The Center for Consumer Information and Insurance Oversight (CCIIO)
Consumer Operated and Oriented Plan (CO-OP) Program

Advisory Board Meeting
Fairmont Hotel
Washington, DC

March 14, 2011

I. Background

The Consumer Operated and Oriented Plan (CO-OP) Advisory Board is the Department's statutory public advisory body to foster the creation of qualified nonprofit health insurance issuers. The Advisory Board will assist and advise the Secretary and Congress through the Department of Health and Human Services Center for Consumer Information and Insurance Oversight (CCIIO) on the Department's strategy to foster the creation of qualified nonprofit health insurance issuers. Specifically, the Board shall advise the Secretary and Congress concerning the award of grants and loans related to Section 1322 of the Affordable Care Act (ACA).

This Advisory Board is required under section 1322 of The Patient Protection and Affordable Care Act that calls for the establishment of the Consumer Operated and Oriented Plan (CO-OP) Program, which will foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets. The Advisory Board is governed by provisions of Public Law 92-463, as amended, (5 U.S.C. App. 2), which sets forth standards for the formation and use of advisory committees.

II. Purpose of Meeting

The purpose of this third meeting was to assist and advise the DHHS Secretary and Congress, through CCIIO, on the Department's strategy to foster the creation of qualified nonprofit health insurance issuers. At this meeting, the Advisory Board heard public comments on the draft of the final report. In addition, four subcommittees reported back on their final recommendations and open questions in the areas of governance, finance, infrastructure, and criteria, process, and compliance. Finally, the Advisory Board discussed and resolved open questions. The following summary highlights the main points of the public comments, subcommittee reports, and discussion of the draft final report.

III. Convening of Board and Introductions

Mr. Allen Freezor, Advisory Board Chairman, opened the meeting by noting that much work had been done since the previous meeting, and a draft final report had been sent to the Board members for their review. The meeting would begin with a message from the CCIIO director, then a public comment session, after which the Board would examine pending issues in the report and work to resolve them.

IV. Welcome from CCIIO Director

Mr. Steve Larsen, Director of CCIIO, thanked the Advisory Board for their work and dedication. He noted that they had set an aggressive timeframe for themselves, but they did a lot of work and met the schedule. CO-OPs will address many of the ACA charges, such as consumer-oriented care, competition in the market, and improvements in the quality of care. Creating a more equitable health care system requires choices, which CO-OPs will provide.

V. Public Comment Period

The first member of the public to speak was Nandini Pillai Kuehn, PhD of Health Services Consulting, which is based in Corrales, New Mexico. Dr. Kuehn's organization has created an ad hoc group to look at planning a CO-OP. They are focused on the consumer and provider pieces, and have physicians and insurance representatives in the group, many of whom are innovators. The organization is looking at health disparities, as they have a large minority population in New Mexico and a lot of poverty. They have found that having coverage does not necessarily equal better health. If the focus of CO-OPs is going to be on financial aspects and not the health risk and health management, there will be no progress. Incentives should move quality forward. Dr. Kuehn's group wants to be involved as consumers and investors both. They want assistance in finding health risk management systems that have worked, those that have failed, and ways to avoid mistakes. They want technical assistance to create a plan in New Mexico, and they are not sure they can create the CO-OP without it. Their goal is to create a new model of healthcare.

The next speaker was Mark Blum, representing America's Agenda: Health Care for All (AAHCA), who provided highlights from his written comments. AAHCA represents business, labor, providers, and political leaders in both parties. The organization is particularly interested in care coordination and delivery, and driving down costs while improving care. AAHCA represents 22 national labor unions, a number of Fortune 500 companies, and others, with a mission that is aligned with the ACA, especially Sections 1311 and 1322.

Mr. Blum wanted to draw attention to the labor experience in delivering nonprofit consumer-oriented healthcare. Labor unions and business have cooperatively managed Taft-Hartley self-funded health plans serving tens of millions of beneficiaries. While these are not CO-OPs, the expertise of labor and its partners in managing these funds is germane under Section 1322.

The delivery innovations pioneered by Taft-Hartley plans are essential to improving quality of care. Labor has rich experience that will be a substantial and essential contribution to CO-OPs in some states. This experience includes purchasing medical services and equipment; aggregating and representing beneficiaries; designing plans responsive to the needs of participants and more. The result is that labor is a unique leader in this area that cannot be overlooked.

Mr. Blum made four recommendations to the Board:

1. Labor unions, their affiliates, and state federations should be specifically recognized as eligible to receive federal loans and grants allocated for establishment of CO-OPs under ACA Section 1322(b).
2. Combined entities of labor unions and businesses experienced in joint management of Taft-Hartley health funds should be specifically recognized as eligible to receive federal loans and grants for establishment of CO-OPs.
3. Rules pertaining to the establishment and operation of CO-OPs should assure adequate and effective representation by labor on governing boards of all CO-OPS established under the ACA, Section 1322.
4. Rules pertaining to the establishment and operation of CO-OPs should assure adequate and effective representation by members of the business community with appropriate experience on governing boards of jointly managed health plans. This will help ensure the level of customer service and consumer focus needed to make the CO-OPs a success.

