a

scalability standpoint, we need to be able to operate in all market segments. I think historically we started in the larger group market and over time have migrated into other markets. We've always had a commitment in the Medicare program as well, but it's been largely large group markets and Medicare market is where we started historically.

Over the course of the last five years or so, I would say we've increasingly emphasized and marketed in small groups and midsize groups. And as I look at our marketplace long pull and where the employment base is going to be, small group and midsize will be very important as will individual.

MR. FEEZOR: 125,000 is about 10 percent, is that right?

MS. WALSH: Uh-huh.

MS. BIRKETT RAKOW: We also have a similar percentage, about 10 percent, in the individual/small group, and it hasn't been a dominant area, but as Andrea said, it's going to become a more and more dominant area, so it's an area that we're looking for growth down the road.

We've actually grown significantly in our individual and family business over the last couple of years. The small group has actually been a real challenge due to cost trends, a lot of aging groups, and we also have a fairly strong association, set of associations, in Washington state that often tends to sort of get out the healthy business. So that's been a little bit of a declining area for us.

MR. FEEZOR: And a tough question: In terms of allocating expenses, is that pretty much evenly throughout or is there disproportionate on your smaller market because of your acquisition cost and so forth?

MS. WALSH: Actually, from a financial standpoint, we allocate cost internally to reflect the true cost of the market segment.

MR. FARROW: Our small and individual block is probably about that same percentage. It's darn close to it, and I think it could speak to kind of the nature of the organization and the history of the organization. My predecessor, the founder of the cooperative -- the founding general manager of the cooperative -- it started with large group, and so for

a big chunk of our history that was the focus.

We were a direct writer up until five years ago. We've only used independent agents for five years. It's grown, and since then, a lot of our commercial growth has been in the small group market. But just kind of as a legacy, it's still a smaller portion of the market.

As far as management expertise, I think I'm proof that you don't need a management expertise to --

(Laughter)

MR. FARROW: -- to keep the whole thing going. But in terms of -- and I think the greatest challenge we have in Eau Claire, Wisconsin, is probably attracting out-of-area people to come work there unless they really like to fish. The fishing is good. But we have been able to do it, and we've attracted people who have been drawn to the mission.

We did just replace a -- our chief medical officer retired at the end of the year, and we were able to replace in a recruit. That only took a year and a half with some that literally had grown up in (inaudible).

We, fortunately, in all of our organizations have that strength that our communities recognize that we are very mission-driven organizations. It motivated our employees, and they come into work for that reason every day.

MALE SPEAKER: Kind of -- recollecting back on your question on the proportion of the business was individual and small, I think it really -- the implication is, is how important the development of the exchanges is to the development of this program because it really changes the business model.

MR. FARROW: And if you had list of things that you can go back and change in the statute or reinterpret very creatively, I think that would be one of the first ones is if you save substantially or something where maybe 60–70 percent small group so that you can find some critical mass elsewhere and have the flexibility to go a little larger -- Barbara said when they --

MR. FEEZOR: Or substantially over time or something like that is interesting.

MR. FARROW: Yes. Or it that’s a target or

something, but that could be a challenge.

MR. FEEZOR: Rick.

MR. CURTIS: Just so I don't forget to mention this, it seem to me there could be creative ways where -- and we don't have time to get into it now -- but where a new co-op has partnerships with provider systems and with an ASO, which is probably going to normally be the case where these things are going to be survivable, there could be ways for independent webs that align with the co-op for large employers to participate in all the same systems and get you the economies of scale --

(Off the record)

(On the record)

MS. ANNIE: I just have one announcement on public comment for this afternoon. We're looking forward to receiving a wide variety of comments from the audience for our committee members, so to ensure an orderly process, we ask that if you intend to speak during the comment session, please sign in, print your name at the speaker sign-in sheet at the front table. And then during the comment session, we'll call up

speakers one at a time.

If you've previously submitted your comments and received an email confirmation for the speaking order then, don't worry about signing up. Thank you.

(Off the record)

(On the record)

MS. YONDORF: ...throughout it is the importance of being in compliance with State regulators and divisions of insurance and those rules and working closely, but the co-ops are going to need to work closely with their departments of insurance. So we have a great panel today. We've got -- we're not sure -- hold on a second. Yes. Sorry, we were just checking who we've got on the phone.

So we've got a three-person panel. We have live Sandy Praeger. If you want to come up to the table, Sandy. And we also have on the phone Cindy Ehnes, who had a really bad cold, but we think we're going to be able to hear here, and Mike Kreidler.

So let me just tell you very briefly about each of these people, and I'm pleased to know that I've known all of them for quite a few years back when our

hair was, I think, dark black or something like that --

(Laughter)

MS. YONDORF: -- but a long time, a long time, and I'm pleased to be working with all of them again.

Sandy Praeger is Commissioner of Insurance in Kansas. She was elected the 24th Commissioner of Insurance in 2002 and began serving on January 13, 2003. She was reelected in 2006, and congratulations, again in 2010. She serves as the chair of the health insurance and managed care committees for the national conference -- the National Association of Insurance Commissioner that we've been talking about, the NAIC, and she was past president.

On the phone, we have Cindy Ehnes. Cindy and I are both former regulators from Colorado, and her husband, Jack Ehnes, was commissioner when I was the director of policy. But Cindy is the director of the California Department of Managed Healthcare and is a key member of California's healthcare reform implementation team working to implement the Federal healthcare reform provisions in California.

Finally, again on the phone, we have

Commissioner Mike Kreidler from Washington. He is a former member of Congress, and he was first elected at insurance commissioner in 2000 and was reelected to a third term in 2008.

We also have Brian Webb here today -- and sure will be a resource for us if we need him -- from the National Association of Insurance Commissioners. Thank you, Commissioner Praeger.

MS. SANDY PRAEGER: Thank you, Barbara. I -- just a bit, perhaps Brian should sit up here with me so I would get lonesome.

And it’s good to have Cindy and Mike on the phone with us as well, so I look forward to hearing their comments.

As you said, I am Sandy Praeger. I’m the commissioner of insurance for the State of Kansas and the chair of the NAIC’s health insurance and managed care committee. And I really do appreciate the opportunity as does the NAIC appreciates the opportunity to be here before you today to speak on behalf of the NAIC, which does represent all the nation’s insurance regulators, to talk about the new

consumer-operated and oriented plan that will be sold, can be sold, through the health insurance exchanges beginning in 2014.

Just as an aside, we've started our planning process in Kansas and actually applied for one of the early innovator plans, so we're -- in spite of the fact that we have a government turnover in administration, turnover in party. And the letter had to be submitted on December 22, which made things a little bit interesting to have a governor to sign off that is leaving office and a new governor coming in that doesn't -- was not as familiar with the issues, but we got it done anyway.

These plans may have the potential to provide consumers with a different model of coverage, one that has shown some promise in limited areas where it has been tried to date. However, it really is important that the Board recognizes some of the unique challenges that co-op plans will face and the need to maintain a marketplace where all participants compete on a level playing field that protects consumers from abuse and from insolvency. State regulators expect the co-op

plans will be subject to all the applicable State law and regulation.

Nonprofit health insurance companies can face significant challenges in raising the capital needed to meet State solvency requirements, maintain a buffer against unexpectedly high claim costs, and to expand their operations. So for this reason, many successful nonprofit insurers tend to maintain higher than average reserves. This difficulty may be compounded for co-ops, which are required by TUPACA (ph) to use any profit to lower premiums, to improve benefits, or to otherwise improve the quality of healthcare delivered to their members. So by their very nature, they need to have expanded reserves, and yet on the same time, there is a requirement that reserves not get retiperate (ph) because part of the law say it need to be returned to the members.

In addition, the co-op plans will face the same formidable challenges that all new insurers face. The most daunting of these will be the difficulty if assembling a provider network and negotiating provider payment rates that allow them to be viable all before

they amass significant market share that will give them leverage in negotiations and make themselves attractive to providers, and there will be some competitive forces at play there. The existing environment is not going to want to have that kind of -- that additional competition in the marketplace, so they're going to be continually challenged.

Given these difficulties, it would be tempting to simply cut these plans so slack and reduce the regulatory standards that co-op plans must meet. And I really strongly caution against this course of action. These standards were put in place for a reason: To protect consumers. Furthermore, if there is one thing that insurance regulators have learned over the years is that insurers competing for the same purchasers must be required to play by the same rules. Failure to do so can lead to adverse selection for carriers that operate under rules that are more advantageous to higher risk policyholders attract those individuals forcing them to raise premiums to account for the higher claims cost, driving away the lower risk policyholders that can get a better deal from carriers

operating under different rules and it just becomes, for want of a better analogy, a death spiral: Higher cost, higher premiums, people seeking out more affordable coverage, and eventually it's not sustainable.

In any event, Congress was very clear in requiring that a co-op plan "meets all the requirements that other insurers of qualified health plans are required to meet in any State where the insurer offer a qualified health benefit plan." This requirement is vitally important to preserve a level playing field for all and to ensure the co-op plans are neither unfairly disadvantaged nor held to a lower standard.

It's absolutely critical for the protection of consumers that co-op plans be treated identically to the other insurers or the HMOs depending on how they're organized, whether they are an insurance company or whether they are organized as an HMO.

If the co-op plan organizes as an insurer, it should meet the same licensing and risk-based capital standards as other insurers.

If a co-op plan organizes as an HMO, it should

be subject to the same licensing, networks, and depository requirements that are required of other HMOs.

Whatever new benefits might be offered to consumers by these plans will be meaningless if they become insolvent and cannot pay claims or provide the needed services to enrollees.

In addition to the critical protections offered consumers by solvency regulations, there are a number or other important regulations in the area of consumer protection. HMOs and insurers offering products featuring provider network must meet network adequacy requirement to ensure that there are sufficient number of providers that are available throughout the company service area to provide timely services. So as I've already noted, assembling inadequate provider network with reimbursement level that allow a new insurer to charge competitive premiums can be a substantial challenge.

However, network adequacy requirements are core consumer protection. And holding co-op plans to a lower standard would not be in the best interest of

consumers, and doing so could lead to those with coverage being unable to access care and would create an unlevel playing field that would disrupt the insurance market.

And just as an aside, the one area that we as regulators have in terms of the contracts between providers and the insurance company where we can intervene is when we feel that they're not negotiating with providers in a certain area or with certain types of providers in a way that would limit some of their insurers from getting access to care. So the provider networks are really another critical component of consumer protection.

Co-op plans will also be subject to all State consumer protection laws including State rating rules, which limits variations in premiums attributed to certain rating factor such as age and gender and all the new Federal requirements that are included as part of the (inaudible).

And finally, they will be required to abide by all State laws and regulations regarding the marketing of insurance policies including the requirement in any

State -- ours included -- that all marketing materials be approved in advance by departments of insurance so that they're readable, that they fairly represents the benefits, and that consumers are not mislead in any way by the marketing materials that are out there.

So in conclusion, I just want to thank the Board for inviting me on behalf of the NAIC to testify today. I look forward to any questions that you might have and working with all of you throughout this implementation process, and don't hesitate to call upon the NAIC, and I can be your backup, but call Brian first, and we look forward to working with you. And thanks for the opportunity to be here.

MS. YONDORF: Thank you, Commissioner Praeger. And we have on the line Cindy Ehnes and Mike Kreidler.

Cindy, are you there?

MS. CINDY EHNES: I am. Can you hear me?

MS. YONDORF: Yes. How are you feeling?

MS. EHNES: Well, I'm doing better, but I was afraid of being a social pariah at a hearing where I was sneezing and coughing.

MS. YONDORF: Okay. Why don't you go ahead

then.

MS. EHNES: Well, first of all, it's an honor to follow Sandy Praeger. She a wonderful commissioner, and I will be echoing many of her comments and also will be advising you to call her, who's advising you to call Brian Webb with any questions that you might have.

But I'm Cindy Ehnes, and I'm the Director of the California Department of Managed Healthcare. We are responsible for regulating 108 managed healthcare plans in the State of California. California has a dual regulatory structure where HMOs and a large swatch of PPOs are under the jurisdiction of the Department of Managed Healthcare, and then other insurance entities are under the jurisdiction of the California Department of Insurance.

We are a standalone State agency with responsibility for that sole oversight of HMOs, which is approximately 21 million Californian. As well, we also oversee solvency for 230 medical groups that received capitation. That gives the department a rather unique viewpoint and insight into the ecosystem

that represents managed healthcare.

And with that in mind, I first of all wanted to echo, as I said, the comment of Commissioner Praeger. I think she's hit many of the points that we hit upon in our testimony related to the importance of State licensure, level playing field, and strong oversight.

So I will not read from that testimony but will rather try and hit some of the points that we think are particularly important relative to California.

First of all, California fundamentally believes in innovation. We have tried to create a marketplace opportunity at the Department of Managed Healthcare that allows smaller regional entities to innovate and to play in that marketplace in ways that advance public purposes. In addition to having approximately 53 full-service health plans, we have approximately 28 to 30 local health plans that are MEDI-CAL provider organizations that provides services to the MEDI-CAL population in California.

In those 30 health plans, were always born

weaker entities, but they in many ways have grown strong, and we would cite CalOptima, the L.A. Health Plan, and they compete well in their local marketplaces. In California, approximately 7 in 10 MEDI-CAL recipients who are choosing a MEDI-CAL plan choose the local option because the provider community is often very favorable to the local health plan serving MEDI-CAL populations. And that's an odd phenomenon, but it would potentially advantage a local entity in a community.

At the same time, however, as Commissioner Praeger said, that issue of getting those provider arrangement and those favorable terms in a local area relative to the commercial plan when in fact the commercial plan has a lot of power to drive those rates can be a real obstacle and in circumstances can mean that that smaller plan, the unknown plan, is paying the highest rates to the provider community because they don't have the possibility of getting the favorable terms. That has huge implications for the long viability of that plan.

And so I think that that's one example where,

again echoing Commissioner Praeger, you have to have that level playing field in terms of all of the protection of State oversight and State licensing. But it does make it difficult in terms of potential barriers to entry for new participants.

And just in terms of talking about what the Department of Managed Healthcare requires, we do view these entities as having to meet all requirements of the Knox-Keene Act. The BMAC (ph) licenses have to demonstrate that they have adequate capacity to perform all the essential administrative functions required of health plans: Claims processing, network management, medical management.

California also has extensive standards for timely access to care including authorizations and referrals, claims payments, plan and provider dispute resolution, benefit design, disclosure of coverage, grievance rights, language assistance for limited English speaking participants, and then consumer and provider customer service requirements.

As I said, these present very high standards, and I've often remarked that our MEDI-CAL managed care

plans probably are the highest regulated plans in the country, which can be either very good or very bad when you're talking about trying to participate and compete.

So in terms of some of the particular concerns that we might have about the co-op plan, again, without going back and trying to go over what Commissioner Praeger and my remarks have already covered, we would say that this issue of the professional management is a very key concern for the department.

Unlike the MEDI-CAL managed care plan in which the population is generally regarded as a pretty good risk mix, this plane will be competing in that exchange place without a strong individual mandate pushing for health participants into the exchange. The risk mix may be difficult, and again, there may be reinsurance available; but, again, that risk mix potential for really being unpredictable from the outset and having huge implications for the need for claims reserves and the payment of that claims is something that should be attended to. It's just a potential issue that makes them unlike your MEDI-CAL managed care plans in California.

