March 4, 2010

Brian Chiglinsky
Office of Consumer Information and Health Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9983-NC
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Comments to OCIIO-9983-NC

Dear Mr. Chiglinsky,

This responds to your agency's Request for Comments as published in the February 2, 2011 Federal Register. We appreciate the opportunity to comment on the development of the Consumer Operated and Oriented Program.

Beam Partners, LLC is a health care consulting firm that has formed and managed health insurers, Medicare Advantage Plans. We also develop provider networks, ACO arrangements as well as provide Data Analytics and Revenue Management services.

We polled our consulting associates and have developed the following suggestions in response to your questions. Robin Fisk, Attorney at Law, also provided significant support. Your questions and our responses are attached.

Sincerely,

Terry S. Shilling
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**A.**

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

Many organizations could successfully establish a CO-OP, including specialized consulting groups, currently self-insured employer plan trusts, large integrated provider organizations, organizations that create and manage networks of providers, and state provider associations that have traditionally provided their members with extensive assistance with managing care, cost and relationships with Health Plans. The critical issue is whether the organization possesses the skills identified elsewhere in this document. For example, a clear distinction can be made between an organization that currently operates an employer-owned health plan (implemented after July 16, 2009, as indicated in the Affordable Care Act), and one that merely offers health benefits accessed through one of the commercial carriers. In our experience the former would have the infrastructure and expertise in place to operate a CO-OP.

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

Applicants for the initial grant should demonstrate an appreciation of the variety of skill sets needed to operate a CO-OP and provide a business plan for how the Applicant will equip itself with these core competencies where inadequacies exist. We believe it is critical that key members of the Applicant's management team have significant experience in operating a managed care organization or other type of health plan in either the same or a similar market. To the extent possible, the executive management team should provide documentation demonstrating its collective success in the areas of:

- Health Plan product development and pricing;

- Member growth and retention;
- Financial and medical management;
- Provider network development and management;
- Network adequacy analyses, including for specific populations;
- Regulatory compliance and reporting;
- Quality measurement and improvement; and
- Measures of stakeholder satisfaction.

In the initial stages, it will likely be necessary for Applicants to outsource some of these core competencies. Should the Applicant obtain some or all of these skills externally, a plan should be in place for managing these costs.

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

The relationship between the CO-OP and its members should be member-centric and proactive, taking into account the changing health care needs of the member over time. To promote initial and continued enrollment, the CO-OP should strive to create and perpetuate awareness of the benefits of membership. The CO-OP should not be viewed as a cheap alternative to “better” insurance. If a member is accustomed to accessing his/her claim and other benefit information through a prior health plan’s website, for example, then a web portal is no longer considered an optional, but rather a standard.

Our experience indicates significant consumer education will be required to help the consumer understand the CO-OP concept.

A CO-OP should drive initial and continued enrollment by the following attributes:

Medical Home Model: CO-Ops should encourage and incentivize the use of the Patient Centered Medical Home. We believe the Medical Home Model offers the best member experience available, results in better overall healthcare, and cost reduction. Members with complex or chronic conditions or conditions that require care from different providers or in different settings should, whenever possible, be involved in conferences concerning their care.

Additionally, we believe, the member experience requires these elements to be successful and competitive:

Ease of Access to Care:

- Electronic Medical Records are a necessity;
- Ease of making appointments within a reasonable number of days;
- A strong provider network with open access and broad geographic coverage;

- Augmentation of staff-model plans with primary care network across the area served;
- Wide range of benefits plans, including Vision and Dental and Health Savings Accounts;
- On-site clinics or "near work clinics" for employees of different organizations are very appealing to both members and employers.
- Members should be given summaries at the end of each medical encounter describing, in easy-to-read terms (i.e.; low Flesch score, large print, translated into native language) the recommendations for their care, the reason why each therapy, treatment or prescription was ordered, etc. and instructions on how to comply with the practitioner's prescribed course of treatment.

High perception and reality of Quality of Care:

- Preventive programs offered at little or no member cost;
- A focus on outcomes-based medicine;
- Ongoing measurement and comparison of performance to clinical quality standards;
- Strong medical management;
- Early screenings, including systems to remind Members of overdue screenings;
- Coordinated care programs for groups and individuals
- Frequent opportunities for the member to participate in the planning of their care.

Exceptional Member Services:

- The CO-OP should rate and reward providers who truly listen and understand the patient's overall health not just the episode and spend more than a normal amount of time with the patient;
- Member claims paid and information issued quickly;
- Explanations of benefits should be understandable to Members;
- No lengthy waits with call centers or in offices;
- Ease of getting appointments, tests, treatment and results
- 24 hour Nurse line
- Wellness coaching
- Discounts on fitness equipment, gyms and weight loss programs

The CO-OP should regularly conduct market surveys to ensure that its package of member services is at least equal to other insurers in the market area.