Jeffrey Endick, a principal in the law firm of Slevin & Hart, introduced himself by explaining that he was testifying on behalf of the United Food and Commercial Workers International Union (UFCW), a labor organization representing 1.3 million members working in a wide range of industries such as retail food, meat packing and poultry, food processing and manufacturing, and retail stores. The UFCW has a long history of providing health coverage through collective bargaining under jointly-administered health and welfare plans, as well as single employer sponsored plans. These plans, which cover hundreds of thousands of UFCW members, are administered by boards of trustees that contain an equal number of employer and labor trustees. They are established as tax-exempt vehicles under Section 501(c)(9) of the Internal Revenue Code and are known as Voluntary Employee Beneficiary Associations – VEBAs. The Union would like the Board to give special consideration to those CO-OP arrangements having significant organized labor representation.

Plans operated by organized labor are traditionally designed to pay benefits and maintain reserves of 6 months or more. Organized labor has experience in ensuring an actuarially sound, high-benefit program that maintains quality over the long term. Officers of labor organizations have the experience to ensure that a CO-OP arrangement is consumer-oriented. Labor leaders have extensive networks with providers. If their members are not satisfied with the coverage, unions hear about it. Labor organizations also have the perspective of value-driven partnerships across a member's lifespan, because they cover care into retirement and have organized healthcare models focused on long-term health. Finally, labor organizations know the healthcare marketplace, have years of experience, and could create immediately competitive CO-OPs that are ready in 2014. Critical mass is needed to make a CO-OP viable, and unions can do this. UFCW asks that development of CO-OPs take into consideration the role labor has played over many years.

Mr. Freezor noted that Taft-Hartley plans are not excluded from CO-OPs. An issue the secretary might have to grapple with is reconciling cohesiveness and consumer

mass. Another issue is how to reconcile large national union numbers, and the qualified health plans requirement, which might be in conflict with unions.

Mark Rust, of the Barnes and Thornburg law firm, represents health plans and providers. He stated that a large segment of the healthcare provider community is very interested in CO-OP creation. He represents potential CO-OP providers in several states, and they have several concerns: 1. How the "substantially all" requirement will inhibit participation. 2. The degree of unnatural restraints beyond the statutes that may be imposed. 3. The potential for a playing field that may not be level, especially when it comes to marketing for the healthiest patients. In the interim, the provider organizations are clinically accountable to the CO-OP board in the current design. Development of infrastructure is costly, but these groups are proceeding on the hope that they will not be inhibited by unnecessary regulations.

Mr. Rust was asked about his concerns regarding the arrangement of an initial board that can be flexible, followed by an ongoing board. Mr. Rust agreed with that concept and was more concerned about an unnatural restraint designating percentages of certain groups having to be on the board. He believes those who put money into the CO-OP should have an initial say, followed by governance through free and fair elections.

The next speaker was Alan Mytty, Director of Payer Contracting at The Carle Foundation, an integrated health delivery system and health plan operating in Illinois, and also the principal of Health Care Assets Management, a firm that provides managed care consulting and brokerage services. Mr. Mytty had some very specific comments on the draft report. He cautioned that it is important for CO-OPs to be successful competitors and not like the HMOs that began as nonprofits and eventually became for-profit organizations.

Mr. Mytty read two pages of written comments, which are included in the appendix at the end of this report.

Mr. Roger Neece, of ESOP Advisors, Inc., based in Reston, Virginia, read highlights of his written testimony, which is also included in the appendix. His specific recommendations are also included in the appendix at the end of this report.

Paul Hazen, President and CEO of the National Cooperative Business Association (NCBA), said that he was very pleased with the recommendations, although he still had some concerns. He praised the Board for recognizing the need for technical assistance, which is vital to sustainability. Mr. Hazen did not present written testimony, but made the following points:

- NCBA is very pleased that the Board recognized the need for technical assistance, as it is vital to ensure success.
- On page 7 of the recommendations, point 2, NCBA believes there should be dates and benchmarks for the transition from the formation board to the operational board.
- The Association is also concerned about the notice of change in governance to the Department, and recommends that there be a discussion of the impact on consumer control that includes some type of loss of funding.

- On Recommendation 5 on page 7, the Association has concerns about board representation and strong consumer focus and control, and would like stronger language.
- On page 10, in the discussion of conversion, NCBA is generally in support of the language but would argue for stricter conversion requirements.
- Finally, on the finance recommendations, page 12 point 4, NCBA is very pleased that the Board is advising that review of governance documents be part of the recommendation to the Secretary.

The final speaker was Melanie Nathanson, representing the Freelancers Union in Washington, DC. She thanked the Board for their work, noted that this is the Union's top priority, and said that they will be happy to support the effort in any way.

VI. Presentation of Subcommittee Recommendations

Subcommittee on Governance
The Subcommittee reviewed two recommendations on which there was consensus:
• A CO-OP can be formed by a variety of organizations including but not limited to nonprofit organizations, professional group practices, and business entities, but the resulting CO-OP must be governed principally by its members.
• Language regarding eligible pre-July 16, 2009 issuers was beefed up to ensure that eligible prior nonprofits are only those that had the mission of covering underserved and uninsured populations.

For the second bullet, the Subcommittee had some additional language in the text listing various requirements for conversion. There might be reasons why management would want to continue, and they are not barred, but the chief concern is ensuring that unjust enrichment from conversion does not occur.