The other issue that we think is very important is this issue of solvency. There are requirements at the frontend that presumably the grant can help to allay those requirements at the frontend. But how far will support go? These plans, as Commissioner Praeger said, have to have strong reserves; and yet, if the Government isn't providing those reserves, those will have to come from somewhere.

We've experienced a lot of very nuanced financing arrangements with some of our provider groups that are in the MEDI-CAL managed care space trying to put together financing with loans from Nigeria, loans from investors, partnering with for-profit health plans to try and provide some of the financing. And so that issue of where is the money going to come from over the long term is a very significant issue because if the Government isn't going to be partnering over the long term with that, then there are a couple of decision. Is it acceptable to have this entity essentially wrapping not-for-profit structure around a for-profit health plan that will actually be providing the financing and all of the arrangements.

Secondly, is there a point at which the Federal Government decides that it's appropriate to pull the plug on its own support of this plan, leaving it on its own and, again, leaving it for the State to figure out should it be allowed to continue. We have a huge issue in California about that exact point: The question of when does the State pull the plug on an entity and decides that it simply is not viable from a financial standpoint any lower. And of course, every State has that, but we have it in perhaps a greater sense because we have so many provider groups accepting capitation that we have a lot of roiling in the marketplace that relates to these issues around solvency and when in fact do you decide to pull the plug. But the Federal Government would need to make that decision as well as to how much support is enough.

The third and final remark I would make about them, the first being, again, the professional management requirement for assessing risk; second, the solvency issues; the third is times a wasting. If these entities are going to be up and functional in the 2014 timeframe, then in fact they have to hit the

ground running at that point, which when you back that up for a 6-to-12 months licensing process, and then, obviously all of the formation requirements for a not-for-profit entity and all of the formation kinds of concerns, getting the financing in place, you end up with a very short window in which to effectuate the decisions that are necessary to put these into a position where they can start their planning process.

So with that, I will conclude my remarks, am pleased to respond to any questions.

MS. YONDORF: Thank you, Cindy. We're going to have all the panelist speak first, and then we have a process here where people are putting up their name tags if they have questions, and they're starting to really go up, so there will be questions.

Commissioner Kreidler, are you on the phone?

MR. MICHAEL KREIDLER: I am indeed.

MS. YONDORF: Welcome, and why don't you go ahead.

MR. KREIDLER: Oh, thank you and apologies for not being able to make it out there to Washington, D.C., to join you in person like my colleague Sandy

Praeger has been able to do.

Let me just say that what I've heard from Sandy and what I've heard from Cindy I'm going to sound a lot like I'm reinforcing what they've said in their earlier testimony, and I'm not going to read my testimony because it covers much of that same -- the same issue here relative to formation of co-op and how it is mechanically done and how they've gone through the process of putting together rates and policies that they would be issuing once they are formed and just exactly what structure they'd choose.

In the State of Washington, we're still a little bit unique in that we still have a differentiation here between health maintenance organizations and healthcare service contractors, HCSs and HMOs. Most state I believe probably merged them, and we will eventually too because they're so similar.

And I'd like to talk a little bit then about what I see as somewhat unique from the standpoint of a co-op. From the standpoint from the State of Washington, ever since Group Health Cooperative of Puget Sound was created we've regulated them through

the office of the insurance commissioner in the State of Washington, so we have a long history; and as pointed out, I've been a commissioner now for 10 years. So for 10 years I've regulated Group Health as the regulator in the State of Washington.

I should also in all fairness point out that for 20 years I was an employee of Group Health Cooperative in Puget Sound not in a distinguished position like Margaret Stanley, one of your fellow board members, but in the capacity as a clinical optometrist, and so I have a personal understanding of group health, and it's only added to by now being the regulator of Group Health.

One of the major comments that was made -- a couple of comments were made both by Sandy and Cindy about the necessity here for having a level playing field when it comes to regulation and solvency. I would strongly emphasize that too. It would be very difficult to have people in the market that operated under different rules. It would be difficult to be able to regulate them and, obviously, offer the same kinds of consumer protection that is necessary to make

sure that they're going to be there to deliver on the services that they've effectively advertised.

One of the challenges that we're going to face is the potential here for new entrants coming into the market. There's really two challenges that they'll face entering the market and the creation of a co-op, and that would be one is putting together, as has been pointed out by others, an adequate network of providers.

That's not an easy task, and when you enter that market, you're challenged as a new entrant to go up against established carriers that have been in the market for a number of years and frequently have some power within the market to negotiate provider rates and is much more challenging then for a new entrant to come into the market and be able to effectively be able to accomplish an adequate network at rates that are going to be competitive with the existing carriers. And that's a challenge there from the standpoint of coming in and being able to exercise some kind of market strength as you enter the market both from the standpoint of putting together the carrier with the

network adequacy and be able then to get the kind of rates that are necessary for you to be competitive.

This is one the others have pointed out too. It would be important in putting together that network that you probably have some very capable staff that are a part of creating the co-op or you wind up having some consultants that are hired that are going to wind up being able to provide the kind of technical assistance that's necessary. This is going to be a critical part really at all levels of formation, of having that kind of technical expertise is going to be so critical and having the kind of leadership that comes from the group that is forming the co-op that they have that kind of background and experience that they can enter this game and not be overshadowed by the other participants that are already in the market.

Stepping back and looking then to a brave new world, and I agree with Cindy it's going to be a real challenge to be able to go through all of the formation requirements and establishing a co-op and have that realistically I place and fully operational by 2014. That's going to be a real challenge. Typically, it

takes several years in order to go through the entire process, all of which is required before you really have a plan that could enter the market and be fully operational.

The second part, the challenge of getting it up and operating, but second to that would certainly be to makes sure that with the creation of the co-op that they're not put in a disadvantageous position relative to the competition that exists in the marketplace. And that's going to be a real challenge for the states, for insurance regulators, and others in the states as they proceed to establish the health insurance exchanges that to make sure that there isn't adverse selection that takes place either inside or outside out the exchange or even within the outside market and the inside market. And the co-op is going to, obviously, be at the center of that to make sure that as we work from a regulatory standpoint to make sure that there isn't adverse selection taking place in the market. We're going to be challenged to make sure that doesn't happen, but simultaneously, anybody who enters that market is going to be, obviously, very cognizant of

those challenges.

As I look at what might be kind of unique to be successful in the market, some of which I've touched on here relative to the expertise, that I think is going to be absolutely critical either in the management of the group that's forming it or the kind of outside consultant support that they receive, I think from the standpoint of a co-op it's going to be critical from my vantage point of looking a state that regulates a very significant player in Group Health Cooperative in Puget Sound, and I recognize that you just heard from Diana just before your lunch break as to what group health is all about, one of the things that going to be unique -- take place that's going to make a distinct difference here and give a unique vantage, in my opinion, for a co-op is it that they really involve the people that they're going to want to try to encourage to become members of the co-op so that there is a true sense of ownership.

In my written comments, I said that one suggestion here might be that we move toward a governance structure maybe more akin to what we see in

the modern credit union activity and creation around the country maybe that being the kind of sense of ownership. Frequently from my experience, people that are active with and participate in credit unions have a real sense of ownership. It is quite different -- and I see the same thing with Group Hospital Cooperative Puget Sound that I see with our other major health insurance carriers where they do not have that kind of sense of ownership that would give our founding co-op a unique advantage of that is really distinct as they attempt to enter the market and go up against existing carriers.

Other issues that I've listed here would certainly be one I mentioned before: Make sure that senior management has the kind of experience and knowledge to be in this market and that they the co-op can demonstrate that it has the ability to offer the kind of comprehensive healthcare services that they'll be advertising and are expected in the market, that they have the financial responsible organization here that is going to make sure that they can meet their obligations satisfactorily, and that they have

procedures in place for offering healthcare services and offering and terminating contracts with enrolled participants that are going to be reasonable and equitable.

But those being followed, I think would be strengths for a founding co-op that would certainly assist them in entering what's in the state of Washington is a competitive market, and it certainly would be challenging for a co-op to form in any state where you have a real competitive market or in some states where they're dominated so thoroughly by one major carrier, in order to break into that market and be able to established themselves successfully, really in my opinion goes to having some kind of unique advantage here that separates them out from the rest of the market and a sense of ownership on the part of those who joined that cooperative; and the people that wind up joining it are effectively not -- just taking the healthy people, that's making sure that you're getting the full range of -- there's an average of the market that entering it in such a way that you have real strengths to be able to be successful.

As with the others, I would suggest, as Commissioner Praeger said and Cindy Ehnes also pointed out, contact Brian Webb. He's right there, and I know he's grinning right now and shaking his head, but he is a good contact from the standpoint of the NAIC, and in my prepared comment, I missed two individuals in my office that could be of assistance from a state perspective would be of assistance. So thank you very much for an opportunity to offer some comment (inaudible).

MS. YONDORF: Thank you so much. Those are excellent presentations, and I'm not sure if the three of you had an opportunity to listen to the conversation, but I don't know whether we have came in and virtually harden or not, but you in fact echoed much of what we heard whether it from the consumer or the actuaries or people how have ran co-op plans or other that be ready to face existing market problems, adequate provider network and reimbursement, experienced senior management, solvency, solvency, solvency, solvency, and repeatedly hear from all sorts of different perspectives on why a level playing

really, really isn't important.

So we are getting some comments seen here. And with that, let's start around the table on this side. David

MR. DAVID: Thank you much for all your presentations. The interest that I'm interested in this question is (inaudible) it. I think once the co-ops start in 2014 they have to be in that level playing field. The question I have is what can be do up until 2014 to serve the purpose of this Advisory Board to make it as functionally as possible to create as good as co-ops are available to get to that 2014 starting line.

And the question I have is is there, using your expertise, ways that the Federal processing of looking at the applications and the State processing of approving plans can be worked in tandem or in some kind of cooperative fashion that would allow these plans to meet this very daunting time of situation?

MS. PRAEGER: Well, obviously, the more coordination that occurs right here at the start would facilitate the startup. Waiting until the co-op and

the State has moved along a certain path and then trying to coordinate could mean not having to stop and do things over again.

I think -- it seems to me too having a good dialogue with all of the interested parties in the state, making sure there are ways to demonstrate the value of having this additional choice for consumers. So consumers need to understand what the value is, providers need to understand because if there's an initial willingness for them to, as I said in my testimony, cut them some slack a little bit, not in terms of regulations but just in terms of the willingness of especially in getting the provider network put together.

It's going to be hard to make the case I think initially. I think what has to happen is being able to demonstrate that long term there could be some real benefits to this in terms of additional competition. But I think -- to me the sell to the providers is going to be really critically important to get them to be willing to pine up for a new plan that doesn't have track record yet, that doesn't have the ability to

negotiate in the way these existing plans in the market do.

MS. YONDORF: Commissioner Kreidler or Director Ehnes, did you want to add to that?

MR. KREIDLER: Kreidler here, and I would just add that I would strongly urge any group that is in the process of forming a co-op to come in very, very early and speak with the regulator; and if it's in my office to come in and meet with the Office of the Insurance Commissioner.

As Sandy just pointed out, most state, if not every state -- I think every state does its very encouraging of competition in the health insurance marketplace having more carriers there that are going to be viable and offer choices to consumers. We will bend over backwards to be of assistance. And I think early in the process if you come in and you meet with the regulator you're going to find, one, that you're well-received; you're going to get some very good advice; you're going to have a better understanding of where some of the pitfalls might be in the formation of a co-op, where you face some challenges. Frequently,

we can offer some very good advice as to the path you might want to go down. And if you don't have access to certain kind of expertise, we're not shy in telling you some of the players that are out there that can help you negotiate and manage the market.

MS. EHNES: I would add just a couple of points to that. First of all, it is very important for the entity to get experienced licensing counsel. And I know that the Department of Managed Healthcare has a couple of people who we regard as extremely knowledgeable, we trust them; and when they bring something to us, we really can partner very well.

I would suggest that that's important, and I'm not giving out recommendations and names, but I do think it's important. Sometimes we'll have people come in who say, "Hey, the Federal Government says I have the right to do this, and your little department isn't going to stop me." And everybody in the room goes, "Oh, yes, we can."

And so you really want to ensure that they're bringing in with them people who know the ropes very well, and that's important.

The second thing is that there is a real willingness to partner at the Department of Managed Healthcare. We have had a very, very strong policy of supporting our new initiative program and our local health plan and providing significant partnership. We have technical assistance guides that are on our Web site or are available through our licensing department that assist a new plan in understand what all the ropes are and what exhibits they will have to provide. It's extremely helpful. We did that as a way to lower our licensing time significantly in order to meet our own productivity requirements.

The third point I would make is it really I think important in a state like California to look at setting up a more regional plan as opposed to trying to stretch statewide, and you might consider that you have leverage to do that because in California there is a very distinct difference between the north and south in terms of the availability of provider networks. And again as Commissioner Praeger emphasized, that ability to put those provider networks is critical to success.

So starting locally in an area where they in

fact are meeting an unmet need and have the providers willing with them I think is an important grounding as opposed to trying to spread too far too soon.

Finally, I would just say who is the entity potentially that is going to apply for this? If a department is reviewing an application from a home-grown, local community meeting its needs, we have a whole lot more interest in seeing that grow than if this is as I suggested in my other remarks a wraparound where you have gotten some not-for profit that has no experience in healthcare to essentially partner with a health plan, a commercial, health plan, or some other kind of entity that bring in all of the supporting elements to it; and all that the co-op really is, as I say, a wraparound to this commercial product. That probably isn't going to meet our needs or what we would suggest our needs in our state is for real competition.

So I would just ask you to look at who are the entities that potentially really can become co-op and to recognize that that community purpose is something is something that is very central to the goals of co-ops as opposed to what we might call an imposter co-op

that really is coming in just putting a figurehead at the top of the organization to meet the requirement to pulling down Federal funding.

That's my remarks.

MS. YONDORF: Allen.

MR. FEEZOR: To the commissioners that are on the line, Allen Feezor, and just I'd like to invite the audience if they have not seen Commissioner Kreidler's paper it lays out -- while it's unique to Washington -- it lays out the admission the process in Washington. It's a great paper on what the kinds of documentation and the kinds of process that most of the states will look to, and so if you have not read that, I commend that to your reading.

And I guess I'd like to raise about four or five things -- and, Brian, you probably want to get your pencil ready -- that we might think collaboratively, and then I have a tough question for all three of the regulators that was suggested at the morning session.

The first is that I wonder what would benefit I think this group and, Brian, we're likely to come

back to the NAIC, and look at the specific that are normally asked of companies that are wanting to be licensed. And I think it would help this group to have that because we're going to be looking at some of the evidence of some of material. And to the extent if there are two separate processes that in fact that at least they don't conflict with each other to the extent they can use some of the same evidence or exhibits seems to make some sense.

Along that line, if we in fact are using -- maybe even if we pushed that a little further, there may be some -- the application of -- and I'm thinking out loud -- this is not speak for HHS. But there may be that there are some of the forms that in fact they're using that licensing process that may be very helpful either in terms of the grant application or the loan application process this group might think about as we move to our next stage of business.