Sophisticated Technology Support: Because CO-OPs will be required to deliver care efficiently, plans must strike a balance between "high touch" services that matter and services that can be provided efficiently through other means. A qualified plan should create a web portal to provide members with access information about services provided, including Electronic Medical Records, with a personalized member chart

- Appointment Scheduling
- Determining Claim Status and paying bills

- Refilling prescriptions
- Health Assessments
- Checking immunization records
- Checking retail discounts
- Communication with physicians and nurses
- Interactive website

CO-OP Governance: Successful CO-OP Applicants will actively promote member participation on their boards and will advertise this fact. Meetings should not only be open, but the date prominently advertised in ways shown to increase both current and prospective member awareness of the role of members on the board. The CO-OP Members could elect the Governing Board. CO-Ops should be required to meet minimum standards as evidence of active Board elections.

- The CEO of the CO-OP could serve as a voting or non-voting member of the Board.
- The members should be chosen from a pool of members with substantial knowledge of health care delivery and financing.
- Insurance brokers/agents should be excluded from the board.
- 51% of the Board should be drawn from the membership.
- Boards should be required to actively review reports of clinical quality, member satisfaction and other key performance measures.

2-3 provider representatives would be helpful in support of clinical integration and care improvement activities.

Member decision-making participation, including Policies and Procedures, would be helpful.

**Member Retention Program Components**:

Other programs that we have seen increasing active member involvement with their CO-OP include:

- Member advisory Councils to provide feedback
- Personal consumer advocates
- Periodic member surveys determining member satisfaction as well as determining member support for programs and initiatives
- Newsletters
- Member Appreciation Events
- Birthday Cards
- Member Advisory Councils
- Participation in CO-OP committees or task forces

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

CO-OPs operating in rural areas will often face geographic monopolies that could impair their ability to negotiate favorable provider agreement terms. Rural CO-OPs can fail to meet network adequacy requirements in a region simply because a single specialty provider refuses to contract. Even in areas where a plan can have a waiver of network adequacy requirements because of a provider's refusal to contract, the plan will have to allow members to use out-of-network providers, often at unfavorable rates. Assisting members to locate a provider, or preparing authorizations to see an out of network provider, can be labor-intensive and could represent added costs. Downstream, the processing of claims could require manual intervention to assure pended claims are cleared and that the reimbursement is calculated accurately. In the context of Medicare Advantage, this issue is largely resolved by the requirement that providers who participate in Medicare accept Medicare fee-for-service equivalent rates when providing services to a Medicare Advantage member.

In Health Professional Shortage Areas the CO-OP may need to explore establishing a rotation of physicians to the areas in which access to providers is limited. Additionally, telemedicine can support this effort.

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

Ideally, 18-24 months would be appropriate, based upon our experience. These factors may affect the timeline:

- Clear guidelines for what types of proposals will be accepted;
- Grants being awarded on time, with clear definition of limits on usage of funds;
- Approval of the license by federal and government agencies;
- The ability to contract with providers and facilities;
- The availability of a Medical Home Model in the marketplace;
- The ability to hire executives, staff and/or consultants. Health plan experts are not always readily available in every market;
- The ability to build an organization from concept to successful operation, while at the same time dealing with government requirements for licensing should not be underestimated;
- Ability to create a financially sound organization. (If CO-Ops are required, rather than encouraged to show broad community financial support for the start up, this could increase the time a Co-OP needs to launch.);
- Ability to offer competitive products in the market;

- Legal challenges on the federal level.

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

The Feasibility Plan should require enough detail to ensure that the entity making the submission gets experienced assistance early on. We recommend the Applicant indicate thoughtful analysis about many of the functions they will need to master to become operational, including the following:

- Executive Summary: business/product summary, current stage of development, anything unique about the CO-OP or proposed product, high-level marketing costs, start-up costs, financing needs
- Product/Service Description: fit to current operations, fit in current market, changing market needs
- Market: current market size, target market, penetration, growth potential, industry trends, member and customer profile
- Price and Profitability; three year financial projections including enrollment, premium revenue, benefit costs, administrative expense assumptions, start-up costs, state statutory requirements and limitations, estimate of loan-payback period
- Plan for further action: applications, government approvals, financing, licensing, CO-OP infrastructure
- Financial and Actuarial analysis
- Description of operations, what services will be subcontracted, to whom, cost to subcontract, etc.