The Subcommittee presented four recommendations that required further discussion:
• CO-OP conversion or sale to a for-profit or entity that is not a CO-OP – request to provide for permanent HHS veto over conversion in "Conversion" section was not accepted.
• CO-OP conversion or sale to a for-profit or entity that is not a CO-OP – "Conversion" section language added to strengthen conversion limits and penalties.
• Delete 5.f of "Relationship" provision that states "The entity may carry over the management team and assets of the former organization."
• A nonprofit insurer who was an insurer prior to July 16, 2009 may dissolve and an eligible new CO-OP may be formed, but a prior insurer's board directors are permanently barred from serving on the new CO-OP's board.

Discussion initially focused on the Secretary needing to approve conversion. This would be the case regarding forced conversion or emergency actions. In the case of members of the initial board being disallowed as members of the management team, the concern was to ensure against unjust enrichment. It was advised that

point 8 on page 8 of the draft specify whether the entity running the CO-OP is a state-regulated entity.

It was noted that it is not the Subcommittee's task to cover every contingency, though they tried to anticipate most. On page 10, point 13a, the 5 percent interest rate is not based on a standard. The general thought was to avoid using taxpayer dollars to enrich someone. The Subcommittee was open to other suggestions. It was suggested that they check into some of the property and casualty insurance regulations, which calculate the interest rate by a formula.

Subcommittee on Finance

The Finance Subcommittee reviewed five recommendations on which there was consensus:

- Loan versus Grant definition and use.
- CO-OP definition – "CO-OP" as used in these recommendations refers to the nonprofit health insurance entities created under the Consumer Operated and Oriented Plan Section of the Affordable Care Act. These entities may include nonprofit cooperatives as formed under state cooperative law.
- Two-phase application: initial application for planning (not required) and second application for start-up cost and solvency grant.
- A committee of experts would review applications that include actuaries, accountants, individuals with expertise in developing provider networks, individuals with expertise in starting health plans, individuals with investment experience with approving loans to business entities, and individuals with expertise in reviewing cooperative formation and governance documents.
- "Substantially all" has been interpreted to have a wide range of meanings depending on different situations and cases. Recognizing that it may be difficult for a CO-OP to achieve and maintain financial stability if it has to rely too heavily on the issuance of policies or contracts to individuals and small employers, the Advisory Board recommends that HHS exercise maximum flexibility in interpreting substantially all and give applicants a number of years to meet the "substantially all" test.

The Subcommittee presented one recommendation that required further discussion:

- To address the need for the CO-OP to reach critical mass – allow the CO-OP to affiliate with a sibling issuer (newly formed) that offers coverage to the large group market, but otherwise shares administration, etc. Legislative intent and language are both met as long as the government's financial support is isolated to the entity that sells in the individual and small group market.

Discussion about the recommendation centered on the possibility that a sibling insurer could complicate matters. The Subcommittee had extensive discussions of the concept that to achieve economies of scale with services and provider arrangements, there could be CO-OPs that enter into a coordinated arrangement with, for example, a third-party administrator (TPA) used by large employers in the area. Provider arrangements would then include financial arrangements. More in-depth discussion of sibling insurers was held for the afternoon session. Most of the CO-OPs will need critical mass to have an impact on the marketplace, so it would

be good to have a more affirmative statement. A related issue is clarity that the public money used to start CO-OPs should not go to existing insurers. Additional discussion was held for the afternoon session.

Subcommittee on Infrastructure

The Subcommittee on Infrastructure listed eight items on which there was consensus, which the presentation referred to by item number:

- Item 1 – Marketing recommendations;
- Item 4 – Recommendations regarding flexibility in start-up dates for applicants;
- Item 5 – Requirement for management staff;
- Item 6 – Evidence of network development;
- Item 7 – Development of IT system and function;
- Item 8 – Description of consumer-focused complaint and resolution process;
- Item 9 – Plan for customer and provider service development;
- Item 11 – Plan for quality oversight and improvement.

The Subcommittee the presented four recommendations that required further discussion:

- Item 10 – First sentence changed to: To the extent applicants intend to rely on third party administrators (TPAs) and other vendors to provide any of the plan infrastructure, applicants should provide management and operational plans on how they will manage, supervise, and integrate the contractors with regard to the services and infrastructure they provide. This should include information regarding…
- Item 3 – Added bolded: "It is the conclusion of the Advisory Board… those that emphasize developing a relatively weaker statewide network."
- Item 2 – Section 2b(i), added bolded: "For example, for the purposes of this application, a detailed description of payment for Patient Centered Medical Homes or use of Accountable Care Organizations as defined by CMS regulations would be one way to meet the criteria of integrated care."
- Item 10 – Section 2b(iii), added paragraph: "Other definitions of integrated care (taken from published articles, briefs) include: the seamless and coordinated provision of health care services, from the perspective of the patient and family, across the entire care continuum, irrespective of institutional and departmental boundaries; an approach characterized by a high degree of collaboration and communication among health professionals that involves sharing among team members of information related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient; and treatment-delivery models in which physicians work together to coordinate their patient's care."

The Subcommittee spent most of their time on Item 2, discussing the definition of integrated care. They developed wording to offer guidelines for those applying for the loans. Integrated care is very important to the success of the CO-OPs and the experience the patient will have in the system. Other definitions are still in flux, especially that for Accountable Care Organizations (ACOs).

There was concern about expecting too much of a start-up CO-OP. However, another point of view was that the ACA is meant to change health care in America, so it is appropriate to think of how to change integrated care. There should be consideration of how it ought to work for patients. In 2014, not all of the country will be ready for these changes, but the Board should set aspirational goals.