And then something for the NAIC is whether or not given the timelines that all three of our speakers have perfectly pointed to that we're facing a tight timeline is whether or not there might be a fast track,

dual track, process that we might consider a look at. Again, I don't know. I'm just raising conceptually if that might make some sense.

Certainly, I think following up on Commissioner Kreidler's listing of the two individuals in his department that are great resources for folks who are thinking about seeking admission or seeking becoming a licensed entity, Brian, I think it would be quite a great opportunity if the NAIC might list who would be the key contacts in those states so that anybody thinking about forming a co-op could early on have a discussion. And underscoring what all three of you have said is get in early talk to it, don't bring any papers already done, find out what you really need to put in those papers, I think that would (inaudible).

And then a couple of issues, this one is a little more -- there're two troublesome issues that we might -- maybe that the NAIC and OCIO might look at or raise. I think I know what the commissioners answers would be on this, but in the untoward event of an insolvency would State insolvency insurance solvency rules persists or would it be Federal bankruptcy? And

I know when I used to be a regulator I could tell you what my answer was: Jim Long would have shot me if I didn't do it otherwise. But the reality is let's make sure we know that on the front end and not be arguing about it after the fact three years from now. So it's I'll look at.

And then finally -- and this is something more maybe for your financial examiners to think through -- the normal capital guarantees that I think you've seen as a regulator provides for the adequate capital normally are in probably a little different vehicle than something that's back by the U.S. Government, and I don't know whether that offers some additional ways of thinking about it, whether there are some additional instruments that in fact if part of that is backed by the good faith of the U.S. Government whether that has any (inaudible) -- I'm just raising that issue because certainly the trouble with raising capital and future capital needed is something that is prominent in the discussions going forward.

So that's my list of things we might think about as we go forward both from the state regulator

side and from the facilitating of co-ops.

My question -- and to one extent or the other, all three of our regulators spoke about the difficulty of new plans, getting either the market penetration or the leverage needed or the rates, more specifically, the rates need from providers to be competitive. And there was some discussions this morning -- and in fact the presenter from the Commonwealth Fund had suggested that maybe States wanting to enact legislation that in fact would give co-ops the best rates, force providers to give co-ops the best rates. There was some question of whether that would be legal. We have a legal authority sitting on the Board suggested that probably the States could pass that.

I guess I would ask both of the insurance commissioners, since they were former legislators as well as regulators, whether that suggestion has any merits. And the flipside of that would be do you see any activity -- since it’s very clear that at least in some States -- or in some markets I’d better say -- that the most favorite nation status with some insurers had are being used not only to the competitive

disadvantage of current competitors but to really forestall any new folks coming in and whether or not there might be some regulatory attention given to that.

MS. PRAEGER: Your last point, Allen, I think is a valid one about the most favorite nation clauses, and I think they would be -- they would make it difficult -- they do make it difficult in our current environment. As to whether or not States could pass legislation that would give the co-op an advantage, we see the calls at the capital is pretty full from any awful lot of interested parties lobbying very hard against that. So it would just depend on the political climate in that state whether or not something like that could pass --

MR. FEEZOR: (Off microphone)

MS. PRAEGER: Right. Yes.

(Laughter)

MS. PRAEGER: And, oh, and then there are, of course, the providers who are going to be very concerned about what does that mean to their reimbursement. It just occurs to me maybe there's a way of creating other kinds of incentives that would

make the co-op attractive to providers that are not centered maybe around dollars but around other quality initiatives and maybe give the opportunity for a co-op to experiment with even accountable care organizations or some other benefit that could in fact be to everyone's financial advantage but not just focus on the reimbursement rate but somehow giving them -- and maybe it's the so-call safe harbor, maybe there's some opportunity with the port system to give some sort of any advantage -- could then I think quickly spill over, which I think might be a good thing anyway.

But may be there -- I just -- there may be some other ways to create some attraction to the co-op. We'd probably have to find it would probably have to be done in some sort of a legislative way at the state level, but I think you might be able to use the co-op as a way to maybe drive some of the system reforms that need to happen, which if we're going to get healthcare cost under control have to happen or all of this really doesn't do much.

MS. YONDORF: Commissioner Kreidler, did you want to weigh in on that?

MR. KREIDLER: I would add just from the standpoint of medical malpractice liability one of the things that's been interesting in the State of Washington since we have rather broad experience now with Group Health Cooperative of the Puget Sound is that their legal liability relative to individual providers is significantly lower within group health than you see in the provider community at large outside of group health.

And I really do think a big part of that is the kind of sense of ownership. Medical malpractice costs are going to be a small part of the total challenges that a startup co-op faces, but there are advantages, obviously, to providers being in a community where they have more of a sense of ownership.

I think Sandy is right on relative to the challenges in trying to establish some preferential rates from providers. I don't think it would be -- it be extremely difficult to get something like that to the legislature because of provider resistance that you'd wind up receiving, and there'd be resistance from the existing carriers that somehow they were not

operating on a level playing field if they were getting rates than other providers.

I think that in the long term -- and maybe this kind of speaks to how much commitment we wind up making for co-ops getting them operational in 2014 or whether it's something that comes in over the next decade or some period of time after 2014. And that would be that perhaps on provider rates that we move closer to an all-payer system, and maybe that's going to eventually be what has to evolve her so that you don't have the power that exists right now within certain provider groups and the power that exists with certain carriers because they have significant market share in order to effectively level that playing field. Once you move closer to having universal coverage, it become easier to move toward a system where you do have an all-payer rate from providers and essentially move the advantage that would exist to certain provider groups over others and certain carriers because of their significant market share and act as a disincentive then for the formation of a co-op.

That's something in (telephone signal

interrupted).

MS. YONDORF: Thank you. Yes?

MS. PRAEGER: Barbara, and I just want to again echo the underlying message that I think all three of us is going to convey is that whatever happens that makes the co-op a little bit different than others, you'd still have to be very careful to guard against the adverse selection and market segmentation and everything. So you have to be very careful.

MS. YONDORF: We are running a little overtime, but this is a critical panel, so I'm, going to ask the rest of the people with the cards up, one, if it's not a burning question we'll write it down; all 25 of the questions that you still got -- and Brian is answering them. I heard everyone say your bosses said you would answer all of them. And then I would ask the rest of you your question if you can say it in about 15 words would be great.

FEMALE SPEAKER: I think I've got a quick question although I don't know that it's an easy one. I want to thank you to the panel again.

This morning we heard that there's some

tension between requirements for returning profit to the members and adequate building up of surplus. And we know there's surplus level in risk-based capital and NAIC model law and the Blues Association has their own requirement. And I'd ask the regulators if what they thought a good target risk-based capital level that would adequately protect against solvency before profits were returned to members?

MS. PRAEGER: I can tell you our risk-based capital requirement for for-profit companies are (inaudible) -- we -- if a company gets to that level, we're already looking at presolvency issues. So most company maintain a much higher level of risk-based capital than what technically is required. It's there just as a benchmark for to trigger some sort of a regulator action. So it's just -- it just depends on their book of business. So we were all concerned about avian flu, and we had companies that had some fairly significant reserves. We thought we'd sure have egg on our face if we forced them to return some of those reserves to their policyholders and then we had an avian flu outbreak, and all of a sudden they get hit

with huge claims. So it's hard to put an exact amount in or an exact target, but it's just -- it really does depend on the demographics of their book of business. Is it's an older population, is it -- it depends on where they are located. Are they in primary service sector? Is it manufacturing? Is it mining? So it's just -- I think it's hard to quantify. Maybe Brian has a better idea on that.

MR. BRIAN WEBB: That's where I'd probably encourage to have a good conversation with our financial folks because there's differences between HMOs and PPOs and affinity plans, how all of these are thought about, how they're going to be organized. You have this full faith and credit of the Federal Government stepping in with these loans, however that's going to work.

We do have experience with this. When we did the Medicare Part D plans, the standalone prescription drug plans. We had to work fairly quickly to make sure the risk-based capital formula worked for them because it was a little different bearing or risk.

And these co-ops because of this new

arrangement of giving the money back or giving it to -- there's benefits, but that does change the formula, how they're organized, how they both spreads their risks among the providers, that's all going to change the formula. So I'd recommend and we do offer a conversation between this Board and our financial folks to kind of walk through some of these issues.

MS. EHNES: May I just add, we use tangible net equity, not risk-based capital although we tend to use an eye toward risk-based capital because we think it's a better manager than T&E.

But I will say that in our oversight of risk-bearing organizations, none plan provider groups that are risk bearing, we really emphasize the role of cash and cash equivalents. And so I would just note to you that as an aspect of the risk being borne by a young entity in which the major concern is the ability to pay claims that you look at the role of cash and cash equivalents as being very pronounced versus other kinds of assets that we tend to allow a more mature entity to count toward those requirement. I would just note that.

MS. YONDORF: Okay. Very quick question.

MALE SPEAKER: Okay. I will attempt that. First a comment. The word co-op keeps getting used and especially since you're heads of your respective state insurance department. These may or may not be cooperatives. I head up a cooperative trade association, and depending on how these are structured, we wouldn't even recognize the entity that has been created any kind of co-op.

Secondly, just to reiterate -- and I won't do this as a question -- but it would really be helpful because I understand you're (inaudible). I was a state regulator for 14 years, but if you can point out where there's assistance that can be provide to these and put it in writing to the committee and where that can happen, that would be really, really helpful. Because if I am just an outsider looking at this, I see all these barriers that I have to overcome, I may or may not get part of the $6 billion to help form this entity, but it seems like a pretty daunting task especially when I'm up against the marketplace, and I can't vary from the market to be successful.

So if you can provide -- just given your incredible expertise that you have -- if you can provide suggestions that would be really helpful.

MS. YONDORF: You've got the last question, my colleague from Colorado.

MALE SPEAKER: Thank you, Barbara. Real quick, a real quick question. What role does reinsurance play as far as reducing the risk capital that needed?

MR. WEBB: Well, the temporary reinsurance program will help in the initial years, help at least the individual market. It won't help the small group. It'll help the individual market to a certain extent. Risk adjustment going forward will help some, but you need to keep in mind these are tools, and we don't want too much volatility in the marketplace. I know every time tend to bring up adverse selection there's a certain group of people who say, "I want risk adjustment." But you don't (chuckles) too much money changing hands. You don't want that much volatility. You want to limit that and selectively limit the need for the risk adjustment and reinsurance in the initial

years.

But they can help if they're starting up in those initial years and that reinsurance program is in place. And whether people want to -- states wants to continue any kind of reinsurance program would be a question.

MS. YONDORF: Thank you very much. This has been as superb panel, and we very much appreciate these offers of help and the welcome that you presented that people who are interested in co-ops your doors are opened and in fact you'd like for them to come in early and have that dialogue. We're really pleased to hear that, so thank you very much.

(Applause)

MR. FEEZOR: For the rest of the afternoon -- we were scheduled 15 minutes ago to have a break. I would invite members of the audience and members of the Board to take you break at your own leisure because we're going to in order not to short circuit the time from comments from the public, both telephonic and in person, we'd like to move immediately into that unless anybody strongly objects, and that'll get us back on

time.

And just as a warning, we have -- Patricia, I don’t know whether you -- who is having to leave much before -- by 4 o’clock?

(No audible response.)

MR. FEEZOR: 4 o’clock?

(No audible response.)

MR. FEEZOR: Four. And this just so that folks -- I expect that we will use our full allotted time for comments from the audience. What the Chair may do is to suspend the comments from the audience for about 10 or 15 minutes so that our departing panel members can in fact provide some comments either in terms of additional questions they’d like to have issues that they want to have the -- maybe drill down a bit deeper. Either between now and the next meeting or at the next meeting, one of the things that we will be asking this group to participate in are there some inconsistencies or ambiguities in what we’ve heard and what we think the legislation says. And that’s not to say the legislation is what is it but just to identify some of those things that maybe are contrary to what we

think might make judgment.

So in those two categories, what sort of questions you have, you want more information on a subsequent. Secondly, there some sort of ambiguities or conflicts that seems to be in terms of what we've heard versus what we at least interpreted the law to read.

And then just know that any of you are leaving early may in fact get tasked with heading up one of our subgroups, but that's that.

(Laughter)

MR. FEEZOR: Other than that, that's fine. So is that all right? What do we need to do to -- I know you have a pecking order for the folks to come up.

MS. ANNIE: Yes. I'm just going to call people up in the order that they signed up, and I can -- expecting you to come up and sit at the table. I have a microphone, and everyone will get about three minutes.

MR. FEEZOR: And would you go ahead and read the first three and let them come up to the table, and that way --

MS. ANNIE: Okay.

MR. FEEZOR: -- we can sort of process it through here. Bill

MR. OEMICHEN: Is there going to be any written record of these comment?

MR. FEEZOR: I assume there is.

MS. ANNIE: There's transcription as well. I'll --

MR. FEEZOR: A transcript.

MS. ANNIE: call out the names. John Morrison. We have Frank Knapp by phone, and John Jemison.

MR. FEEZOR: And if you would, be sure to identify yourself and your affiliation if you would. John.

MR. JOHN MORRISON: Thank you, Mr. Chairman and members of the committee. My name is John Morrison. I'm the senior partner in the law firm of Morrison, Motl & Sherwood in Helena, Montana. I flew here from Helena to be with your today to talk about an exciting development in Montana, the Montana Hospital Cooperative.

I served, as some of you know, as the insurance commissioner of Montana from 2001 to 2008. I've been very involved in health coverage initiatives and issues. I'm the past chair of the Health Insurance and Managed Care Committee of NAIC as Commissioner Kreidler is now the present chair. It's been my pleasure in my state to help establish Insure Montana and Healthy Montana Kids, two state-based initiatives that are covering tens of thousands of previously uninsured Montanans, and I'm a new member of the board of The Center for Health Policy Development, the parent entity of the National Academy of State Health Policy, which I was involved with as commissioner as well.

I'm here today, however, as a board member of the Montana Health Cooperative, a mutual benefit nonprofit corporation that's seeking health cooperative status in Montana, for Montana. And our board sends you their greeting and thank you for your service.

Montana has a long and positive history of member-owned cooperatives. Many Montanans buy their telephone service, electricity, natural gas from cooperatives. Our ranchers and farmers sell their

products and buy their goods and services almost exclusively through cooperatives. And our many strong credit unions are member-owned cooperatives that provide credit and financial services to thousands of families in our state. So why a health cooperative in Montana.

Montana has perhaps the least amount of meaningful competition for healthcare dollars of any state. Most of our communities have a single hospital, and one insurer has the lion’s share of the coverage in all 56 counties.

Our initial work group is comprised of individuals with a proven track record in civic involvement and represents the great diversity that is Montana, business and labor leaders, Native Americans, and academics, persons from all walks of life and from all regions of our large state. Most of them have experience with healthcare administration or healthcare plans. We have reached out to the medical provider community so as to build a truly statewide, integrated delivery model of care centered on primary care. Our nascent board includes a retired CEO, retired CEO of

one of our state's large hospital, the director of our only inpatient mental health center, and the president of the state's largest independent physician clinic.

We intend the care delivery model to be built around the patient-centered medical home concept as developed by the Center for Health Policy Development and the Bureau of Primary Healthcare, and we've engaged the full cooperation of our community health center movement in Montana. CHCs serve 10 percent of Montana's population and yet have been neglected by many private payers, and we intend the CHCs to be a center piece of our delivery strategy.