A Marketing Plan should include:

- Executive Summary
- Product Descriptions
- Goals (strategic goals and specific sales figures)
- CO-OP Analysis: focus, culture, strengths, weaknesses
- Customer Analysis: potential number, type, value drivers
- Competitor Analysis: market position, strengths, weaknesses, market shares, summary of opportunities and threats
- Environment Analysis: political and legal, economic analysis as well as an organizational SWOT summary (Strengths, Weaknesses, Opportunities and Threats)

- Marketing Analysis: How much and which media, public relations, promotional items/programs, budget with the expected results
- Conclusion
- Exhibits

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

There are minimum operational costs regardless of enrollment (IT, facility, staffing, compliance and advertising costs). These costs also have variable components related to enrollment size. Funding needs may or may not be different for plans already in existence, depending on the size of the plan, how long it has been in existence, and the level of additional capital that already exists over statutory minimums.

The investment required to develop sufficient heath plan information technology systems that include administrative, claims processing, and electronic health records is fairly substantial and the level of investment will also determine the amount of direct control an entity has over all of its IT initiatives.

The basic options are to:

- Establish an internal IT department consisting of direct hired or contracted staff and purchased or leased software and equipment. (Option 1)
- Contract with third party vendor(s) to provide all claim processing, reporting and other administrative services. (Option 2)
- A combination of the above. (Option 3)

Each of these options detailed below assumes a CO-OP will maintain a basic IT infrastructure of PCs or laptops, server(s), and Internet access. This structure is part of the minimum investment.

For all options there is a minimum level of investment that will be required regardless of the size of enrollment although that investment can be mitigated if the entity forming this new line of business is already in operation and has hardware and/or software in place.

Each of the options has variable pricing components that influence the total investment:

Option 1 – Server and software costs including periodic updates are quite substantial; however, the costs include fixed components. The size of the enrollment generally does not affect these

costs unless it creates a need for increased data storage capacity and processing speed. The cost of staffing an internal IT department is also quite large, and those costs are usually influenced by

- Geographic location
- Size of the enrollment

Entities with large member populations tend to employ this option as their primary IT structure as it is the most responsive. However, it is also the most costly option.

Option 2 – The total investment is directly affected by the number of members due to the common practice of third party vendors providing services based on a tiered price structure based on enrollment. Most, if not all, client IT requests will incur an additional hourly charge ranging from $50 - $200 an hour. These requests are subject to the vendors':

- IT priorities
- Availability of IT resources
- Coordination and charges incurred in the event of data interchange between vendors

These factors could result in the need for additional outsourcing. However there is less of a hardware / software / staffing investment needed so that entities with small member populations may choose to employ this structure as its primary IT structure.

Option 3 – A hybrid option is used as CO-OPs who initially started with one of the earlier options either, a) try to reduce costs (in the case of option 1) or b) try to gain more control over IT functions and initiatives (in the case of option 2).

The following estimated initial investment costs assume approximately 20,000 members. Unless noted, costs are projected on a yearly basis and are based on our experience with clients.

**IT department maintained In-House:**

- Software Purchase Costs (Claim Processing and Management system, NCQA software, Medical Management, EDI, Database, Security): $500,000 – $750,000; yearly licensing will also be required
- Equipment Costs (Servers, email, Networking, Backup, Storage, Customer Service Phone System and recording): $1,000,000; leasing equipment will reduce costs

- Minimum Staffing needed (Manager, DBA, Programmer/Analysts, System Operators, IT and Phone Support Rep): $750,000 - $1,000,000
- Other Major expenses – Staff Training for management systems: $50,000 - $200,000
- Total: **$2.3 - $2.95 million**

**IT department maintained with outsourced services:**

- Software Purchase Costs (Database and File Transfer Software, Email, Security, etc.): $50,000 – $150,000; yearly licensing will also be required
- Equipment Costs (Servers, Email, Networking, Backup, Storage, etc.): $75,000 – $100,000; leasing equipment will reduce costs
- Minimum Staffing needed – (Project Manager, Programmer/Analyst/System Operators, IT and phone support rep): $600,000 – $700,000
- Outsourced Services: $500,000 – $1,000,000
    - Includes Management system, Medical Management, EDI, etc.
- Other Major expenses (Implementation Fees for setting up outsourced management system): $250,000 - $500,000
    - Consulting fees for larger IT projects: $50 – $200 per hour
- Total: **$1.475 million – $2.475 million** and may require additional hourly consulting fees

Monthly outsourcing service fees will vary with the number of CO-OP members.