Another concern is the notion of local versus statewide. The comments on this have noted that there are situations in which work in one state and live in another. In other words, sometimes "local" means "multi-state." Because some centers already get patients across state borders, the assumption is that the situation will remain the same, with networks crossing state lines as they do now.

A Subcommittee member stated that there is little about the type of quality of care that needs improvement. The Subcommittee does not have all the answers, but the intent was to describe where they want to go. Offering fewer descriptions rather than more would be a mistake. Another member added that integrated care is not a mandate for a CO-OP, it is a preference, and part of the Board's charge is to contribute to the thought process.

There was discussion as to whether the language favored insurance options that are provider based versus those that will contract with providers. This is an insurance option, not necessarily a delivery system. The Board's task was to stick to Section 1322. The idea is to reshape the paradigm of health care, with systems designed for better care and lower costs. For integrated care, there should be recommendations to go with a successful model of CO-OPs showing how health care ought to be done.

However, some on the Board care believe the applicants should indicate a long-term goal of providing integrated care, and the Subcommittee's recommendations reinforce that. These entities have a challenge to get started. If the Board places on them a set of expectations not currently required, that constitutes harm to the original intent of the statute because it becomes more difficult. The Subcommittee tried to be inclusive of the sites that might not be able to incorporate the medical home concept, and sought to include different means of payment. However, it was noted that it is not necessary to have a provider-generated CO-OP in order to have a medical home.

Subcommittee on Criteria, Process, and Compliance

The Subcommittee on Criteria, Process, and Compliance reviewed seven recommendations on which there was consensus:

- "Private support" should be defined to include: committed funding, committed in-kind support, letters of intent to participate in the CO-OP or its formation from key stakeholders (e.g., provider groups), and letters of support from key community leaders.
- Where there is more than one qualified applicant from a single state, in addition to the factors listed in ACA, weight should be given to other factors,

including type and level of expertise, stage of development, innovation, and commitment to CO-OP goals and objectives.

- HHS could consider discontinuing funding for a CO-OP if it fails to meet: substantial conditions for any stage in the funding process; HHS contract terms; business plan benchmarks; state solvency requirements; qualified health plan requirements; provider network adequacy standards; or quality-of-care standards. Other reasons could include: court-ordered bankruptcy; lack of consumer support; falling enrollment that jeopardizes sustainability; persistent problems with consumer complaints; and audits indicating serious, ongoing financial problems.
- Applicants should be required to demonstrate engagement with local and state insurance regulators and knowledge of licensing requirements.
- HHS should approach national foundations about providing technical assistance directly to applicants and grantees.
- The Advisory Board recognizes that the need to compete for plan members means it will be highly desirable for CO-OPs to be ready to enroll members during the first Exchange open enrollment period in late 2013. Therefore, it recommends that HHS issue draft regulations in Spring 2011, and be ready to receive and review applications in Fall 2011.
- After the first round of applications, HHS should receive applications on a rolling basis thereafter with defined intervals of review and award.

The Subcommittee presented two recommendations that required further discussion:

- Discontinuing funding should be a last resort. HHS should make every effort to help a CO-OP succeed by, for instance, providing technical/management support where needed and providing additional funding – along with closer oversight by, and more frequent reporting to, HHS – to protect the investment already made.
- The Advisory Board recommends that loan repayment period should not begin until enrollment has been achieved.

VII. Board Discussion of the Draft Report

The Board reviewed the draft final report by section.

In looking at the Overview, an issue arose regarding the key goals. There was concern that “solvency and the financial stability of coverage must be vigilantly maintained and promoted” was not on par with the other three principles. In stressing the reserves, it is important to not set over-capitalization as a goal. It was agreed to change “must” to “needs to be” and take out “vigilantly.”

The Board discussed whether they should comment on how Section 1322 fits in with other elements of the ACA. There are those who still do not understand how this provision would reshape the healthcare system. In envisioning how to create change after 2014, it appears that greater choices will facilitate improvement in the healthcare system. There is a significant lack of understanding on how CO-OPs and the exchanges could facilitate shifting the paradigm. The last 2/3 of a paragraph on page 22 of the report starts on that path, and the Board agreed to consider what to insert there.

Regarding governance, point 13 on page 10 includes language about the life of the loan or grant. The concern was about too much government involvement. Many comments stated that that this is a risk. Given all the other requirements regarding conversion, the Board has made it very difficult and put in a lot of barriers and protections. Point 13b is a bar against unjust enrichment. The intent was to say that there is no bar to carrying over management from the first board to the second as long as there is no unjust enrichment. It was suggested that they keep that language and add new language about current and past board members receiving unjust enrichment. That was countered by a Board member saying it was covered in 13b, sentence 2. The problem is that "financial gain" is fine, but saying that management cannot participate is going too far. However, it is not just the financial gain benefit, it is relating it to the incentive of the board and management members to push the deal through. There is a legitimate concern about how to prevent this, but there is also concern about losing expertise of those from the first group. It was suggested that the Board take some time to consider that participation of management may be allowed provided there is no unjust enrichment. There is also the issue of parent companies.

On page 9, point 10, some suggested expanding the list even though it says "not limited to." The language gives the flavor of the flexibility. There was some talk about new entities incorporating and nonprofits obtaining IRS tax status. There was some disagreement about whether the IRS is fast or slow, and most people do not view an organization as a nonprofit until they have their IRS status. Mr. Freezor said that these entities must be incorporated and, in most states, will fall into one of these categories. To be eligible, an entity shall have appropriately incorporated but might not be ineligible for having not yet received state designation. An applicant who has not received state tax exemption should not be excluded. If they have applied for state tax exemption, they are eligible to apply.