Financially, we've retained an actuarial consulting firm, and our initial actuarial projects are included in handout that I believe were given to you previously. As a former insurance commissioner, I understand the importance of building co-ops that on a sound financial footing. We are reaching out to private foundations for startup grants, and we're convinced that this enterprise is not only in the consumer's interest, but it can be self-supporting an viable in a short space of time.

We recognize that there has been some skepticism of the concept of 50 single state health cooperatives competing meaningfully against the big 70 giant insurers. We believe that we can successfully compete in part because the large carriers are saddle with stockholder demands for profit, large overheads, antiquated legacy processing systems, and other inefficiencies.

And let me take this opportunity to mention a couple of specific things that I hope the Advisory Committee will look at. One of them is that the statute calls for membership ownership, and to the extent that these entities are formed a mutual benefit companies, they're subject to premium tax under state law. Health service corporations, which Blue Cross-Blue Shield falls under, and other entities that are health service corporations in the state don't pay premium tax. So we want to make sure that the co-ops qualify as health service corporations so that they don't have to pay premium tax. If they do, that's an additional competitive hurdle that they have to overcome.

Also want to just mention that in addition to the most favorite nation issue, there is also the any willing provider statutes in the state; and to the extent that the co-ops can be granted some safe harbor for the development of relationships with providers that serve the purpose of encouraging primary care, encouraging a health center for the enrollees then that would be very helpful in the development of the cooperatives.

I'm also here to speak today on behalf of the National Alliance of State Health Cooperatives, NASHC. I'm honored to serve as the incorporating president of this new organization. Acting under the auspices of the ACA Section 1422(d), NASHC hopes to develop a strong private purchasing council as well as to provide other trade association type services. By purchasing services together, co-ops can provide better, less expensive service to their members than is currently available. And we have provided literature on the National Alliance, and we invite interested parties to join NASHC so as to provide a centralized means of communication, education, purchasing, and advocacy.

Thank you for providing this opportunity for public input, and I'd invite any of you to contact me for further information after you've contacted Brian Webb and to come to Montana to see the great work that our team has done there.

MR. FEEZOR: Thank you, John. Annie, who do we have on the phone?

MS. ANNIE: Frank Knapp.

MR. FRANK KNAPP: Yes. I'm Frank Knapp, president and CEO of the South Carolina Small Business Chamber of Commerce. Thank you for the opportunity to be with you today by telephone. I want to first apologize for some grammatical errors and one reference to a wrong state that was included in our first submission of our comments. We found out about this opportunity to participate just before the deadline of submission, and the proofing process was not adequate.

We appreciate the important work of the Board and the Department to craft a successful implementation strategy to foster the creation of qualified, nonprofit health insurance insurers. The South Carolina Small Business Chamber of Commerce is a 5,000-plus member

advocacy organization has supported the passage of the Affordable Care Act. While many of our state officials have both vocalized and taken action in opposition the ACA, many small businesses across our state have already taken advantage of components of the ACA and most look forward to utilizing the soon-to-be-implemented insurance exchange.

Our organization has brought together numerous trade associations very much interested in exploring the possibility of establishing a qualified nonprofit health insurance insurer. One of these nonprofit groups, the South Carolina Primary Healthcare Association is interested in both being a provider to and a user of this new nonprofit health insurance entity.

The State of South Carolina has not yet decided whether to create its own insurance exchange or default to the Federal Government. If the State opts to create its own exchange, it’s clear that it would be more in line with the laissez faire Utah approach. In such a scenario, simply allow insurance carriers to post their policy, specifics, and rates will not change

the dynamics that have given our state a one-carrier dominated state. Only a nonprofit health insurance co-op offers hope that an exchange will provide significant competition to yield savings for small businesses. If the Federal Government is handed the responsibility to create the insurance exchange for our state, a nonprofit health insurance co-op would still be important as well as required to provide the greatest opportunity for small businesses to benefit from the ACA.

As mentioned earlier, the interest of South Carolina small businesses exploring the creation of a nonprofit health insurance co-op has been demonstrated. The former director of the South Carolina State employee health plan believes that a small business health insurance co-op would be successful in our state, but a feasibility study would be required to verify his opinion.

Unfortunately, our coalition of small businesses does not have the resources to commission a feasibility study or secure the consulting services that we need to move forward in the expeditious manner

with preparing a proposal for funding. While funding is essential, it must be in the form of a planning grant. Any discussion of a loan for this purpose will stop our efforts immediately.

In addition to planning funds, timing is also critical for a health insurance co-op to be in place and functioning on or before January 1, 2014, will require a planning grant to be obtained in 2011. Due to the uniqueness of this effort in our state, we anticipate that it will take considerable time to conduct a feasibility study to determine the potential success of a health insurance co-op before real planning and preparation can take place.

I thank you for the opportunity to offer our thoughts in this very important matter.

MR. FEEZOR: Thank you very much. Jim.

MR. JOHN JEMISON: My name is John Jemison. I'm a developer with Workers' Cooperative National Association, a company that is planning to develop co-ops in six charted states, referred to as region 1, to reform healthcare in America. Member-run cooperatives are not focused around a particular interest group or a

particular stand. They will provide an impartial objective voice that is based only on the premises that the good of the whole is more important than the interest of the few. That's to paraphrase The Mayo Clinic Health Policy Center.

Our mission: To create and make available to all Americans an affordable, consumer-driven, free market healthcare system in partnership with government agencies.

Brief description: The Workers' Cooperative National Association, a nonprofit association whose initial members are Workers' Cooperative of Alabama, California, Florida, Georgia, Tennessee, and Texas. These states, referred to as Region 1, were selected as charter members based on need. Texas has the largest number of uninsured in the United States. According to July 27, 2010, *New York Times* article by Kevin Sacks, there are more uninsured residents of Texas, 6.1 million and counting, than there are people in 33 states.

And Alabama is dominated by one insurance company, and insurance companies have great monopoly --

have near monopoly in all charter member states and can raise their rates and reduce options with impunity.

The ideas of WCNA is that the business is owned by its members and everyone works together for the common good to provide a affordable, quality healthcare to members over the pursuit of profit.

Cooperatives have had a long history in the United States -- a long-valued history in the United States. The cooperative is a model business structure originated in 19th century Britain in response to depressed economy conditions similar to the condition in America today. Some people began to form cooperative business to meet their needs.

Among them was a group of 28 workers -- they were textile workers -- who were dissatisfied with the merchants in their community. They formed a consumer cooperative known as the Rochdale Society of Equitable Pioneers in 1844. The society began by operating cooperative stores that sold such items as flour and sugar to its members, and the society quickly grew to include other enterprises.

In the early 1900s, the United States

Government began to pass laws that provided a favorable environment for cooperative development. The depressed conditions in the agricultural section in 1908 prompted President Theodore Roosevelt to propose to Congress to pass the Federal Farm Loan Act of 1916. American agricultural sector went through a tough period as prices collapsed after World War I ended. As part of the response to the economic conditions, similar to the healthcare market in America today, three Republican presidents, Harding, Coolidge, and Hoover, strongly endorsed agricultural co-ops. The agricultural market of 1929, which included the establish of funds for cooperative loans, also helped strengthen the cooperative movement.

The truth about healthcare and cooperative. Some in government, business leaders, special interest groups, and politicians have misrepresented the new healthcare law, the Affordable Care Act, as a Government takeover of healthcare that will increase cost and cause disruption in the marketplace. Those statements are self-serving and false. This is the same kind of ploy another special interest group,

utility company executives, tried to pull in 1935 to keep the Government from forming the Rural Electrification Administration, the REA, when they wrote a report claiming that very few rural farmers were without electrical services. But the newly elected REA and the related Rural Electrical Cooperative proved the utility company executives report was self-serving and false. Franklin Delano Roosevelt signed Executive Order number 7037 establishing the REA on May 11, 1935. Now nearly every farm in America has electrical services thanks largely to the effort of --

MR. FEEZOR: John -- John, nobody loves history more than me, but we really need to try to constrict your remarks to recommendations that this panel ought to take under consideration in trying to facilitate the growth of health co-ops.

MR. JOHN JEMISON: I agree, and I would have rewritten this -- reformed it had I known this meeting would have been what it was today. Just the last paragraph.

Member-run health cooperatives can bring the

same advance to the America healthcare system that electrical cooperatives brought to rural Americans 70 years ago. The Workers' Cooperative National Association will lead in the way in the (inaudible) reform.

Let me say this, and I hadn't heard it said, but most might know this, but the co-op provision of the new healthcare law Section 1322 was put in the bill to compete with the insurance companies that the Government selects to offer healthcare plans through the exchange. So for co-ops to compete with the major insurance companies, we cannot have 15, 20, 30 cooperatives operating all under different business principles. You got to have one association, and this is what we've done in forming Workers' Cooperative National Association. We'll play the major role in the management and development of co-ops throughout the United States with one administration -- operation, one TPA (ph), to handle the claims and so on and so forth.

So there's got to be some continuity of business principles in developing these cooperatives and business (inaudible). Again, you can't have 50 --

40 or 50 co-ops all operating under different business principles to compete with the major insurance carriers.

MS. ANNIE: Mark Russ, then Peter Beilenson and then you have Rosa Young on the phone.

MR. MARK RUSS: Mr. Chairman, Board members, I'm Mark Russ, managing partner of the Chicago office of Barnes & Thornburg and chair of its national healthcare department. Barnes & Thornburg is a 520-attorney firm with offices in 10 cities. We represent health insurers including nonprofits, provider-sponsored health plans.

In addition, we represent a larger number of healthcare providers all around the country. Many of those providers are interested in and are pursing development and sponsorship or a co-op under Section 1322 for the purposes of purchasing health benefits for themselves, their employees, and families and offering the same insurance to members of the public and partnering with their patients in governance.

Providers are consumers too in that they purchase health insurance in individual and group

markets for themselves and their beneficiaries. For example, large hospitals may self-fund and administer their plans and my consider a variety of ways to participate with the co-op. Their independent position staff members purchase insurance for themselves and their employees on the open market.

Providers are motivated to make the step into clinical integration as accountable care organizations under Section 3022, and they will demonstrate an even higher level of the sophistication needed to successfully compete in a co-op.

This may be just the innovative idea Commissioner Kreidler described just a moment ago. There will be three legs in the stool of co-op creation: Infrastructure, providers networks, and funding. For the providers, the rental of insurance companies infrastructure, as we've heard this morning, will help build the guts of an operations quickly and delay a large portion of upfront cost. The formation of networks, which is usually the hardest part, will become the easiest piece for our clients since the provider networks themselves can be among the co-op

founders.

The third leg, funding, presents two hurdles. The first is the method by which the Office of Consumer Information and Insurance Oversight initially certifies an entity in formation as justified to receive loans to defray startup costs to avoid the chicken and the egg startup funding problem.

The second hurdle is the question of how to fund initial reserves. We would strongly urge this Committee to recommend that the National Association of Insurance Commissioners develop a model approach to calculating upfront reserves and the purchase of reinsurance so that founders of those co-ops can understand what capital they will ultimately need to do business under state law.

If this Committee can resolve these issues first, providers who have taken steps to become accountable care organizations will be well-positioned to develop credible business plans, take care of the provider network issues with innovative medical management and reimbursement design, interjecting real competition into local markets.

Members of the Committee, thank you very much for time to speak today.

MR. FEEZOR: (Off microphone.)

MR. MARK RUSS: At some length, yes. The drafters of the statute were unclear, and in fact they didn't really have a -- well, first of all, as a legal matter, I think, when it says that in each states it's going to be a corporation that formed as a nonprofit virtually every state already defines the word "member." And so by operation of the statute the way it should work is that the member or members, the initial incorporators, if it's 1 or 20 or 30, would sort of serve that definition since it wasn't defined in the statute.

But it's clear that the drafters of the statute didn't mean that. It's clear that they meant something closer to the idea of beneficiaries like the attorney from Group Health was talking about today, and it's used eight times in the statute including one title, and the one time that it's used in a meaningful way it's more like beneficiaries, not the legal idea of state law.

MR. FEEZOR: You knew exactly where I was going. Thank you very much. Peter.

DR. PETER BEILENSON: Hi, I'm Dr. Peter Beilenson. It's a pleasure to be here. I was Baltimore's health commissioner for 13 years. I'm now Howard County's health officer. It's a county halfway between here and Baltimore, and I'm cofounder of the Evergreen Project, which is our Maryland-based co-op.

We started this about April or May of 2010, just after the signing of the ACA. We formed a steering committee composed of experts including venture capitalists, investment bankers, insurance executives who have the appropriate mission in mind, public health experts, and providers as well. We've received $175,000 of grants from our local and regional grantors to have a feasibility study that's been going on, and we've been validating our initial assumptions with a variety of health economists and health specialists.

I think it's been a great meeting. We agree with most of what you've been talking about, maybe have a couple of little differences. There's only one issue

that I wanted to talk about very briefly that we have found in our nine months of so of going about this feasibility study that has not been dealt with extensively today, and that is the absolute need to leverage the Federal funds with private dollars and making that a possibility.

We're extremely appreciative, obviously, of the Federal funds that are coming in for the reserves, etcetera, but in terms of startup costs, operating capital, particularly until we get the stream of revenue coming in to our co-op as we're starting up, we need to raise private equity, and there has to be a mechanism, hopefully through the regulations, that whatever income is generated from these co-ops not only inures back to improve the activities of the co-ops and rebates for the members but has to be able to provide an ROI for private investors. That's the only way we're going to be able to attract the capital, and it's the only way we're going to be able to compete with the insurance companies that are existing. Thank you.

MR. FEEZOR: And on the phone is Anne?

MS. ANNIE: (Off microphone.)

MR. FEEZOR: Rose -- Rosa. Excuse me.

MS. ROSA YOUNG: Hello, can you hear me?

(Pause)

MS. ROSA YOUNG: Good afternoon. Thank you for hosting this. This is a wonderful opportunity to learn and, hopefully, teach. I'm member of the senior management team at First Carolina Care Insurance Company in North Carolina. We're a small nonprofit issuer that's wholly owned by a 501(c)(3) hospital health system, and like many other nonprofit health plans all over the country, we believe that we're operating in a manner that is very close to what was envisioned in Section 1322. We have a community-based board. We have strong collaborative relationships with our providers and with your clients, who are primarily small businesses in our local community.

It has taken us approximately 10 years to reach 16,000 members. This is a very, very challenging business for an independent health plan. We compete every day against the likes of Blue Cross Blue Shield of North Carolina, United, CIGNA. And we have so far been successful in doing that.

You have heard from the previous panel how difficult it is to be a startup in a very competitive environment that's dominated by very large players. And even once you get licensed, it's a very challenging proposition to stay in business and to maintain solvency.

We hope that the Board and HHS will look at independent nonprofits like First Carolina Care as a resource with considerable operational experience and just street smarts about how to make independent health plans work, and we would be very happy to help make co-ops a successful a program.

Moreover, I just want to note that there are many regional managed care plans like First Carolina Care. There are probably over a hundred throughout the country, and like us, they're already pursing and accomplishing the aims of Section 1322.