**8. What level of investment would be required by a qualified non-profit issuer to develop sufficient health information technology systems necessary to operate a health plan in the health insurance Exchange market, including the use of electronic health records? Is there a minimum level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, enrollee characteristics, or other factors, and by how much? Are funding needs for this purpose different for any qualified non-profit issuers that may already be in existence, and if so, in what way?**

The requirements for information technology as set forth in questions7 & 8 are essentially the same. Both require a comprehensive plan management system, which has been detailed above.

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

The range of funding needed to capitalize and fund the establishment of a new qualified plan is highly dependent on the state or geographic region, state regulatory environment, enrollment projections and mix of membership.

An Applicant's ability to raise these funds privately depends on whether there are any foundations whose mission it is to assist with these plans. An Applicant's ability to raise funds privately may be improved if there is an organized group of small employers in the area who would benefit from the addition of a new competitor in the market and are capable of making donations to support its start up. As a practical matter, these funds tend to be available from larger employers who would not benefit and might be injured from the entry of these additional competitors in the individual and small group marketplace.

Many states offer tax credit programs, awarding tax credits to projects that meet state objectives. The recipient of the award is required to sell these tax credits and the buyer, in exchange for buying some of the Applicant's tax credits is allowed to deduct a percentage (in New Hampshire 75% from state tax obligations). If states were willing and able to offer tax credits to assist Applicants to raise start-up funds, this could significantly increase the willingness of small employers to contribute to them.

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

The investment in competent management, systems, internal controls, and appropriate use of external actuarial consultants are the factors driving the achievement of the objectives of appropriate fiduciary management and oversight.

**11. Are you aware of any State laws that could create opportunities for or barriers to the formation of qualified non-profit issuers? Do you think States are likely to create or amend licensure laws to accommodate the formation of qualified non-profit issuers? Under what circumstances could regional qualified non-profit issuers serving multiple states be formed? Is there a role for a federation of qualified non-profit issuers to serve more than one state or**

**region, with risk shared among the issuers? Would this approach be desirable for specific types of communities (for example, agricultural/rural communities)? How would such a federation be organized? How would it be capitalized? What are the advantages and disadvantages of a regional qualified non-profit issuer or a regional federation of issuers? What barriers would need to be overcome? What would be the advantages of, and barriers to, serving a metropolitan area that crosses State lines?**

State capital requirements can serve as a barrier to entry to start-up CO-Ops. For example, New Hampshire requires health maintenance organizations to maintain six million dollars ($6,000,000) in reserves. This can serve as a barrier to entry for start-up Health Plans and the low potential return on the investment relative to other states can deter experienced managed care companies from operating in New Hampshire.

During the debate leading up to the passing of the Affordable Care Act, an issue that seemed to garner support from both Democrats and Republicans was allowing health insurers to cross state lines to offer policies to residents of various states. As health insurance is currently regulated and licensed on the state level, competition across state lines among insurers is inherently hampered. Furthermore, consumers are limited to only the policies and associated premiums available within their own state.

By allowing insurers to offer policies across state lines, consumers would benefit from a much larger pool of potential insurers from which to select their health insurance policy. Regionalization could occur on a state-level, and a metropolitan level, combining neighboring cities into a single service area. The formation of a federation comprised of regional health insurance issuers would achieve economies of scale through combining certain administrative functions, such as claims administration and information systems. However, other functions could operate in a decentralized fashion, such as Medical Management to assure that member communities receive case and disease management that best serve their populations' needs.

Mutual benefits would be attained by communities – even states – with smaller populations that would be included in a federation of qualified nonprofit issuers' service area. Along with operating costs being shared, risk would also be shared among the federation's issuers. For the areas with smaller populations, savings would be achieved through inclusion in a much larger risk pool resulting in more competitive premium prices.

A regional CO-OP could create economies of scale and achieve efficiencies in administration while "building a brand" (across state lines as necessary) that often matches the natural travel and residential patterns of the region.

**12. While ''substantially all'' of a qualified non-profit issuer's activities must be in the individual and small group markets, in what other markets or product lines, if any, would it be desirable for qualified non-profit issuers to participate? For instance, could they participate in Medicaid or the Children's Health Insurance Program (CHIP) and still satisfy the statutory criteria for being a qualified non-profit issuer? How difficult would it be for a new qualified non-profit issuer to successfully participate in the small group market? How difficult would it be for a new qualified non-profit issuer to successfully participate in the individual market? To what extent would participation in other markets affect the viability of new qualified non-profit issuers or their ability to satisfy the statutory criteria for being a qualified non-profit issuer? What type of start-up costs are necessary and reasonable for establishing a qualifying CO–OP? What startup costs might be associated with establishing a private purchasing council?**

All governmental, small group commercial and individual lines would be excellent opportunities for a CO-OP, as these lines of business historically have local (in the case of small group) or individual decision-making for health plan coverage.