The next topic was Taft-Hartley. The statute is directed at employers, and it is not clear where Taft-Hartley exchanges belong. Declaring them specifically eligible would not follow the statute. A suggestion was given that they could apply if they were appropriately organized and not specifically limited. However, one Board member thought that if they already existed, would that preclude them.

There was also a concern that the language on page 7 in point 5 suggests that a substantial portion of the board would be nonmembers. This is a significant minority of the board of directors, and the document spells out elsewhere that a substantial majority of board must be members who have purchased insurance. The recommendation is to let some nonmembers to serve on the board in order to have some of the necessary expertise.

On page 55 of the draft report, there were three sub-bullets (referred to as bullets going forward) that could be added to page 9 to give clarity. The last bullet related to the sibling organizations. This might be, for example, a physician practice group that might partner with a CO-OP. In cases of physicians in a for-profit enterprise, that relationship has worked fine, but the language has to be clear in order to avoid precluding physician organizations. It was suggested that attorneys write that rule. The point is that they do not want for-profit insurance companies involved, and a

CO-OP cannot have a relationship with an existing insurance group. An example of a scenario is one in which a group sets up two insurers, one as CO-OP and one for profit, in which they have joint infrastructure and resources but separate governance and boards. The benefit of the CO-OP members should not go to the benefit of the for-profit.

VIII. Discussion of Final Recommendations

After lunch, the Board resumed discussion of the three sub-bullets on page 55 of the draft report. On the second bullet, there was a recommendation to add "parent or controlling company of an applicant…". On the third bullet, there were two options suggested. The first was adding "and the partnership carries out the mission of the statute." The second option was to add "and the partner or joint venture is nonprofit." It was suggested that some partnerships are with businesses that want to save money on their health insurance. The Board should have leeway to include for-profits that want a different system. These may or may not be physicians or may or may not have anything to do with healthcare. A motion was made and seconded to have the language *not* dictate nonprofit status in the third bullet.

In discussion following the motion, a Board member suggested establishing a "safe harbor" for this kind of situation, so that there is a higher requirement for approval. If not, they should be silent on it. It was noted that the language is very broad, and that, as worded, it allows a partnership with a for-profit that might have a subsidiary that is a health insurer. It is possible to control through a partnership or joint venture. It was suggested that they state that this partnership cannot be with an insurer that was in business before 2009. It was argued that intent is clear to define the nonprofit characteristic. This can lead to other provisions, but the point was about the controlling entity being a partnership or company, and this is wordsmithing. More substantive is whether any good is done from including this language. The document might be better without the third bullet. The IRS has spent countless decades trying to define legitimate joint ventures, and the Board is not going to do it in an afternoon. However, they should signal that there is a way to do this appropriately. The second bullet gives that impression, and if they stop there, the language says to stay away from all for-profits. What they need to say is that there should be flexible ways to have for-profit entities involved beyond arms-length contracting.

This is a thorny issue. As the minutes are part of the record, it was suggested that the Board say they have these concerns and they cannot think of all the examples on the spot. That way, the minutes reflect their intent while they find the right language. It was observed that there may be a consensus on the sentiment, but the language is an issue. The idea is to preserve the ability to work with for-profits without allowing abuse. They should allow appropriate relationships. Another observation was that the second bullet is good and takes care of the horizontal relationships, and the third bullet expresses the level of control. The new language on the second bullet says that the parent or controlling company of an applicant cannot be a for-profit entity. Another point was made that this can be taken to any extreme, and by saying in the third bullet that there can be for-profit involvement,

they have gone too far. If they are having such disagreement on this point, they should not put it in stone.

A review of the language noted that the first bullet has not changed. On the second, they added “or controlling” after “parent.” The third bullet was now “Partnerships or joint ventures will be allowed so long as appropriate benefits accrue to the members and carry out the statute’s mission.” It was suggested that with the word “appropriate” does not really say anything in the way of guidance, no matter how they rephrase the rest of it. The Secretary can interpret that however he or she chooses. Another concern is who is really benefitting. Is it the partner, and to what degree and on what basis? An alternative was suggested, having the words “further the goals of the statute.” It was agreed to use this language instead of the reference to “appropriate benefit.”

Another point was one that the Finance Subcommittee had raised that also relates to governance. The suggestion was to have language stating “In order to enhance the potential for the CO-OP to better achieve its objectives for cost-effective coverage and care for its members, we would allow the CO-OP to coordinate with large employers and employee groups that might help the CO-OP achieve scale economies by utilizing common administrative services and provider arrangements.” The last sentence would be the same.

On the top of page 7, the end of point 2, it seemed that the document asks for notification of changes in governance, but does not state whether those changes need to be approved. This does not necessarily need to be an enforcement section, but there are implications regarding loan repayment and other key elements. Typically, this type of change does not require a public filing, and in most states there is no need to approve the changes unless they applied to the articles, in which case the articles would need to be re-filed. The state does not need to approve the re-filed articles. The section will be left alone. On the same page, section 4, in reference to voting participation, it was suggested that the Board add labor to the list of examples of designated groups. The Board agreed to include that addition. It was noted that side conversations indicated a strong preference to include a reference to contested board elections.