If there could be some way that existing plans could be included in the CO-OP Program, we believe that the funds available under 1322 could be used immediately to expand coverage and to build capacity to improve care and cost effectiveness.

We understand that the prohibition on participation of existing insurers is a significant legal hurdle, but we hope that the definitions of “affiliate” and “successor” could be written such that plans like us who would be willing to restructure could participate and to get some of these funds that we definitely need to improve our IT, infrastructure, and to expand and grow in this new, more consumer-oriented environment. It would really increase the likelihood of there being viable options to the big insurance companies. Thank you very much for your time.

MR. FEEZOR: Thank you, Rosa. Annie, our next three panelist.

MS. ANNIE: Ken Barbic, Edward Grundy, and Adam Schwartz.

(Pause)

MR. FEEZOR: Ken, (inaudible).

MR. KEN BARBIC: I want thank the Committee for the opportunity to present our thoughts and comments on your considerations today.

My name, again, is Ken Barbic. I’m with the Western Growers Association, and I’m presenting these

comments on behalf of the National Council of Agricultural Employer, which represents agricultural employers and agricultural employer associations, and is a principal voice for agricultural employer labor issues in the United States.

NCAE's members employ approximately 75 percent of the U.S. agricultural workforce. Western Growers is an agricultural trade association whose small, medium, and large size members grow, pack, and ship almost 50 percent of the annual U.S. production of fresh fruit, vegetables, and tree nuts.

Western Growers is also a not-for-profit agricultural health benefits provider with more than 50 years of experience in tailoring benefit plans to meet the needs of rural employers and their employees. We have the privilege of coordinating the NCAE healthcare reform working group.

NCAE is working to ensure the healthcare reform legislation will enable agricultural employers to continue to provide health benefits for their employees and allow those who currently cannot provide coverage mechanisms to do so.

During the development of the Affordable Care Act and the subsequent regulatory implementation process, NCAE has raised the unique cultural, administrative, and economic challenges that the Affordable Care Act presents for the seasonal agricultural industry and has proposed or contemplated a number of approaches to address these hurdles including on the subject of co-ops.

With regard to produce, our agricultural businesses depend on seasonal workers. Crops are grown, cultivated, and harvested outdoors by seasonal farm employees. Providing healthcare coverage to agricultural employees is administratively challenging because of the transitory nature of many farm-related jobs. Some of these jobs can last a few days, and some can last several months. In addition, an employee may work for multiple employers in a year across state lines. Moreover, there is often high turnover in this industry with a significant percentage of seasonal workers also being H-2A guest workers.

Nonetheless, the Affordable Care Act appears to apply to these employees. Their employers are at a

loss for how the Affordable Care Act can be implemented for many in this population.

From an economic perspective, agricultural has unpredictable revenue cycles; and unlike other industries, we are price takers, not price setters. As such, the ability to pass along increase cost is very limited because of this aspect of our industry. Nationally, healthcare plans that can meet these challenges are largely unavailable or require premiums that are unaffordable to farmers and their workforce.

These significant administrative and economic challenges are compounded by the cultural challenges associated with providing healthcare coverage to the seasonal agricultural workforce. Immigration status will likely preclude seasonal workers who are not currently provide basic care from accessing coverage through a state-based exchange. Paying anything for healthcare cost including insurance, insurance premiums, and doctors' visits is inconsistent with the commitment many of these employees have to providing for their families here or abroad. So for many of these employees that currently receive coverage, the

employer is paying all of the cost associated with premiums and deductibles.

Seasonal agricultural employers have tried for decades to provide basic coverage at extremely low cost for their seasonal workers who are simply uninterested in spending any amount for this purpose.

In an effort to meet these challenges briefly described, NCAE is considering the utility and possibility of establishing an agricultural co-op under the Affordable Care Act. We would appreciate the advisory panel's consideration of the following points.

Can the law or implementing regulation allow for the establishment of an agricultural or rural-focused co-op at the state and/or national level?

Because the seasonal agricultural employees will not use a state-based exchange established under the Affordable Care Act, a rural co-op that enable seasonal employees to access coverage will also need to operate outside of an exchange as well.

Will the funding that the Affordable Care Act provides for establishments of co-ops be available for the establishment of a state or national agricultural

or rural co-op both within and outside of an exchange?

In addition, we think that entities eligible to establish co-ops or convert into co-ops should include group health plans. With the establishment of a waiver process that allows for current annual dollar value of benefits to be retained, Western Growers' members will be able to continue to provide healthcare benefits to approximately 77,000 employees in 2011. We believe the waivers will form an essential component of any seasonal agricultural health benefits mechanism including a co-op.

We understand that the establishment of regional subexchanges are allowed for in the Affordable Care Act may also include the possibility of an agricultural or rural subexchange. We would like to know how a subexchange would relate to a co-op. Could an agricultural co-op be part of a subexchange mechanism?

These are some of the concerns and questions that we have, and I thank you for the opportunity to bring these two the panel today.

MR. EDWARD GRANDY: Good afternoon. I'm

Edward Grandy. I'm the executive director of the American Sleep Apnea Association. The American Sleep Apnea Association is the only national nonprofit organization dedicated to educating the public about sleep apnea and supporting those with the condition. And I appreciate the opportunity to be able to speak to the Board.

Despite the fact that the word sleep does not appear once in the 2,000 pages of the Affordable Care Act, we feel that the ACA is an excellent opportunity for those with sleep apnea to get the coverage that they need.

Very simply, given the prevalence of sleep apnea among adults in the United States and children as well, we would encourage the Board to recommend to the Secretary that diagnosis and treatment of sleep apnea be considered as a part of model coverage. We would also ask that sleep apnea be recognized as a chronic condition and that a disease management model be used to address the condition among patients.

The association is available to co-ops and to the Advisory Board for any additional information that

we can provide on the subject.

MR. FEEZOR: Thank you, Edward. I hope you're also making those comment to the Institute of Medicine, which I think has the panel that's looking at designing or at least defining what the central benefits or providing some input to the Secretary on that. Adam.

MR. ADAM SCHWARTZ: Good afternoon. My name is Adam Schwartz, and I'm the vice president of public affairs and member services for the National Cooperative Business Association. I originally had not planned on speaking today because my boss, Paul Hazen, submitted testimony and appeared before you; but having been with you all day, there are a number of items that have come up that I'd just like to offer a few maybe comments to help illustrate and maybe clarify some of the issues.

One in particular on the capital issue, there's been some very good discussion about the risk-based capital and how we balance the need of a cooperative to have solvency yet to inure those benefits back to the members. I would submit that that

tension is not unhealthy. That is one of the dynamics of the cooperative business model that makes it unique that there is that consumer interest, so you focus on what the needs of the consumers are, but you also focus on what the needs of the cooperative are as well.

So I think there is a balance that can be met. In other cooperative sectors certainly it does exists, and the idea of retained earnings begin held, especially if it's for the solvency of the organization, it would not be against cooperative principles to build up that capital reserve to make sure that the institution can be solvent on the long haul.

There was also the question I think Mr. Gardner had asked regard to outside investments and other capital, and one of the previous speakers on the public section also mentioned that as well. I do think that through interpretation you can find a way to leverage some of the Federal funds that would help to attract some private investment, but I think one of the problems that you're run into because of the mandate that it be done on a nonprofit basis.

There are other cooperatives that operate under different sections of the tax codes that are eligible to attract outside investment through preferred shares or nonvoting common shares, and they can get a return on that investment, but they do not get any ownership rights. But you're thrown the additional complication of being mandated that you're a nonprofit, the outside investment model becomes a bit more complicated and might need to be more structured as debt than investment. So I would offer that for your consideration as well.

On the issue of board training, I've heard a lot of good comments about the need for expertise on the boards as they go forward. I would also offer the fact that you need cooperative expertise if you want these entities to operate at consumer-owned and operate entities that use the cooperative business model.

We outline in your testimony how that is possible. If you would, the medical would be in the old days when you had overhead projector and you put on slide on and then another slide on top of it, so you have the nonprofit model, and you overlay of it of the

cooperative governance model so that you get close to approximating the way of the types of cooperatives. But you can only do that if you have board expertise in the cooperative model, and I think that that should be part of the mandate going forward as well.

Another issue of great concern to us is the marketing restriction that's in the legislation because how can entities go forward and attract new clients or consumers to be part of the cooperative if the entities are not allowed to market. So we would really emphasize that an extremely narrow definition of that be put forth.

Finally, of the seven cooperative principles, the one that is the favorite among many is number six, and that's cooperation among cooperatives. You will find a great ability of those both in the cooperative healthcare sector and in nonhealthcare to aid and assist both this Advisory Board going forward and with the establishment of co-ops in the individual states.

Bill Oemichen's group is one that exists in Wisconsin and Minnesota. There are likewise state groups throughout the country, and of course, the NCBA

remains at your disposal as well. So thank you very much for the opportunity.

MR. FEEZOR: Thank you, Adam. Annie, before we go to the next trio, how many more do we have?

MS. ANNIE: (No audible response.)

MR. FEEZOR: Ten?

MS. ANNIE: Two.

MR. FEEZOR: Two. I'm going to ask our two last speakers to hold for a minute because we're running up on a 4 o'clock departure for three of our guests -- not three of our guests -- three of our fellow board members and would like to give them the opportunity make some public comments in advance of the broader group discussion that we'll have following the public's input and would ask any of them if there are some themes that they want to sort of underscore or highlight that they think we need to be considering or that you would like us to come back and spend a bit more time on either in some sort of discussions or maybe drill a little deeper in terms of research. Anything that -- that sort of category 1, category 2 would be anything that is troubling, maybe some

inconsistencies to what we've heard versus what we think the legislation may be saying so that we can do some research on that as well and anything else that you would like to sort of have us be thinking about or your colleagues be thinking about.

So it's Patricia, Dave, and David. David, do you want to go first?

(No audible response.)

MR. FEEZOR: Who else?

(Pause)

MALE SPEAKER: I'm sorry, panel. Thank you very much. Geez, late.

MR. FEEZOR: All right. Well, we'll run it down the line. Patricia, how are you on time?

MS. HAUGEN: (Off microphone.)

MR. FEEZOR: Okay. So, we'll so three and then -- three -- all right. David.

MR. DAVID: My comment has to do with the elements of success, which is a very helpful presentation to focus our task and specifically how might other areas in the U.S. vary from the Washington and Wisconsin models presented today and what

considerations and risks should we access or anticipate for in developing successful co-ops in different markets with different sociodemographics and different state receptivity.

The climate in both Washington and Wisconsin temperature and otherwise are different than in other states, and I feel like they have great models that we can learn from, but I also want to learn what pieces of that are not generalizable across the country, and I don't know if there is someone in our group that can explore that.

MR. FEEZOR: (Off microphone.)

MR. DAVID: I guess I'm going to give some general comments as I leave, and then we can carry out with them. I had kind of centered around five quick things I guess.

Number one is consumers -- it's in title -- it's surrounds us -- the involvement of the participation, the two-way street idea is very fundamental to me, and I guess I would want that to be something I would have us continue to explore and involved.

Number is there's this tension about the need for a network, and yet Group Health and HealthPartners the network is part of the organization. And can tell you from a provider's side there's a lot of providers who really -- at least on the primary care side -- really don't like the current system and would participate in a new and novel and innovative ways to provide more healthcare, and I would have the co-ops investigate -- I mean in my mind providers were part of what was discussed about who would be part of the co-op effort, so I don't know exactly where to go with that, but I just would raise that as another point that I want to look at in the next meeting or two.

Number three is risk capital. I'm really worried about his whole element of risk capital. I thought we had at least the start of something that we would be able to provide and they'd be able to build. It really concerns me about will the risk capital be there to provide sufficient nature for cooperatives to exist.

And then finally, is the whole issue of the Federal/state regulations. I really fear them going

through two separate processes, and I was really encouraged by the speakers regarding -- the regulators -- if there is a way to work in tandem or work together or -- and Allen, your ideas of a common forms and processes really encourage me about at least helping them in that mind. Those are kind of off the top of my head, so I apologize for the...

MS. HAUGEN: Thoughts from I guess a consumer perspective and then just some areas of concern that I think impact whether the model can be successful from a business standpoint.

So first of all, I think some additional thought on how the consumer model and governance is really implemented to make certain that it is a robust as it needs to be but isn't restrictive or too prescriptive.

And there have been some areas of conversations that would indicate concern on whether the Act or the language in it in some of the requirements negatively impact the chances of success; the issues of some of the restrictions on the individual and the small group versus maybe some

broader definition; the restrictions on marketing; the amount of capitalization; and what is the access to funds; and some of the 5-year repayment; are there some definitions here that by default may restrict the chances of success moving forward; that all of us want the benefits to be realized, but they can't if this is not a successful business design.

(Pause)

MR. FEEZOR: (Off microphone.)

MR. CURTIS: What I would surmise -- a number of people who have said, which indicated a new startup entering a market trying to negotiate as a traditional insurer or a traditional PPO provider rates isn't going to be competitive. And I take from that it's going to have a very hard time to be viable.

And then -- over and over and over again this issue of net revenue being turned back being a potential problem, and it seems to me that through definitions of revenue or guidelines from the Department that say, "Look, we're going to recognize setting aside for both the growth and reserve requirements as well as growth requirements more

generally capital before you get to net revenue amount," I think it could be handle definitionally. I wouldn't think we'd need a national academy of accountants to do that.

The related thing is -- there was a lot of discussion by various folks including some who are like Montana they're trying to develop relationships with providers.

It was quickly mentioned, but I think this is important in a relationship back to what are the reserve requirements for these animals. If there is risk sharing with provider entities including primary care physicians who are contracted by those things that should reduce somewhat the reserve requirements on them.

And then the fourth thing, I would just mention a couple of distinctive characteristics about Minnesota and Seattle beyond the obvious they're north and they're cold and so forth. They have these big physicians group model either practices, in the case of Minnesota, that they were able to deal with. In many part of the country, those don't exist.

But I was really struck by this over and over again were these same kinds of things succeeded, and this includes Kaiser, it included large employers. So while I don't think there are clever ways around what the law says in terms of what the co-op is per se, it seems to me that our advice to the Department and the Department's guidelines could make it clear that it's okay to have some other partner organization that having the same arrangements with providers and so forth, but isn't part of the same risk pool and don't -- isn't advantaged by the Federal dollars that provide the reserves and the operations for the small group and individuals. Again, I think that sort of thing could work well. I don't think it's inconsistent with either the intent or the substance or the wording or the law.

And I think for these things to succeed -- have a chance of succeeding in many parts of the country, especially the startup, something like that may well be essential.

MR. FEEZOR: Rick, to underscore your -- make sure I'm comprehending your last comment. Is that partly because of the sense of urgency and also to

assure success and sort of have immediate economies of scale, if you will, is having co-ops be able to either tandem operate or operate in some sort of fashion with an existing, ongoing entity that in fact there could be some shared operations even though there could be separate constructs that would allow co-op monies to be used for co-op purposes, so to speak,

MR. CURTIS: Well, just an example, if it was partnered with an ACO that it was contracted with -- and that included some large hospital systems -- the large hospital systems could have the same arrangements on a self-insured basis for their own workers with exactly the same provider payment conditions so forth and so on, and the same ASO services for the providers. That'd be one example.