The ability of a CO-OP to be successful in any of the lines of business noted above is highly contingent on being aware of and able to capitalize on the nuances of the local marketplaces in which they would operate. Success in operating in these markets is dependent on appropriate price and ability to generate a culture of excellence in member and employer customer service. This focus on the local marketplace must be coupled with the ability to forecast minimum levels of membership that will allow the qualifying CO-OP to remain viable in the marketplace.

As mentioned above, if a start up CO-OP is required to privately raise some portion of the funds required to become operational, it would benefit greatly from the ability to raise funds from larger employers. These large employers, in turn, will want to be able to buy coverage through the qualified benefit plan. If there is any way in which qualified benefit plans can be allowed to compete in the large group market for a percentage of their business – at least for a finite period, this would enable them to engage large employers (and their contributions) and the addition of large numbers of members would allow CO-OPs to become financially viable more quickly, all other things being equal. One possibility is to allow CO-OPs to compete for large employer groups in markets where the number of competing commercial health plans in the marketplace is below a certain optimal threshold.

**13. Should there be limited time periods for which Federal loans for start-up costs may be available? Are there any start-up costs that would be incurred after the qualified non-profit issuer begins to provide coverage under one or more plans?**

Start-up costs would be incurred primarily before coverage begins. Unless the federal government wants to get into the business of guaranteeing the finances of these qualified benefit plans (not a good idea), loans should be limited to a finite start up period and / or loans granted after start-up to make it possible for an existing CO-OP to expand into an underserved area.

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

A number of factors could impact a CO-OP's durability in a market. Encouraging economic trends such as an increase in new businesses and a decreasing rate of unemployment should equate to steady growth in enrollments. However, the same trends could cause the market to be appealing to other CO-OPs/plans, thus increasing the number of competitors in a service area. The feasibility and market studies should include a thorough analysis of population trends as well (e.g., segments by age, birth rates, relocation tendencies (city / suburb / rural area), etc.).

Other factors affecting CO-OP durability include its ability to achieve favorable contracts with providers and to work effectively with these providers to manage costs over time.

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

Minimum plan enrollment depends on the size of the available market and existing competition in a specific geographical area. Sufficient minimum enrollment opportunity must exist to allow the plan to spread risk and achieve economies of scale after the initial start-up period. Medicare seems to have determined in the context of Accountable Care Organizations that minimum enrollment is 5,000. State insurance departments and or the National Association of Insurance Commissioners would be good resources to answer this question on a state-by-state basis.

Having providers bear risk could result in either upside or downside to the financial condition of the insurance plan, depending on the specifics of the risk arrangement between the plan and the providers. If providers are able to bear the risk, including utilizing prudent levels of stop loss insurance and sufficient population to allow risk sharing (see reference to Medicare's 5,000 minimum enrollment for Accountable Care Organizations above) as well as adequate IT systems

to manage the risk, the CO-OP could be better positioned to predict and manage its costs. However, this tool for predicting and controlling costs is only as reliable as the provider group is. The CO-OP must always be ready to step in if the provider's performance falters.

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

Technical assistance as currently provided through the use of the HHS.GOV website along with the periodic technical assistance call will be effective. The use of webinars for certain topics that may be complex or controversial may also prove helpful. All changes to IT guidance should be communicated in a timely manner either through the use of the web or email. A periodic email or web page made available to participating plans that summarizes those changes or additions to IT guidance would also be helpful.

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

Many urban markets already benefit from heavy Health Plan competition, although not necessarily in the small group and individual markets. No particular geographic area is inherently more or less hospitable to a CO-OP. Those geographic areas which contain a locally based CO-OP or provider sponsored plan might likely have less need of a newly created alternative. With the right supports, as mentioned above, CO-OPs can expand health insurance options in secondary and rural markets.

There are unique challenges to developing a CO-OP in a rural area in addition to the provider network issues mentioned in Section A.4, above. Principal among them is the difficulty enrolling a sufficient population to adequately spread risk. With a small population, fluctuations in disease incidence or cost can quickly jeopardize a health insurer's solvency. We believe this can be alleviated somewhat by the availability of adequate stop loss insurance at lower per member limits and lower aggregate limits than required in urban areas. We believe that an Applicant should show the type and amount of stop loss it will buy as well as an awareness of the cost. We believe that ensuring the availability of reasonably priced, actuarially sound stop loss insurance can promote viable CO-Ops in rural areas.

The lower population in rural areas and consequent lower premium return has also served to deter health plans from investing the funds to meet state capital requirements. In New Hampshire, for example, health maintenance organizations are required to maintain six million dollars in reserves. This has served as a barrier to entry for start-up health plans and the low

potential return on the investment relative to other states has deterred experienced managed care companies from operating in New Hampshire. Other sparsely states are similarly situated.