Regarding large employers, they could have board representation through their unionized employees. The unions know health care and know how to compete on health care costs. They have to pay for the plans of employees. The issue is who will be in control. Unions have experience with member education and outreach. This language could also go under the “substantially all” requirement.

The proposal is for the three bullets as defined, added under section 10 under governance section, and the paragraph “In order to enhance the potential for the CO-OP to better achieve its objectives for cost-effective coverage and care for its membership, a CO-OP may coordinate with large employers or employee groups who could help the CO-OP achieve scale economies by utilizing the same administrative services or provider arrangements.” Staff will determine where it best fits. It was suggested that this be two motions. “Coordinate” can take different forms. “Partner” might also work.

In discussion, it was pointed out that insurers are large employers, and the Board should consider whether to explicitly include them. If the insurer were larger than the CO-OP, they would have to have a contractual arrangement for administrative services, so that should be made clear. This is most important where there is an opportunity to work with providers toward integrated systems of care.

Language was suggested for the 3rd bullet in section 10: "The Advisory Board cautions the Secretary to ensure that the review focuses in part on potential abuses that may be caused by the partner controlling the partnership for its benefit and to the detriment of the CO-OP and its members." This language was added to the third bullet. In discussion, there was concern that this says it would be fine to have an insurer as a partner, which goes against what the Board discussed about precluding them from being issuers. Another suggestion was to have this language as a separate bullet. The sense of what they want to say is that the Board had concerns that if the partner is a major issuer, a lot of the efforts that went into the law to change the dynamics would be thwarted. Yet another suggestion was to state that "partnerships will not negate nonprofit status" to replace "will not be allowed."

In a vote on the third bullet, with the addition of the proposed amendment, one member voted against it and the rest voted in favor. The motion passed.

Moving on to finance, attention went to pages 32 and 33, which included the detailed language on "substantially all." The Finance Subcommittee thought the provisions allowed a CO-OP to start out by issuing policies to large employers and obtain critical mass. Critical mass is necessary for two things: overhead and meeting solvency requirements. Each entity must meet solvency requirements, which is why the Subcommittee removed the language about sibling entities. It was noted that there is a major difference in quality in relation to providers in integrated care versus any other group.

It was noted that the definitions of the terms "issuing activities", "plan", "policy", and "contracts" differ. There was concern about interpretation and allowing grants to serve as capital reserves for a CO-OP most of whose members are with large employers. The intent of the CO-OP provision of ACA is to mainly serve individuals and small groups. The term in the statute is "plan." The "plan" is not the member, however.

The CO-OPs will have to go beyond small businesses and individuals if they are to have any success. Otherwise, they are being set up for failure. The language is somewhat ambiguous. Mr. Freezor suggested looking at point 8 on page 13, which says there are various ways to measure activity. The CO-OPs should have a way to reach scale and survive. There has to be some flexibility, maybe in the number of contracts, but they should not say that this is the only way the Secretary should pursue this.

Another suggestion was to mention the possibility of a newly formed issuer. A newly created issuer does not violate the prohibition of being a previous issuer. In an earlier discussion, there was the concept of using sibling issuers. If both are

newly formed, one can pursue large accounts. It was suggested that this might go on page 33 at the end of H. There was discussion about adding it at the end of point 8 page 13 instead and using the word “collaborate” instead of “coordinate.” This is a provision in the law on the topic of cost effectiveness, which is important. A vote was unanimous to add the language.

Editing notes included adding text about the experts in start-ups and experts in integrated care, probably on page 33. It was suggested that the Board briefly revisit item 3 on page 12, about the level of detail. There was concern that the Board might put the Secretary in an awkward situation by asking HHS to react to applications on a tight timeline. The application process will be a strain on the Department. It also might be more like dealing with state regulators, who may for refinements over a period of months. It was suggested that the final report include a footnote stating that the Board understands that many entities will not have a refined business plan at this time, so ongoing dialogue will occur. Because the document states that the Secretary should follow implementation, it might be necessary to specify that the Board understands that plans change. It could be that organizations will present business plans and the funds would be disbursed according to the meeting of milestones. Mr. Freezor said that they will clarify in Section 3 the concept that some early business plans will be more general and that ongoing monitoring between the Department and the grantee will lead to further dialogue.

They might also want to mention proprietary information here. This is an important point, that competitors not be able to obtain this information. It was suggested that they say the Secretary should take into account what is typically proprietary. There are already situations in HHS where proprietary information is protected, such as contracts and grants. Two suggestions were to state that the information be afforded the same protection as the Medicare Advantage plan, and that it be afforded the protections given in other situations.

On infrastructure, the biggest obstacle is defining integrated care. The Subcommittee spent a lot of time on that and developed the test on page 34 point 2. They also came up with the definition of marketing in the middle of page 14. The issue is marketing versus education and outreach, and whether they should instead be discussing “membership development and membership education.” It was suggested to add that at the end of the first sentence. Membership development is essentially the welcome package and information sent to a new member, explaining what is involved in being a member of a CO-OP. This will go in as a footnote. The other element is line 5, where “marketing” was to be replaced with “membership development.”