Another example might be an employer coalition. Montana has a large employer coalition that I know you're well aware of. I don't know if they'd be interested per se, but something like that could make available to its members who could be on a self-insured basis, or there could be a cooperative with a large employer that was parallel to the cooperatives, to

small employers, to individuals. And there could be several different ways it could work, but it seems to me, again, critical to the success of these things, to the startups, are very probable in many parts of the country and not inconsistent with the intent of the law that -- as I read it. They don't want these Federal dollars going to subsidize the administrative cost and the risk bearing for those larger employers. It's supposed to be part of the (inaudible) of these people. In fact there'll be savings for our target populations of individuals and small employers because of the economies of scale and the all new administrative systems and the better ability for the providers to organize appropriately.

MALE SPEAKER: Yes, I think Rick is right on the money, and I do think it's consistent not only with the spirit but with the letter and looking at the statute just to ran off his thoughts since we're spending a couple of minutes on it.

Now the statute speaks in terms of the issuers being restricted to individual and small group markets. It doesn't say that it can't be affiliated with other

issuers that may be issue to large groups. The only restriction being that they can't affiliate with insurers that existed -- issuers that existed prior to July 2009. So in essence you create two issuers that are new: One that's a co-op and one that isn't that operate side by side. It'll be perfectly consistent with the letter of the law. And I think for reasons that Rick said it would be consistent with the spirit because you would be isolating the -- not only the grant and loan benefits but also there's this tax exempt provision that you don't want that to spill over (inaudible) as well.

So you would isolate that in a separate subsidiary. As long as the regulations were clear that essentially these qualified co-op issuers can affiliate with entities that aren't qualified co-op issuers.

MR. FEEZOR: Any, from our departing members of the Board, any last calls or questions that -- the presentation of each other has raised? If not -- and we do have the meeting set. Our next meeting for February 7. That'll be Mark following up on that, and there'll be some assignment between now and then in all

likelihood so that -- I thank those of you who do have to leave early for your work. And Pat, again, my apologies for sending you to the wrong restaurant last night.

(Laughter)

MR. FEEZOR: And if you would, Annie, who are our last two panelist?

MS. ANNIE: Althea Erikson and Roger Mease (ph).

(Pause)

MR. FEEZOR: Althea, if you would please go heads.

MS. ALTHEA ERICKSON: Hi. So my name is Althea Erickson, and I'm the advocacy and policy director at Freelancer Union. I want to thank -- Ahmed earlier gave us a little bit of a shout-out, which we appreciate.

I just want to start by saying that we are huge fans of the co-op, and we're super excited about this program, the idea, I think Senator Conrad's vision, and just the opportunity to really build the field of mutualist organizations that both meet social

goals and or sustainable over the long term.

I want to just give you a quick background on Freelancers Union in case you're not familiar with us and where our comments are coming from. We're a national membership organization of independent workers. We have about 150,000 members nationwide. They are freelancers, self-employed people, independent contractors, folks who don't generally get benefits through their job and are sort of causalities of our current health insurance and healthcare system.

And what we do we do both advocacy and policy and may also offer them benefits, and in New York, we offer group rate insurance to our members. We started out doing that in 2001 by offering basically group rate policy contracting with an existing insurer. And then two years ago, we actually went out and formed our own insurance company mainly because our interests were not and the interest of our members were not really aligning with the insurance company that we were contracting with had to fix negotiations and things like that.

So two years ago, as I said, we started a

state-licensed health insurance company. It is a for-profit health insurer that is wholly owned by the nonprofit Freelancers Union. There are no private shareholders. It was financed with about $17 million in philanthropy loans and grants, and currently we cover about 23,000 lives in New York, two-thirds of whom were formerly uninsured or on COBRA. Our premium prices are about a third to a quarter of the price of what's available on the individual market in New York. And now that we sort of transferred from working on coverage to actually being the insurer, we really started focusing on primary care, disease management, medical home model, these kinds of experiments to both improve our members' quality of care and also reduce costs over time.

So I tell you that about our model just to say that we feel like we really share in the vision of the CO-OP Program. And my comments to you today about sort of recommendations are more along the line of how can we think about building this field and ensuring the long-term success of these models.

So the first thing I want to talk about is

building social covenants into the requirements of the -- either the requirements of the law or the selection process. And I know you know there are efforts through the bill to sort of prevent traditional insurers from taking part and making sure that these organizations are socially and mission driven. And I just want to draw your attention to some models that are already out there to look at.

For example, the PRI's the program-related investments that the foundation world currently uses -- those are basically foundations make loans, low interest, long-term loans, and they incorporate into those loans certain social requirements, so we were funded through PRI's. We are actually required to cover a certain number of uninsured people if there are any proportion of low-income communities, and those are several models that have been developed in the philanthropic community that might also apply as we think about insuring social purpose in the CO-OP Program.

Also, there are a number of examples coming up. Be (ph) Corpse (ph) is another sort of model that

has been codified in different states. And what they are, are actual corporate entities that build social goal and social mission into the core of their business model, and there are rules and regulation around sort of what constitutes social impact and how you measure it, and those might be models to look at as you consider fulfilling social impact into the CO-OP Program.

The second thing to consider when we think about making this a long-term sustainable program I think is to consider making this a revolving loan fund as opposed to the one-time disbursement of grant. And I think -- I believe the laws are silent on this point, but we talked about the need -- a lot today about the need for ongoing growth capital. Turning this into a revolving loan fund also allows us the opportunity to learn and iterate from the first round of grants, and I think anybody that's been involved in startups and entrepreneurship knows how important that is to sort of have many chances to build and grow and learn from prior experience.

And that would also sort of allow us to take a

little bit more -- we talked tightness of this timeline -- but actually to allow us to scale all of these co-ops at a reasonable rate and allow co-ops over time of these sectors to build more and more market share would (inaudible) our overall goal.

And then, finally, when we're thinking about structuring co-ops, I think it's important to consider both the short term -- and I believe you talked about this before -- encourage long-term thinking in addition to the short-term thinking.

And at Freelancers Union, we have no private shareholders, we're not paying people out, but we also don't put all of our revenue back into pushing down premiums. We spend a good amount of our income on research and development and working on these new medical home models and provider partnerships in ways that we can look over the long term about reducing cost, providing better care, being there not just for the members that are getting health insurance from us today but that'll be getting health insurance from us 10, 14, 20 years from now.

And I would also encourage you to think about

that as developing a governance structure and sort of defining that and thinking about building in both short-term and long-term interest into that board and governance structure. We wouldn't want, I think, all of the current members to vote to keep premiums down at the cost of long-term sustainability or solvency, and that's a tension which I think does exists in the co-op model, but I think it's one that can consider both side of.

I think that's it. Thank so much for giving me the opportunity to speak, and I also offer up Freelancers Union as an entity that has some experience in this area if you want -- we're happy to work with you or answer any questions (inaudible).

MR. FEEZOR: Do be careful of that offer, my dear.

(Laughter)

MR. FEEZOR: Roger.

MR. ROGER MEASE: Thank you very much for having the opportunity to come and talk with you today. Just to give you a little background here. We've been working in Virginia, which is where I'm from, for

almost a year kind of below the radar here working on these efforts, and we're also interested in helping to form a regional Washington, D.C. metropolitan area co-op because as you're well aware of we basically have four states in this region. You have the southern part of -- you can't say Southern Maryland because that has a specific definition -- but Montgomery County, Howard County, and other surrounding the Washington, D.C., area. You have the Northern Virginia area, which is often seen as a separate state in Virginia. You have the District of Columbia, which is its own interesting animal, and then you have the Panhandle of West Virginia. That basically constitutes the Washington metropolitan statistical area.

And if you're going to do business and gain some scale here, it's our point of view that you might need to think about serving that regional area.

My own background is I've been working in the corporate finance and investment banking area for the last 20-some odd years and came to Washington to start the National Cooperative Bank, served on the implementation commission.

After that, I had the great good fortune to be an executive at two different insurance companies, one of which and actually prior to the time I came to Washington and formed the cooperative organization called Co-Op America. And Co-Op America as far as I know is the only cooperative health insurance program on a national basis that's ever existed in the United States, and it existed from 1980 to 1984.

So with that background, we have tried to bring that particular background and expertise to the development of a Virginia co-op and also trying to assist various other states who are reaching out and looking for technical knowledge.

The approach that we're taking -- I mentioned the regional side -- we have a very interesting and I think from what we're hearing today somewhat unique approach to consumer involvement. It would take much too long to try to explain that here, but I would recommend that the Board reach out to the international. There's a very successful international integrated healthcare and health insurance cooperatives because there are models there, best practices there on

the consumer side that we definitely are going to try to do and utilize. And basically, they have to do with the idea of utilizing this cooperative difference. In other words, cooperative members want to be involved. They want to participate. They want express their view. They want to be active in the operations of the co-op, which means they want to active in their own healthcare.

So if you can construct a situation that will do that, what you will do is you drive down utilization rates of expensive patient care.

Secondly, we think that we have an interesting and somewhat unique approach to the provisions of incentives for providers to come in and join us. And I do have some writings I have done on this, and I'll be happy to provide the Board with some insight into that. I was in fact able to talk with Ms. Praeger and just to try out on her a couple of the ideas that we have for these kinds of incentives, and she said she didn't think that there would be any problem from a regulatory standpoint with implementing these.

I do have a number of questions I'd like to

basically get out, not in the form of comments but questions because I think there are a number of areas that need further clarification for us in Virginia to be able to proceed forward.

Number one has been brought up by very many other, is the Board or HHS contemplating any kind of development or technical assistance funding that would be available (a) not in the form of loans and (b) prior to the time -- roughly September by my timeframe or so, which would be the first time that there would be any disbursements of the loans and grants contemplated here.

We are here, and in New Mexico and in other groups are basically out of gas. And we've got a business plan. We've got a lot of other thing to do to be able to make a valid application to you, and it isn't clear exactly how we're going to get the gas in the tank to do that.

Secondly, what would be the HHS metrics for assessing what the significant private support requirement in the bill? I mean what is this? Is this letter of support? Is it perspective members sign up?

Is it private funding? Is it endorsement of support from local, state, or Federal political leaders? What are the kind of metrics you're think about? What's a working definition of state sponsorship?

Being in the corporate finance field, for example, many, many states have a number of specific finance facilities whereby nonprofit organizations can utilize tax exempt revenue bond financing. Some potential counsel has suggested to us that if you were to utilize those programs you might run afoul of the state sponsorship. I would suggest that that should not in any way be the case. These programs are available in general to all nonprofits. Some of them have specific-purpose funds, but you're basically obtaining a revenue bond and using those tax-exempt funding, and that would be extremely beneficial to co-ops to be able to use to purchase and operating assets, provider network, for example, all kinds of other operating assets.

What's the basis for defining whether co-op has substantially all its operations in the small business and individual markets? This has been brought

up before. There need to be some flexibility there. Otherwise, co-ops are going to be exposed to the most volatile part of the market, the individual and small businesses through the exchange and will not have the ability to build up any other base of business which might offset that kind of volatility.

Several times today, basically the risk -- risk adjustment systems and reinsurance has been mentioned here. The co-ops need to understand how those things are operating. We understand how those things operate, for example, in the state of Maryland, where there is community risk pooling for the individual markets and small businesses, and that might causes us, for example, if we were to be deemed to have enrolled a group that had less risk than perceived to be average, we might have to take, make a payment into the fund. But what is going to operate at the Federal level? How are these reinsurance -- temporary reinsurance and this risk adjustment program going to operate at the Federal level and impact the co-op.

Also there’s language in the bill that suggest that market reforms must be implemented in the states

in accordance with the ACA prior to the time that the co-op can operate. What specifically are those market reforms that have to be in place? Because it is our point of view that we want to enter the marketplace as soon as possible, and that is sooner than 2014.

Sort of technical question here: Is noncompliance with a loan or grant requirement automatically trigger a loss of the 501(c) or 501(c)(29) status? What status would exist for a co-op that's no longer subject to grant/loan requirements. In other words, if the co-op has been operating successful and has repaid the grants what relationship therefore is left with respect to the rest of the requirements of the ACA and requirements of HHS might establish?

Back to the state sponsorship. Does the prohibition of government sponsorship create a barrier for co-ops entering into strategic partnerships with local governments? There are a number of ways that that partnership could work. For example, local governments could enroll their employees in the co-op. Clearly, it would seem that that does not mean state

sponsorship. But if, for example, that employee or group -- that employee group came in early and constituted a very large number of the groups and the state was guaranteeing the payments of the premiums and things like this are we sliding and they wanted some influence and maybe a seat on the board are we sliding into what is known as state sponsorship here and, therefore, is prohibited under the bill?

Lastly, with respect to the bill, it talks about a purchasing council. What would not be good was for HHS or the Board to make any recommendations with respect to the operation of purchasing councils or other things which by grant of current operations co-ops already have the power to do this, and other private sector businesses already have the power to perform all sorts of allegiance, alliances, strategic purchasing councils, purchasing groups, and everything as long as they do not run afoul of antitrust and other types of laws. And HHS nor this Board should not recommend anything that would basically have constrict the ability of co-ops to use all the available mechanisms out there. And some of those mechanisms,

for example, could end up negotiating with providers. Thank you very much.

MR. FEEZOR: Thank you very much, Roger. Some questions and I saw quite a few nodding heads. I think maybe you were reading somebody else's paper --

(Laughter)

MR. FEEZOR: -- or that similar observation had been formed by many members of the Board here.

MR. ROGER MEASE: Well, I guess I'd also make the obligatory thing: I would happy --

MR. FEEZOR: Good.

MR. ROGER MEASE: -- to make myself available if that would be...

MR. FEEZOR: We will do that. Annie, just confirming one more time we have cleared the decks and anybody on the phone.

Then, now we get to the fun part where we count on the energy and acumen still be present after a very long day and to let you know that this is not scripted. This is sort of free discussion, and I would suggest that if we want to start with some sort of just general reactions to what we've heard, then begin to

focus on some themes that each of us that maybe have perked our minds, and then I'm hoping -- but again, it's the wisdom of this group -- that our thinking and some things that we've heard might fall into a handful of buckets, two or three buckets of issues that have some commonality that then we would divide ourselves -- and I've got some likely suspects depending to lead those work groups --

FEMALE SPEAKER: (Off microphone.)

(Laughter)

MR. FEEZOR: But anyway -- and I don't really know who would like to start given the questions that we've had. Michael, do you want to start with some of your thoughts, observations, and also any questions that we want more research or maybe some other experts to come forward on.

DR. PRAMENKO: Thanks, Allen. First of all, it's very heartening to hear the energy out in the last session opening it up to the folks that came today to hear the energy around and the excitement for the possibilities that exists to create more collaborative focus out there in running the healthcare system in

America. We're often citing the triple aim these days in trying to make things more efficient. And one of the main ideas of getting to successful co-ops is to move toward the triple aim: Improving the experience, population health, and the overall cost of the system.

And I came in here with a preconceived idea of what we needed to do as far as a successful co-op in that scheme and not just success at the level of co-op, but also success at the level of the overall performance of our system. And I see some interrelationships that just simply can't be ignored and or backed up by some of the testimony today in regards to that interrelationship between what this Board is doing, what the exchanges will be doing, what ACOs will be doing, and with what the FTC might need to do to help the whole thing along.