Another problem that has resulted from the obstacles mentioned above is that many rural areas have lower managed care penetration and therefore less experience working with a tightly managed care. Such a health plan may grow more slowly and new Members may have a greater learning curve. Providers in these same rural areas have less experience working with managed care plans, less experience accepting capitation, etc. In addition, a start-up CO-OP in such a low managed care penetration rural market will have difficulty finding experienced members for their management team locally.

**18. How can qualified non-profit issuers build provider networks? What strategies have proven effective?**

Approached correctly, providers have a natural inclination to promote and sustain competition among health insuring organizations. Further, a local option is often more attractive due to the ability to nurture an innovative relationship between the CO-OP and the provider organization(s). In many markets, we expect providers will be the principal source of private funding to the start up qualified benefit plan although significant cash outlays from providers should not be expected.

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

Those areas having limited competition among insuring organizations are, at the most elementary level, likely to have the most interest in pursuing alternative methods of financing the health care of the local population. That said, those geographic regions who have provider organizations who are more highly integrated than the norm would also be fertile ground for CO-OPs, as these integrated organizations are more likely to have an interest in, and ability to work under innovative arrangements

**B.**

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

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

As has been noted elsewhere, the ability of a provider organization to shoulder risk in any form is a significant advantage over more loosely formulated fee for service arrangements. These arrangements by definition, place the provider network and the CO-OP out of alignment with one another. Thus, the ability of a CO-OP to contract with an integrated organization is a significant benefit over other, more loosely organized fee for service arrangements.

When measuring levels of integration, organizations with the following should be given priority:

- Have a significant percentage of primary care practitioners organized as medical homes;
- Are currently using protocols that allow the provider to manage a patient throughout an episode of care; and
- Have an interoperable shared electronic medical record;

**2. How should ‘‘significant private support’’ be defined in this context?**

It should be equal to the total cost of starting up a qualified benefit plan minus initial government grants and loans. This level of private support will be significant.

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

Please refer to answers provided elsewhere in this document. Donors should not be entitled to any special consideration in the form of below-market premiums, expanded benefits, undue influence over the qualified benefit plan (perhaps a limit on the number of board seats that can be occupied by individuals affiliated with any employer or group industry of profession), etc.

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

**2. How might the Secretary encourage the establishment of a CO–OP in a state without a qualified non-profit issuer?**

Generally, allowing a viable CO-OP from a neighboring state the first opportunity to expand its operations would be attractive. Each state could be set up as a separate organization, using any opportunity for efficiencies that may exist.

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

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

The restriction should be implemented in accordance with established rules of accounting regarding segmentation of funds and in accordance with Policies and Procedures of the CO-OP regarding the restriction.

**2. What other sources of financing for marketing would be available to CO-OPs?**

In the Start-up phase and Year 1, the following types of marketing funding should be pursued.

- Enrollment for individuals and small group plans to be managed by agents/brokers of current health insurance products, such as MA and MA supplements, LTC, small group and individual. Sales costs will be borne by brokers, with commissions paid from premiums and/or membership dues. Field marketing associations may also participate.
- Advertising to be funded by yearly participation dues from Physicians, Medical groups, Hospitals, Skilled Nursing Facilities, Durable Medical Equipment Providers, etc. Additional source of advertising funding would be sponsorships of events and printed materials such as bill stuffers, member newsletters, etc. to be paid by local businesses. This may include donation of services such as printing. An additional source may be advertising start-up loans from a business coalition, participating providers or investors.
- A CO-OP Foundation with mission to promote preventive health (such as immunizations, preventive medicine, health assessments, stop smoking, diabetes management, etc.) should be formed. The Foundation will provide market positioning and image building for the CO-OP. While this approach does not provide cash to the CO-OP, it creates the "halo" effect that is very beneficial in support of marketing funds.

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

The CO-OP can segment funds in its accounting system, with different entry codes for loan and grant funds and marketing funds. Programming can prevent posting to the wrong account. The executive team should review periodic reporting on the segmented funds, with ongoing reviews by the CO-OP Board of Directors. In addition, external auditors should review yearly.

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

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

Obviously it would be good for competition if each state had its competing qualified benefit plans up and running by January 1, 2014. However, the providers, employers, members and government lenders are all better served if the emphasis is on creating viable qualified benefit plans that will survive for the long term.

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

The stated goal of having one CO-OP in each state should not take precedence over creating viable qualified benefit plans that will survive for the long term. The extent of existing competition in a state, perhaps even the extent of existing competition from not-for-profit insurers could be one factor among many in determining which Applicants are eligible for funding.