The Criteria Subcommittee had a few items to discuss. On page 18, point 4, the issue was the circumstances under which one could consider discontinuing funding. On line 5, the Board voted to add “governance, or control” after “demonstrated lack of support.” On page 19 point 9, a couple of Board members felt the wording should be “mature enrollment.” “Loan repayment period” could refer to when the clock starts. That leads to the question of when does the 15 years start, and when should the CO-OP start repaying the loan. Mr. Freezor said that they should address the

Secretary moving more expeditiously, and note that there may be circumstances under which continuing care for individuals may follow a merger or purchase. The reality is that they will have to be regulated at the state level. Another question addressed whether, if a merger is required due to a fire sale and repayment has not started, HHS will look at the acquiring company for the repayment. This was not clear.

On page 22, in the second paragraph, there is language about health exchanges that might be improved by a reference to the fact that the purpose is to change the paradigm in U.S. healthcare. There should be a message that the states, through their exchanges, can change the paradigm somewhat. The suggested language was "CO-OPs, if effectively designed and implemented, can facilitate the development of higher quality, lower cost health care within the state exchange." It was agreed to add this statement.

While the idea is for CO-OPs to be very collaborative for economies of scale and such, there is a real concern that the Board should emphasize that the money spent in starting up the operations should be targeted to the defined audience: individuals and small groups. Where there are large employers, the Federal government should not be underwriting the enterprise. Federal financing should go to new business, not large business. It was suggested that that statement be placed on page 32, under point H(c), and state the legislative intent of for the funds' use.

It was noted that the market of businesses with 50-150 employees was missing. The language should make clear that if a 10,000-person group and single individual each count as one contract, that violates the intent of the law. The difficulty in this document will be to maintain the tension that it is also against the statute that the CO-OPs be set up for failure. The issue of bifurcating solvency into large groups and small groups goes beyond wordsmithing. If, 5 years from now, there is a group with 30,000 insured from three large employers, and 10,000 individuals, that is a violation of the law. Self-funded groups currently have to prove solvency. It was suggested that there be no examples included so that the Secretary can define "substantially all."

Self-funded plans address the insolvency issue in many ways if the plans are making a profit. It does not significantly increase the solvency requirements, and it gives them more bargaining power. Perhaps the best approach is that if a plan is self-funded, it is separate from the "substantially all" requirement.

Mr. Freezor determined that the Board would need to have at least one phone call with an electronic text. This phone meeting must be announced in the public record 15 days in advance.

IX. Board Conclusions and Pending Issues

At the end of the meeting, Mr. Freezor listed nine changes to the final report, by page:

- Page 5 of the draft final report, the concern is that there was too much emphasis on financial stability.

- Page 7, point 4 will be amended regarding the preference for contested elections.
- Page 8, point 7, there will be reference to expanding the latitude of entities to carry out the public purpose.
- Page 9, point 10 will now include three amended bullets from page 55 and caveat language about not going beyond the intent of the Act.
- Page 10, point B, language was agreed upon conceptually, but as yet there is no specific language to look at, regarding a stronger statement about unjust enrichment while maintaining some opening for management under limited circumstances for continuity of operations. The issue is that managers not have a windfall.
- Page 12, point 3, a more general footnote will be added about understanding that some applicants will not have a refined business plan, which will require ongoing dialogue.
- Page 13, there will be wordsmithing regarding collaboration versus coordination.
- Page 14 will now include an expanded definition of activity for membership development, with further clarification and removal of the reference to marketing.
- Page 22, the wording issues regarding self-funded entities will be resolved.

With these issues pending, a motion was made to adopt the draft final report, and the vote was unanimous.

The meeting was adjourned at 4:20 p.m.

Appendix: Recommendations for Changes to the Draft Final Report, from Members of the Public

I. Alan Mytty Recommendations

Summary of Recommendations

P 10 # 13 The first sentence deals with the conversion or sale. Maybe it's understood but could this be revised or re-stated so that it is clear that the Secretary's approval is required "for the life of the loan or grant, including the periods for paying back any loan or grant, plus 10 years."?

P. 10 # 13.b. Can the last sentence be amended so it reads as follows: "There should be substantial prohibitions on the ability of the BOD and management team to receive financial gain or participate in the governance/management of the converted entity, the successor organization or any organization purchasing the CO-OP"? A decision to convert or sell should not be swayed by the opportunity for management of a CO-OP to get a big pay raise when they get hired by the purchasing entity.

P. 10 # 13.c. The second sentence states, "The CO-OP should hold an investment equal to at least 25 percent of the voting shares of the for-profit successor in trust for the benefit of its members." My question is: Does this mean that in order for a sale or conversion to go through, the CO-OP will need to hold 25% of the shares in the successor or the entity purchasing the CO-OP? If so, it seems to me that this would have the effect of prohibiting the sale to the publicly traded managed care firms.

Finance Recommendations

P.11 First Paragraph of the Finance Recommendations. Could the Advisory Board consider adding after the last sentence the following "The Secretary will work with NAIC and appropriate state regulators so that strong hold-harmless language and the assumption of risk by qualified health care provider organizations can be considered in determining whether separate solvency and risk based capital requirements could be allowed for CO-OPs." I read the testimony from Mr. Brian Webb of NAIC and understand his concerns about solvency requirements for insurers and HMOs, but would hope that the CO-OP contracts with providers and the financial strength of substantial integrated delivery system providers could be considered. But if this suggestion would meet resistance from critics who might argue that CO-OPs have an unfair advantage, then it should be ignored.

P. 13 # 8. Will CO-OPs be allowed to make their provider networks and administrative services available to local employers, trusts, Taft-Hartley plans, etc. that wish to self-insure?