Let me be more specific. If we are to draw a diagram and you have ACOs up on the board, co-ops up on the board, and the exchange up on the board, I think we could write arrows back and forth between those three entities; meaning they each help the other foster and succeed. ACOs can help co-ops; co-ops can help ACOs;

exchanges can help the co-ops; co-ops can help the exchanges. And then alongside there, obviously, we'll need the FTC with some help with the ACO.

And so as we proceed with the business of creating and drafting proposals regarding the co-op, I think it would be very important to consider how these intermesh with the parallel endeavors in regard to exchanges, ACO, and patient-centered medical home.

One prime example was what, I believe, Commissioner Kreidler commented on and how do we incentivize co-ops and what outside of not making an unfair playing field. And the idea of creating some mechanism to where the co-ops can work with the ACOs through the idea of some safe harbors I think are very intriguing concepts so that we can look and help, not guarantee but encourage the viability of co-ops.

And so I would hope that as we proceed we do look at the interplay between these concepts.

MR. CURTIS: I may have misheard between the line, but this is just anecdotal, but it's my understanding -- I was quite surprised by this -- that a provider system subject to monastanistic plans,

favorite nation clause can’t even for purposes of its own plan let along for purposes of contracting with a co-op plan provide a rate as favorable as with that monastanistic purchaser. I mean this was just astounding to me that they couldn’t even on their own equal -- that’s not giving them the best price. That’s just making sure they’re not disadvantaged. Is that a correct understanding? I see Tim is nodding his head.

MR. SIZE: (Off microphone.)

MR. CURTIS: Okay. I didn’t --

MR. SIZE: (Off microphone.)

MR. CURTIS: Right.

MR. SIZE: (Off microphone.)

MR. CURTIS: Right.

MR. SIZE: (Off microphone.)

MR. CURTIS: Okay. It was that part and parcel -- what part was it?

MR. SIZE: No, I needed some clarification there on the point -- on what current providers can do. I don’t understand the point that you made, Rick, I’m sorry.

MALE SPEAKER: (Off microphone.)

MALE SPEAKER: I think we're getting a little bit -- spending a little bit too much time on this most favorite nation -- I mean it was a creative idea that Sara Collins had, but it's not going to go anywhere politically.

In terms of what actually happens in the marketplace, most favorite nation only says that if you the provider give a better rate to some other carrier, you've got to give us your best rate. So it doesn't stop providers from giving another carrier the same rate. It says you simply can't give another carrier a lower rate without giving us that lower rate. And so it's not really a barrier to a new entrant coming in and trying to get the same rates. That's not the problem. It's simply that providers don't want to give their best rates unless market clout forces it --

MALE SPEAKER: (Off microphone.)

MALE SPEAKER: -- Okay.

MR. FEEZOR: Mark, can you -- I'm not going to put you on the spot, but to the extent that a provider places itself under employees with a plan other than one that has its best rates, there's some

liabilities there that flow as well?

MR. HALL: Yes. How do you define giving a better rate? Means giving your own employees a better rate in violation of the clause? I don't know. Maybe there's some ambiguities there that are problematic.

MR. FEEZOR: But you still had a puzzle on your face in terms of --

MR. HALL: No. I think my -- we can discuss it further, but -- because we're getting down in the weeds here, but I'm fine for right now.

FEMALE SPEAKER: I pretty much have the same list everyone has, so I'm not going to repeat that. But there's one thought that came up when we were talking with the individuals talking about the private money and what would be necessary as far as providing a good business plan and showing that you are going to be viable. And it occurred to me we might want to talk to entities that have that focus on what in order to qualify for the grant money what type of business plan, what type of parameters because everybody does get very optimistic, entrepreneurs are very optimistic. What kind of parameters should there be around that business

plan to show that it's going to be viable or had a good chance of being viable going forward. I know that was an expertise we might want to investigate.

MR. FEEZOR: Mark.

MR. HALL: Sort of two sets of things in mind. One is sort of all these little sort of definitional questions, and I think we probably spent enough time on that today. I think we sort of -- I wonder if we've gotten off track in terms of what our principal charge is.

So writing a set of regs that help deal with the definitional questions I'm sure -- giving advice about that would be appreciated, but are we also sort of not spending enough time really talking about how it is that one goes about picking among different applicants in a given state when you have more than one applicant. What are the criteria for deciding the better applicant?

And in a given state perhaps where there is only one applicant do you ever say, "No, thanks," to a state entirely? Those are I think our principal questions, and I think need to probably spend more time

thinking about that. And starting to think about that -- Rick posed one question, for instance, what about the less viable one that covers the whole state versus the more viable one that covers a smaller of the state and how do we balance that if you have them within a state.

But I'm also thinking about a state where you get an applicant and maybe they'll make it and maybe they won't, but you're not that confident. And should we be pretty -- should we recommend that HHS be fairly cautious about giving the money out, with the hope that almost all the ones that are funded succeed? Or should we try to give out all the money to the best people we can knowing that, well, probably of them are not going to succeed. So that's another way of frighten (ph) the dilemma. I don't know if that's a fair way. I don't even know if that's under contemplation.

But I think we've heard enough concerns about the very risk of whether these things are even viable and under what condition. It's brought to mind is there sort of a threshold level of viability that an applicant has to meet at least after they get through

their planning stage or their feasibility stage before they get any support.

And then the second question is if you have to viable applicants which is the one that's deferred under what criteria.

MR. FEEZOR: Tim.

MR. SIZE: Everything I've heard actually I totally agree with particularly Mark you good question.

Actually, I was struck by the degree -- I mean I serve on a lot of boards, commissions, and stuff, and I know there's some differences that have been cited, but I heard a lot of consistency to the underlying similar set of thought on both the Board and with most of the people who've spoken, and that's somewhat unusual, and I was pleasantly surprised at that.

Pleasantly surprised at a lot of the positive energy that I heard from the various speakers. I think I'd like to -- I have a whole long list of more specific questions, which before we break tell us who to send them to. A couple of themes -- I think not necessarily frame this question, but I'd want to reiterate there's an appropriate and necessary tension

between entrepreneurship and a Federal program.

And to Mark's questions lead me to think I didn't want to see diversity, a mixed portfolio. I'd want to see some experimentation. I know that frequency runs against the Federal grain, but that would be the kind of recommendation that I would hope that we can make.

We need to accept that with entrepreneurship comes something other than certain success. It means you risk failure, so that's just philosophically. I hope we can struggle a bit more with -- the purpose of this initiative is to create alternatives we really don't know exist. And I realize the reasons why there was language which prohibit existing issuers, but I'm hoping that some regulations guide those very small efforts that I know are out there that really aren't providing the significant alternative because they're not where near scale, but they can use this program to get to scale, and there were some suggestions around that by certain speakers that we teased out.

I also think -- and I'm not being self-serving to the sector I work mostly with, provider -- is we

really need to think deeply about where we have flexibility to really promote provider involvement because I really think in most markets if that's not facilitated the probability of success is significantly lower.

But today was actually much more productive than I anticipated. Maybe I had too low expectations.

(Laughter)

MR. FEEZOR: Tim, let me just push you on one thing. And actually the legislation speaks to provider engagement, provider integrated delivery as being one of the elements that should be in consideration. A couple of folks I think almost got to the -- at times I thought maybe we were promoting new delivery market mechanisms as opposed to financing or issuers -- insurance issuers. And yet I think in picking up on Mike's comment that those two really are interrelated, and in fact it might be suggested that -- what we really are trying to introduce in the consumer engagement in these entities is a new dynamic that might again to push a little differently what has been the dysfunction between the three or four parties: The

payers versus the providers; and the provider is not engaged with the consumer; and the consumer not being engaged with the insurer. And somehow by having that consumer engagement and I think implicitly probably a new relationship -- or at least the provider being in a little different engagement level than they haven't had -- that we might just begin to make some changes in terms of the marketplace, a very -- again, I sort of looked at it from sort of jaundiced eyes of how much money, do they have a good business plan, the classic sort of things that we probably do need to be providing, Mark, some specificity to the Secretary in terms of our recommendations.

But ultimately the theme that we kept hearing and I think the reason there was a lot of enthusiasm was sort of that tripartite patching together that we've got to somehow encourage and try to measure or at least provide some yardsticks that the Secretary might consider measuring and reinforce and yet at the same time be prudent with public resources.

MR. SIZE: Yes. I totally agree, and you read me right with -- your affirmation. And I just had

one last point that I wanted to reinforce. And again, this is something I don't think the Federal Government always does as well which should be is the ACO development, is the exchange develop, medical home, whatever. I think the initiative we're here talking about is quite sensitive to decisions made in those other silos to the degree that the rulemaking and the whole process of protocols that we're going to see -- the loan protocols we set up as much as possible that there's sufficient communication between the other parties within the Department doing that I think is fundamentally important. It may be saying the obvious, but, again, I think worth reinforcement.

MR. FEEZOR: Bill, you've been unusually quiet here.

MR. OEMICHEN: Unusually quiet -- oh. I have one process question: To what extent will we have any availability from the Office of General Counsel? Are we expected to go on our own and between what expertise we have here, legal expertise, make some judgments and determine to go in that direction for recommendation purposes? Or can we actually get at little assistance

to help provide some boundaries to where we go.

MR. FEEZOR: I --

MR. OEMICHEN: I know I'm a lawyer --

MR. FEEZOR: I was going to say neither you nor Mark have be at all reluctant today, and I don't anticipate that starting. I think the reality is that if you're talking about massive sort of questions or parameters being set up, we probably should not count on that --

MR. OEMICHEN: I'm not counting on that.

MR. FEEZOR: -- if we get to a stumping point I think there're probably some questions that we can ask the OCIO staff to float to the Herbert (ph) folks.

MR. OEMICHEN: I was hoping that was the case that there was going to be some availability that -- and my questions or at least my focus from today's discussions goes a lot to what is -- what is meaningful member involvement? What's going to make this entity different from all the other entities that are out there? "Member" keeps getting used over and over again in the statute, and in the governance requirement sub-3, it goes through and give basically three different

indices; one, the majority vote of the members. But who are the members? So what's the majority of that?

Then the governing documents have to incorporate ethics. So how do we begin deciding what are those ethics requirements that we ought to have. And then it also requires a strong consumer focus. And how are we going to define that? I have my ideas, and I'm very happy later to share those ideas. But overall, how can we do this so that we're consistent with the spirit of the statute, but yet we're not hindering these entities at the same time so that they don't have any reasonable probability of success. Because I've been involved in some very easy cooperative building and some very messy cooperative building. And depending on how that's structured makes a real different on how successful that entity is going to be.

Then I have another question, just a couple of really short one here. Just the ability to operate across state line. We have the insurance regulators here, but to what extent can we go across state lines and do more of the regional work that's been discussed

here because to some degree that'll, hopefully, help us catch us from a, not necessarily, a tiny perspective, but have a greater impact. So I'm interested in that.

And then I read the statute, I'm an attorney I know -- I used to be a general counsel in a agency. I know what Black letter law says, and in here it basically says for upfront cost you've to figure out a different way to do that as a loan. And a lot of what we heard today is loans aren't going to work. So I'd like to know from HHS is there some other funding pot out there that they anticipate -- and I know how tight Government funds are -- don't fall over in your chair yet. But is there some other type of funding pot that would help put some upfront money in these entities so that they could get the startup, legal, actuarial, and other systems that they are going to need. Because I think loans aren't going to be much of an incentive for a lot of these entities that might try to get started.

So those are the sum of my questions that I have.

MR. FEEZOR: (Off microphone.)

MR. OEMICHEN: Right.

MR. FEEZOR: (Off microphone.)

MR. OEMICHEN: Right.

MR. FEEZOR: (Off microphone) ... that your conclusion, at least what we heard prevailing was that for that sort of -- not the development but almost for the feasibility phase there need to be some other form other than a loan. And yet the other side of the coin is if it's pure feasibility then there's probably 20,000 groups that will come in saying they want it. I mean that's the other tension there. Okay.

MALE SPEAKER: Yes. I think you ought to tell us what these work groups are, and then we can see if there's something you left out.

(Laughter)

MALE SPEAKER: I have no idea the longer gain or our involvement. I know we have a meeting scheduled, and that's about all I know. I really would appreciate to know a little more.

MR. FEEZOR: Let me -- and it's going to be worth exactly what you're paying for --

(Laughter)

MR. FEEZOR: -- opine as to what I think we

are looking at in terms of sort of process. First off, our appointment is three years from your date of appointment or until you have finished your product or until the Secretary I guess gets tired of us. And so that's sort of the term. It's very clear that there is a sense of urgency. We heard it today with almost every speaker even our regulators, who usually are pretty -- they want nice, slow deliberate things -- they're saying if these things are going to be operational in 2014 -- and I think that's the implicit goal -- we've got to be going. And OCIO and the Department have been very clear they would like our best advice as expeditiously as possible.

Somebody had suggested that that might be done in a month, and we have said that we think it would at the best given the questions raised, given the guidance needed, and just the organizational issues and the intensity of some of the intellects sitting around the table here that it would probably take three meetings, up to three meetings, and that we would have to utilize breakout groups one and two and probably between two and three. But the goal is that by the end of the

second meeting or at some subgroup meetings after that second meeting we would have at least a pretty rough grasp so that by the third meeting we would be polishing recommendations.

And let me underscore recommendation, again, I think the Department is spending quite a bit of energy and resources in assembling this group and expects good work, and I think that will be the case, and yet at the same time, we're not going to have all the answers. And I think the difficult part is -- and maybe you folks -- I view this as sort of we are -- our role is, within the context that we understand the law is to some degree helping to be if not the visioneers at least the facilitator of these thing -- responsible facilitators is maybe I should say -- sort of providing a source of some initial guidance -- and as I think we heard from some of the panelist, there probably needs to be some technical expertise or technical assistance that's generally available for folks who want to work in this area, and that's something I think we probably ought to consider at least providing some lists of references or whatever.

And then thirdly, we're sort of one part loan officer. What are the qualities that we're looking for in the applicants -- or grant officers. Maybe that's a better term or probably both.

(Laughter)

MR. FEEZOR: So that's -- and Barbara, you've participated in some of our -- what discussions we've had prior to this meeting, and is that -- I mean is that a reasonable reflection?

So with that in mind, what I thought we might try to do -- and I'm trying to get just buckets of issues that a couple of us can work with staff on and refine a bit more in terms of what we're looking for. But I sort of had three -- if you put process questions aside, when the loans are and so forth, put that aside for a minute, what is it that we should be looking for and trying to provide guidance?

Sort of bucket 1 is what I call governance and sort of looking at the applicants. That would be -- this is one that's going to be wild to start off with. There were a couple of comments that I caught -- I think probably from Pete -- talking about the passion

of these folks, the real energy behind it. I mean that's an ethereal thing to try to measure, but nonetheless is there real -- may be a commitment is a better term.

Certainly the government structure, the kinds of structures that would seem to make sense given the direction of the legislation, the consumer support, consumer engagement. Involvement probably would fall in that, both generally and how it would be done within the governance of the advisory. Probably even the leadership. This gets more -- we hear a lot about technical leaders, but sort of what is the leadership -- the broader leadership maybe within the community. The experience and expertise, the breadth of some of that leadership or management, and then sort of community supports.