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

We believe a fixed period is generally not preferable, as the path to viability in any given market could vary significantly. However, grants monies should require a minimum availability of three years of operation. After this, the Applicant could re-justify the request through an updated business plan.

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

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

As the intent of the program is to create qualified CO-OPs, rather than to realize a return on the government's loaned funds, then the state's legitimate reserve requirements must take precedence over repayment. Please note that most states must be notified and provide approval before any funds can be removed from a health plan licensed in the state. State overseers could ensure that, so long as minimum reserves were maintained, the repayment of government funds would be the next authorized withdrawal of funds from a CO-OP. State reserve requirements may prohibit the repayment of any principal on interest on certain debt if such repayment would result in an organization falling below statutory minimums

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

Generating sufficient premium revenues will depend on enrollment size, management of medical costs, and management of administrative costs. Enrollment must be large enough to cover fixed costs. Such premium revenue is not likely until at least year three.

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

Quarterly financial statistics, including enrollment, premium revenue, benefit costs, fixed and variable administration costs, net profit/loss.

**G. Section 1322(c)(2) of the Affordable Care Act**

**1. What should and should not constitute a ''related entity'' or ''predecessor'' of a health insurance issuer for purposes of Section 1322 of the Affordable Care Act?**

State insurance holding company laws typically describe what is considered a related entity for purposes of state regulation. These definitions may be useful.

**H. Section 1322(c)(3) of the Affordable Care Act**

**1. How can prospective applicants demonstrate a commitment to operating with a strong consumer focus, including responsiveness and accountability to members? How can prospective applicants demonstrate a commitment to responsiveness and accountability to members from diverse populations?**

CO-OP Applicants could be required to demonstrate commitment to a strong consumer focus in either of 2 ways:

- By dictating the steps the Applicants must follow to achieve a strong consumer focus (See our answer elsewhere in this document.) Applicants willing to commit to these measures and to demonstrate continued compliance with them over time should be considered to have demonstrated the requisite commitment to a strong consumer focus.
- By establishing the effects that a CO-OP should achieve if it has sufficient consumer involvement, and requiring Applicants to be able to show these effects over time.

Here are several key factors of a successful commitment to operating with a strong member focus:

**The Application and Enrollment Process**

Once a prospective member decides to join the CO-OP, the enrollment process needs to be user-friendly and efficient. The CO-OP should notify the member of receipt of the enrollment election and confirmation of enrollment acceptance in a very clear and timely manner. The written acknowledgement notice and confirmation of enrollment acceptance sent in response to the member's enrollment election specifies the correct effective date of enrollment and offers assistance via a toll-free number if there are questions.

**The Disenrollment Process**

If a member verbally requests a cancellation of an enrollment request, the CO-OP should document the request and process the cancellation quickly and provide written notification to the member to acknowledge a request to cancel enrollment. The CO-OP should also use a non-threatening way to follow up the notice of disenrollment with a member survey asking for the specifics of that former member's experience with the plan and recommendations for improvement.

**The Network**

The CO-OP must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services. Without this focus, consumers will not enroll or stay enrolled. The CO-OP must ensure that the hours of operation of its providers are convenient to and do not discriminate against members. When medically

necessary, services need to be available 24 hours a day, 7 days a week. The CO-OP provides or arranges for necessary specialty care.

Additionally, the CO-OP will ensure continuity of care and integration of services through arrangements with community and social service programs generally available through contracting or non-contracting providers. The CO-OP will ensure continuity and coordination of care through procedures for timely communication of clinical information among contracted network providers, with the member, and with his/her designees (if applicable).

A formal mechanism should be established to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's medical policy, quality improvement programs, and medical management procedures. The organization's written contracts with first tier and downstream entities will specify that providers agree to comply with the Plan's policies and procedures.

Written contracts with first tier and downstream entities will contain the provisions that contracting providers agree to safeguard member privacy and confidentiality, consistent with all Federal and State laws, and ensure accuracy of member medical, health, and enrollment information and records. They will also contain a provision that members are held harmless for payment of fees that are the legal obligation of the organization.

The CO-OP should make a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PCP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.

**Medical Benefit**

At the time of enrollment and annually thereafter, the CO-OP should disclose to each member, in a clear, accurate, and consistent form, all necessary plan information. If rules are changed, notice will be provided to all members at least 30 days before the intended effective date of the change.