Other Finance Questions:

- Will there be Federal regulations specific to CO-OPs concerning pricing, underwriting, premium setting?
    - For example, will CO-OPs be required to use straight community rating?
    - Will there be other options for premium setting available?
- Will the financial strength of a provider network that seeks a capitated arrangement be considered?
    - If a small medical group or hospital wants a fully capitated arrangement, will that be allowed?
    - If not, what objective criteria will be used for determining the financial strength of providers that might want captitated contracts?
- Are there instances where state insurance rules regarding premiums and rate-setting would interfere with the CO-OP's ability to compete?
- Will there be rules regarding the minimum risk that the CO-OP and/or its provider network must assume?
    - What if a CO-OP shifts the vast majority of risk to a reinsurer?
    - Are there any rules anticipated regarding the regulatory/financial/organizational requirements of a reinsurer?

Infrastructure Recommendations

P 16 # 7 IT and Reporting. Caution is advised regarding reporting requirements imposed on CO-OPs that could be excessive when compared to other health plans. To be competitive I assume that HEDIS, NCQA and URAC requirements, compliance with HIPAA electronic eligibility and claims, Centers for Medicare and Medicaid Services reporting for Medicare Advantage plans, CAQH participation, and potentially other requirements and organizations need to be considered. A balance among the costs, value, transparency, competitive benefits, etc. needs to be reached so that CO-OPs can compete and show value while not being burdened with additional reporting and other infrastructure requirements that do not add to effective and efficient health care.

Criteria, Process, and Compliance Recommendations

P. 18 # 5. Is it assumed that "oversight" also includes authority by the Secretary to provide interim management for a CO-OP that is experiencing difficulties "where the Department has concluded discontinuing funding is not in the best interests of the CO-OP, its members, or the Department."

Conclusion

This paragraph addresses the challenges to market entry, but does not speak to sustainability or market viability. Before the last sentence, could the following be inserted: "To be viable and competitive, CO-OPS will need to realistically and diligently work to manage the use and costs of health care services while ensuring that high quality covered services are provided." I believe some statement about anticipating and managing costs while competing against other health insurance plans would appropriately emphasize a key challenge that CO-OPs will face.

II. Roger Neece Recommendations

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

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

The Board addresses specific requirements for applications on page 12 of the Draft Report. As contemplated in Recommendation 3 on that page, as desirable as it may be for CO-OPs to be able to provide the Secretary in conjunction with a planning loan application early fall 2011 details concerning its business strategy, its products, its proposed provider network, the insurance regulatory requirements

associated with this strategy , the limits on the usefulness of this information to the Secretary as a practical matter have to realized. Most prospective CO-OPs in organization may have difficulty in meeting this requirement.

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Certain prospective CO-OPs, very few in number, that have received substantial feasibility funding from non-federal parties may be in a position to provide initial representations on these matters. Even in these cases, the Secretary must recognize that representations made at the time of the planning loan application will be very preliminary, and certain operating requirements of the CO-OP will likely not have been specified including the specific requirements for covered benefits in a qualified health plan, and exchange requirements and these requirements will directly affect a CO-OP's representations . Such representations may through no fault of the prospective CO-OP not hold true as the CO-OP proceeds through the detailed business planning process and different representations may be found in the completed business plan. Most CO-OPs, those that have not received any substantial feasibility funding, will likely find that they may not be able to provide more than general answers, and will in general not be on a position to provide this level of detail, prior to having undertaken a detailed business planning process, which is to be funded from the proceeds of the planning loan. ESOP Advisors, Inc recommends that the words "and a general discussion of the " be inserted in line three of Recommendation 3 on page 12 before the words "organizations mission", and that this general discussion requirement apply to all issues prior to the semicolon preceding " and a budget for the use of the loan,".

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

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

Finally, with respect to the Criteria, Process and Compliance Recommendations, and especially the definition of private support, ESOP Advisors generally supports the recommended definition. We would recommend CO-OP applicants be credited with private support that has been demonstrated prior to the application as well as the period for which funding is contemplated in the application. Most consumer oriented CO-OPs currently in development of which ESOP Advisors is aware (not including those currently sponsored or contemplated by heath care provider organizations or organizations with insurance operations) exist today completely through the volunteer efforts of their organizers and pro-bono professional support, including funding of out of pocket costs such as travel and communications. The Advisory Board should recommend that the Secretary' s priority give credit to private support demonstrated by CO-OPs in undertaking preliminary efforts for organization, development, and feasibility that occur prior to their applications for planning loans, by inserting the words "previously utilized and future" after the colon and prior to the words "committed support" in sentence 2 of Recommendation 1 on page 17.

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

Therefore, with respect to stage 1 planning loans the Secretary should not require any commitment of non-federal private funding in order to achieve a high priority rank in the Secretary's funding of such planning loans from among various applicants within a state of for overall priority. An applicant for Development Loans

should be able and be required to demonstrate a higher level of private support in order to qualify for priority in funding by the Secretary, but should not be required to demonstrate any committed non-federal financing or funding in order to receive startup funding for operations, and at this stage the level of private sector support required to be represented would include contracts with potential providers and service providers, as well as executive and operational staff. In the opinion of ESOP Advisors third party private sector funding will not be forthcoming for almost all CO-OPs until federal funding has been received, and any commitments for such funding such as working capital financing, venture leasing, facility leases as well as most program related investments will be contingent upon the receipt of appropriate staged federal funding.