So those are sort of subheading on the sort of governance eligibility criteria -- maybe I ought to give the buckets: Governance and sort of financial and business plan sort of aspects and then third is infrastructure.

And now since I've dealt -- and again, this is

purely one afternoon of -- or about a 30 -- 40-minute conversation with Barbara and with -- with two Barbaras. I have two Barbaras that I have to listen to all the time. Under financial and business plan -- and somehow what is the -- certainly the amount and type of capital or financial support that the entity has access or would be presenting as a part of its application. Or maybe its access to capital that is nongovernmental. What is its marketing plan? What is its three-to-five year business plan? What is its sustainability plan? And what is its pricing and product model? The kinds of things that I'm sure Donna Novak would be very good in helping us think through.

So that's sort of -- what are those elements that identify an entity that -- the financial element if you will? And obviously, the solvency gets into that.

And then the infrastructure which we heard, and arguably your management probably should be a part of infrastructure. But just purely on these, I think we're taking from either John Bertko's or somebody else's testimony.

Your IT systems as both claims, accounting, clinical utilization, and care management. Providers networks. I think a couple of the last panelists talked how important that would be one of the key ingredients. And probably a subset of that would be the vision of integrated or coordinated care or new models.

Actuarial reporting and evaluation systems, administrative infrastructure, quality control and assurances. Mike, getting back to the triple vision -- triple goals.

The appeals process, consumer, stakeholder complaint resolution seems to me one of the sort of infrastructures that need to be looked at both from a consumer engagement standpoint and whether or not it's the kind of entity that is going to be successful.

And then a big one is sort of regulatory relations, regulatory compliance, and maybe even risk management in that.

So those are some sort of things within the infrastructure. Arguably, risk management might go up into financials. So where they are not...

Those were sort of some buckets that a couple of us thought us, and what I wanted to do was sort of get some of the elements that you folks raised and say do they fit in these or are there some better buckets.

Any comments? Terry, and then I'll come back to Mike.

MR. GARDINER: Assuming you don't want to make too many buckets --

(Laughter)

MR. GARDINER: -- I think there is -- and maybe this would go as part of infrastructure -- but there's a bunch of things that have been brought up around technical assistance, whether it's "We need organizational grants, so we've put together a good business plan with actuarial" -- so where do we get the money and the help to do that. That's what we hear from groups.

And there was the issue that you brought up with the insurance commissioners about the state, Federal joint outpatient. And I think these are all in the area of how do we help people succeed and goes to the issue of how do we keep the failure rate down. And

I think the technical assistance and helping people do the best job possible and giving them the most guidance upfront. So that's sort of a -- technical assistance and maybe that would fit under infrastructure.

The other area -- and maybe this -- that I think are really important -- and many people have referred to them particular issue and may go under the financial plan and the business plan, the second bucket, is those marketing issues that have come up and that the partnering issues. Can we have this group whether it's a state group?

I think we heard a lot of different ideas about potential partners whether in markets, whether they're large companies. There's a whole family of things. And again, I think our answers to those issues go to the fundamental question of increasing success. Because as everybody points out, these are startups. They got competition. There's all these reasons they're going to fail. Well, what do we do increase the odds that startups succeed.

If you're a venture capitalist, if you're doing mergers and acquisitions, you get into this. You

try to increase the probability, and you try to help the people you're financing succeed. After you identify whether you want invest, then you try to --

MALE SPEAKER: And is -

MR. GARDINER: -- help them.

MALE SPEAKER: -- that partly a governance issue? Because as you bring in other resources, other partnerships, people to want to have a seat at that table. There's some of it that's not governance too, but I definitely would see that coming up under governance at least in part.

MR. GARDINER: If you've ever gotten big loans from banks, you'll find that your loan officer is becoming your partner. They want you to succeed too. They don't want you to go to the credit department. So it is -- yes, they're not at the seat, but there's a reason you give them monthly financials and you have ratios and you have covenants and all those things. They're actually for your own good.

MR. FEEZOR: Barbara.

MS. YONDORF: Yes. I just was just going to respond to that because, obviously, it's very hard. We

have a little conversation just to brainstorm to put this on the table so you have something to shoot down, but sort of the three-buckets approach, just because 15 divide by 3 seem to work.

(Laughter)

MS. YONDORF: And if someone is sick that day, then the rest of the people can figure it out. But I do think -- just responding to the comment you made -- there's a couple of different things we're going to have to work on. One is we're are clearly charged with sort of making recommendations what the application should look like and maybe some sense of criteria so it -- and someone said let's not be too prescriptive or too restrictive.

So one of them may be: Did you talk to the insurance commissioner? Did you check in with him? Can you give us the list of what you need to do? That's -- that's -- a large part of what we need to do -- we're going to say to HHS, "We recommend that these are the things in the application."

I think a different kind of second bucket, which we -- not second bucket -- a second category of

things is a little different, and that is that I don't know that we can do it. We can say, "This is how it should be." But there's clearly things like -- "What does it means to say significant private support?" -- where we can make some recommendations, where we can do some guidelines. We can say, "Look for this." We can even say, if we wanted to, "We'll -- you know, here's a recommendation for how you define significant support." But that's not part of it, and I think a big one -- and some of those I would argue are almost more critical, to give some indication because for someone to go all the way down this path on an application they've got to know what significant private support is.

I mean I'm making this up, but if you're going to find a $1 million from a philanthropist because we've so limited where you can get your support from, then people aren't even going to start down -- some people won't start down the path, right. They'll say, "No" or "I'm really interested in the term, and we've gotten lots of questions about it," substantially all. First of all, it doesn't say "all." So I think that's pretty important. It says substantially all.

It actually if you read it talks about activities related to the issuance. So I -- Rick thinks it's not okay, but...

(Laughter)

MS. YONDORF: But I think -- I think if you say, "Great. We're going to issue to 500 entities, 10 of which are large employers and account for 5,000 people" I don't see that not in compliance with the law. And we heard from John Bertko and other people that solvency in the initial enrollment is absolutely critical or these things aren't going to work.

So we might have to -- so there's those sorts of things. And whether we want to opine on some of those critical thing front end...

And then finally I would just say what you talked about and I had in my list too. Things like technical assistance, joint application, dual track things, which I think we can suggest, which HHS may not be able to do, so we may on our own go out and talk to foundations or encourage other people to say "There's a gap here." I think a critical one is -- it just doesn't make any sense to me for 120 different possible

applicants to each have to hire a consultant to help them in this whole thing when maybe if we can get a foundation to call a meeting and pull everyone together to hear all that we heard today.

So it maybe that what you just talked about, Terry, are things we ask the three groups as they're talking, I think some of those things will come out, and they'll say, "Boy, we better give them technical assistance. We got a suggested timeline."

So maybe what we do is we tell those three groups keep a parking lot of issues of things that aren't the application but really would help this whole thing. Because the law does say that HHS is charged with doing what it can to encourage the development of the, so -- sorry, that was a long winded.

MR. GARDINER: I just --

MR. FEEZOR: Tim --

MR. GARDINER: -- I think you hit the nail on the head with that. And that's my -- if you want to use the three bucket metaphor, I would say that you we have at least three rooms that we got to carry those buckets through. In the last room is criteria use

whoever is going to review these applications.

Most of our conversation today, appropriately so, is trying -- the struggle with a series of questions to get clarity about what the program is or should be. I'm very uncomfortable making recommendations about how to review a program that I don't understand yet, and I don't think anybody in this room understands it yet. And I realize time is really tight, but I think we quickly need to get our best-guessed answers for all the questions that are coming back in writing and/or received today. We need to answer the question immediate, What we can do to facilitate people applying" because we've, obviously, heard that a loan is not going to cut it. And if we're really want to encourage this, how can we help get people who are serious about applying -- because I take the meaning of your 20,000 applicants if you just want to throw money at it. But that's a serious question that I have no idea where the Department has had.

Then -- and not saying we can't dual track this stuff. I can get serious about, "Okay, how will we review these applicants once they come in?"

MR. FEEZOR: All right. Tim, let me restate, and this is not trying to change what you're saying. I'm trying to make sure I'm comprehending. And Barbara, probably the greater sense of urgency is focusing on and making some recommendations on where there are some ambiguities or what we seem to be inconsistencies or perhaps even barriers that at least might be looked at. We're can --

MALE SPEAKER: Yes.

MR. FEEZOR: -- opine on it. Now let me say, and I'll say this -- I'd rather say it off the record -- but I do not want to be in a situation where -- first off, we're going to make our best recommendations and make them forthrightly and attack the fashion yet at the same time. I don't want to be in a situation where it can be used for political fodder that might undo some other things, so let's think about that.

But nonetheless, so the issues like "substantially all" go ahead and try to get at least if not a legal opinion what we interpret that given both the legislation and the purpose of the program. And for instance, another one might be the issue of no

money spent on marketing, and the reality is that's no Federal funds can be spent on marketing. Okay, fungible fund, but nonetheless, I mean, there's some things -- the Department can clear the path and clear up some of the issues.

The second -- and Terry, this is drawing on yours -- is really beginning to identify immediately the -- I call it sort of path forward that applicants might take. And that's sort of both mapping how they might go and the technical assistance they need to go down that path.

And Barbara, back to your point whether that something -- that there can be some governmental resources brought to bear or whether it's external resources. Nonetheless, we -- assuming that it's we -- when our other colleagues back at the table felt that's great enough urgent need; we need to spend some time on that.

And the third thing, Tim, is back to your point. That third thing we can start to talk about, "Well, what do we mean by their business plan and how should the Secretary perhaps, or staff, judge that."

MR. SIZE: Let me just -- I want to clarify something I said earlier. By no mean was criticizing the program is somehow being mysterious. I think any program and statute you have to go through a process of asking questions like we'd done today. So I don't think there's and unique about this program. I just want to be very clear about that.

MR. FEEZOR: All right.

MR. SIZE: It's just an orderly way one proceeds through.

MR. FEEZOR: I'm trying to look out the corner of my eye to make sure that the staff hasn't fallen out into the aisles over there on that last -- since we've probably doubled the work from what they thought going in.

First off -- and again, any final comments since we are approaching the 5 o'clock hour. If those sort of -- we've reprioritize what are the -- putting aside the buckets, the sort of triaging of what we need to be focusing on first; and again, the sort of focusing on the questions or the uncertainties and trying to clear or at least opine on those.

Second is trying to identify both sort of the process and technical assistance that would facilitate those entities who are, and that may include some sort of developmental grant or something like that.

And then the third would then be coming back and looking at some specific standards for eligibility, the kinds of documents that would be needed or we would suggests might be needed to the Secretary in reviewing the grant process and making judgments, one relative to another if it's an competitive issue or what seems to be of greater importance statewide or innovative engagement of provider or something along those line, so that's the kinds of limit.

Anybody -- is that -- and what I would like to do is simply if you'll -- we certainly welcome any email back to staff, Barbara or -- either Barbara or myself. As you think about this going home, but before you get too far out, let me just say back to the buckets if we sort of deal with some work on what are the elements of governance and community support, measured community support -- Terry thought that either between you and maybe drawing on Bill's expertise in

corporate structure that -- and maybe with some help from Mark that that might make some sense for you two to leave that when we turn to that, and these are all suggested. Think about them, and if you see a “Are you kidding me?” send me a note and let me know otherwise.

With regards to sort of the financial evaluation, business plan standards, or exhibits, Donna, you and it’s going to be easy to pick on him since he was not able to join us probably John Christianson, I think as I look at his credential.

And again, by the way, if any of you -- and I think about it, Herb, given your background and work that might be one that you might want to think about participating in. And anybody who has a strong startup on any of these groups, let me know again; let you know what we’re thinking.

And then, third, sort of looking at the infrastructure that these co-ops might need. Mike has departed. I thought about him since he has dealt with it. And then, Herb, that might be one you might look at or -- I forget, one of your Davids I thought about in terms of that.

So those are sort of -- might be sort of thought leader in developing those standards once we turn to that. But before you folks say, “Wait a minute. Do I have to set up a subcommittee between now and then?” Let us give the two Barbaras and myself about a week to sort of try to digest what we’ve seen and send out a suggested path forward and what might be some grouping.

FEMALE SPEAKER: (Off microphone.)

MR. FEEZOR: Yes. Well -- and the reality is it may be that all we can do is a conference call to sort of see where we’re going on that. Mark.

MR. HALL: Are we still scheduled to meet on the 7th?

MR. FEEZOR: (No audible response.)

MR. HALL: We’ll be hearing about travel arrangements and stuff?

MR. FEEZOR: Yes. And we will be contacting folks for a March meeting, and it may be that on some of these specific issues going back and looking at some of the questions it may be that we -- one of the function at our February meeting we’ll drill down a

little bit more on some of those fundamental questions that have been surfaced to the extent they are still ones that we need more input on.

MALE SPEAKER: Do we have a sense when in March it might be? Because the 250th anniversary of the oldest recorded cooperative is occurring in the United Kingdom, and I was hoping to possibly to be there.

MALE SPEAKER: We'll join you there for the meeting.

(Laughter)

MALE SPEAKER: If you'd like to be in Scotland, that'll be great.

MR. FEEZOR: It's just a matter of travel logistics now isn't it?

(Laughter)

MALE SPEAKER: (Off microphone.)

MR. FEEZOR: And that's duly noted.

MALE SPEAKER: (Off microphone.)

MR. FEEZOR: Yes. I mean go -- yes?

MALE SPEAKER: (Off microphone) --

MR. FEEZOR: Okay, good point.

MALE SPEAKER: -- or you can bring back some 250-year-old Scotch from your trip.

(Laughter)

MR. FEEZOR: Where is the NAIC meeting?

MALE SPEAKER: (Off microphone.)

MR. FEEZOR: Hmm. Okay.

(Pause)

MR. FEEZOR: We'll work that -- if not by the end of the week, some prospective dates will be or first part of the following week. (inaudible), any comments?

FEMALE SPEAKER: No. I would just say that I thought we had terrific panels, and I deeply appreciated the comment from the public. I think those were really constructive in fact to hear from a lot of you that want to apply what your questions are, so I thought that was really useful. And I would just like to say that I'm glad to be a part of such an esteemed group I think. We work well together, looking forward to it, and special thanks to the staff.

MR. FEEZOR: Barbara Smith, anything from the staff's perspective other than heart attack for the

work we have to do and jamming everything up?

MS. BARBARA SMITH: (No audible response.)

MR. FEEZOR: Again, all of you, thank you very much, staff. You guys make the difference and will make this what is almost an impossible task possible

And the other thing for those of you who don't sort of sit looking out, I noticed that Jay Angoff was in and out several different times wanting to hear some of the public discussions and was particularly interested in some of our early discussions. I don't know whether that gave him a heart attack or not, but, nonetheless, Barbara, be sure to tell Jay we appreciate that not only his welcoming remarks but, obviously, his interest in this group's deliberations.

And thank you all and look forward to an very interesting next 60, 75 days.

(Whereupon, Consumer Operated and Oriented Plan (CO-OP) Program Advisory Board meeting was concluded.)

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I, DERICK MARX RAWLS, do hereby certify that this transcript was prepared from audio to the best of my ability.

I am neither counsel nor party to this action nor am I interested in the outcome of this action.

DERICK MARX RAWLS