The CO-OP will have an ongoing quality improvement (QI) program that is formally evaluated at least annually. It corrects significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

**Prescription Drug Benefit**

The CO-OP should offer a pharmacy benefit, and operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers, attempting to assist members in obtaining needed prescription drugs and supplies. Formulary information should be supplied in a clear, accurate, and standardized form at the time of enrollment and at least annually thereafter. This information should be provided in writing, if requested

Prior to removing a covered Prescription drug from its formulary, or making any change in the preferred or tiered cost-sharing status of a covered Prescription drug, the CO-OP should provide at least 60 days notice.

In addition, prior to making any negative changes to utilization management or to the preferred or tiered cost-sharing status of a covered Prescription drug a written notice should be provided to affected members at least 60 days prior to the date the change becomes effective.

An Internet website should include a current formulary for the Prescription plan that is updated at least monthly to providing current and prospective Prescription members with at least 60 days notice regarding the removal or negative change to utilization management or the preferred or tiered cost-sharing status of a drug on the formulary.

Finally, the CO-OP should have internal medication error identification and reduction measures and systems that address ways to reduce medication errors and adverse drug interactions, and improve medication use.

**1. How can prospective applicants demonstrate a commitment to responsiveness and accountability to members from diverse populations?**

The CO-OP will need to create policies and procedures regarding engaging in any discriminatory marketing practice, such as targeted marketing to members from higher income areas, without making comparable efforts to enroll members from lower income areas. The CO-OP should not deny or discourage enrollment on the basis of health status. A toll-free member call center that provides member telephone service, which includes TTY capability should be instituted. For markets with a significant non-English speaking population, the CO-OP should provide materials in the language of these individuals.

The CO-OP should establish written standards for provider consideration of member input into the proposed treatment plan and for advance directives. Health care services should be consistent with the benefits covered in the member’s policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

**2. What type(s) of governance structure(s) should be required? What criteria should be used in determining who is eligible to be members of the organization and of the governing body? What type of characteristics should the governing body have to ensure consumer representation and involvement? What are the options for consumer governance, beyond electing the board of directors, that would most promote ongoing consumer engagement and responsiveness of the qualified non-profit issuer to consumer needs?**

- We suggest that the Board Composition is as follows: Board of Trustees (10-15 total members) elected by their consumer peers or selected from the membership according to strict criteria. The members should be chosen from a pool of members with substantial knowledge of health care. Insurance brokers/agents should not be on the Board. The CEO of CO-OP should be a member of the Board, either voting or as a non-voting member. 2-3 provider representatives for clinical integration and care improvement input.
- Transparency of Board Actions is critical for member buy-in.
- Consumer decision-making participation, including Policies and Procedures, as practical.

A Chief Executive Officer should manage the organization, in addition to the board of directors, supported by an Executive Staff formed of the heads of the various functional departments, a compliance officer, and other positions as necessary to ensure responsiveness to members. The Executive Staff should meet weekly. Also, there should be various committees to oversee key areas of operations. These include a member advisory committee, quality improvement committee, utilization management committee, compliance committee, a pharmacy and therapeutics committee, appeals and grievances committee, and a credentialing committee.

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

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

Board reporting and Board sub-committees would need to be structured to require regular reporting and oversight of financial results and use of excess premium revenues.

It would be difficult to use excess from the current year to lower premiums paid by or on behalf of members in subsequent years because renewals are completed throughout the year and well in advance of financial results for the current year.

Additional benefits are generally preferable to refunds due to the likely complexity of the basis for, and the calculation and administration of such refunds.

As an example, would refunds be given based on plan-specific data or would there need to be a CO-OP-wide excess of premium revenues over expense to declare any refunds? If overall,

would all members receive refunds, or only those in specific plans with reported excess of premium revenues over expenses?

**J. Section 1322(c)(5) of the Affordable Care Act**

**1. Do any States permit newly-formed issuers (or plans) to meet these requirements incrementally over a period of time after enrollment and provision of health insurance coverage?**

We know of no states that allow health plans to meet licensure requirements gradually over time. The states in which we have worked have also required financial projections to calculate the amount of risk based capital (RBC) the health plan will need over the initial operating period (5 years) and to have a commitment in place to obtain that capital as needed.

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

**1. The establishment of definitions, and list of items restricted, for the terms propaganda and marketing as set forth in Section 1322(b)(C)(ii) of the Affordable Care Act Section 1322(b)(C)(ii).**

For example, member materials explaining the benefits of the CO-OP should be exempted from this restriction. Consumer information explaining CO-OPs should not be considered propaganda. Call centers that enroll members should not be considered marketing

This undefined restriction creates these types of questions: Can salaries of staff members who oversee marketing be included in salaries funded through federal grants and loans? Websites are considered marketing, yet are requirements for federally funded programs. How do they fit into this description?