CO-OP Health Plans: Can They Help Fix Rural America's Health Insurance Markets?

Moderator: Carrie Au-Yeung
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Caroline Au-Yeung: Hello and thank you for attending today's SHARE webinar titled CO-OP Health Plans, Can They Help Fix Rural America's Health Insurance Markets? My name is (Carrie) Au-Yeung and I'm a research fellow with the SHARE program. I'll be moderating today's event.

Before we begin I'd like to cover a few technical details. Broadcast audio is available for today's webinar, however if you prefer you can listen today via telephone as well by dialing 888-224-7646. And all phones will be in listen-only mode for the duration of the call.

Questions for our speakers can be submitted throughout the webinar via the chat feature on the left-hand side of the viewing screen. These questions will be relayed to the speakers during the Q and A session following the presentation portion of the event.

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Finally if you're able to log in to ReadyTalk but are still having technical problems, you can ask for help using the chat feature. And with that I'll move on to the substance of today's event.

The Affordable Care Act or ACA allows for the creation of non-profit health insurance plans in the individual and small group market and provides funding to facilitate the planning and execution of such plans.

Given the current limitations of the rural private health insurance market, there is hope that the CO-OP program might provide an opportunity to expand access to affordable coverage in rural areas.

However, the CO-OP program has been flying under the radar a bit and today we hope to inform and promote the discussion of CO-OP plans and their potential under the Affordable Care Act.

Today we will hear from two speakers who are thinking about the issues surrounding CO-OP health plans from slightly different perspectives.

Dr. Andy Coburn from the Muskie School of Public Service at the University of Southern Maine will discuss the consumer operated and oriented plan CO-OP authorized under the Affordable Care Act.

Dr. Coburn will discuss the CO-OP program legislation, identify the challenges to obtaining private health insurance in rural areas and assess the opportunities and challenges of using the CO-OP program to address the limitations of the rural private health insurance market.

After Andy we will hear from Bill Oemichen, President and CEO of the Cooperative Network, an association of more than 600 member cooperative owned by more than 6.3 million Wisconsin and Minnesota residents.

Bill will provide an on-the-ground perspective on CO-OP health plans, discussing the current status of cooperatives across the country, as well as the

prospects for applications for CO-OP planning loans available under the ACA.

As a member of the advisory committee that helped HHS develop the ACA's CO-OP regulations, Bill offers a unique and well-informed perspective. Now I'd like to introduce the Director of the SHARE program Lynn Blewett who will say a few words.

Lynn Blewett: Thank you, (Carrie). Welcome everybody to the SHARE webinar. The SHARE program is the State Health Access Reform Evaluation program. It's a national program office of the Robert Wood Johnson Foundation.

It's located at the State Health Access Data System Center at the University of Minnesota School of Public Health. We're part of a Robert Wood Johnson Foundation Coverage Team.

It's a group of national programs that work to conduct research and analysis on factors that affect the availability of affordable, stable health insurance coverage.

SHARE supports research on health reform issues with the focus on state implementation of Affordable Care Act. We'd like to thank the Robert Wood Johnson Foundation for supporting the SHARE program and making this webinar series possible.

This is an exciting time to be doing health reform research and we're looking forward to the presentations today. Thank you and thank you for participating.

Caroline Au-Yeung: Thanks, Lynn. I'd also like to take a moment to thank our co-host for today's event, the Rural Assistance Center. The Rural Assistance Center, or

RAC, is a collaboration of the University of North Dakota Center for Rural Health and the Rural Policy Research Institute.

RAC is funded through HRSA's Office of Rural Health Policy to serve as a rural health and human services information portal, through its online library at www.raconline.org and call center.

RAC helps rural communities access the full range of available programs funding and research that can enable them to provide quality health and human services.

RAC has played a particularly critical role in promoting today's event to a wide range of rural state (cooler) and we very much appreciate the opportunity to partner with them.

And now I'd like to move on to our first speaker, Dr. Andy Coburn. Dr. Coburn is Director of Population Health and Health Policy and chairs a graduate program in health policy and management in the Muskie School of Public Service at University of Southern Maine.

His research and publications have focused on issues relating to health access and insurance, healthcare financing and rural health.

Dr. Coburn is the founding director of the Maine Rural Health Research Center, one of six national centers funded by the Federal Office of Rural Health Policy and he recently served on the Institute of Medicine's Committee on the Future of Rural Healthcare.

And now I'll hand the call over to Andy for the first portion of today's event.

Dr. Andy Coburn: Thanks very much, (Carrie). I really appreciate the opportunity to discuss the cooperative - the CO-OP provisions in the ACA and how they might apply to the problems in the rural health insurance market and the health system.

I do want to acknowledge before I begin the support that we received from the SHARE program at University of Minnesota which is a national program of the Robert Wood Johnson Foundation.

And I also want to acknowledge my collaborators and colleagues on this policy brief which we did, Jean Talbot, Erika Ziller and Zach Gage-Croll. And as I said earlier there is a policy brief which is available on the SHARE Web site if you're interested in more information.

So with that let me just share with you what I hope to cover today. I think we have a really nice combination of Bill's presentation that gives a lot of on-the-ground information about where the CO-OP program stands.

But what I'm going to be doing is providing a bit of an overview and setup for that by discussing the CO-OP program as it is designed in legislation, and with the rules and RFP now being out on the streets.

Talk a little bit about the background and how the CO-OP program fits with real health insurance markets and opportunities and challenges that I see in building sustainable rural CO-OPs.

And some of the issues that we see and have talked about in our policy brief about balancing the need for viability and sustainability of these CO-OPs with some of the concerns that exist in the rural health system.

So let me just talk about the origins of the CO-OP program. As many of you may know, the CO-OP program emerged from the public debate over the public option in the course of the discussion over the health reform bill.

And Senator Conrad from North Dakota proposed the idea of a CO-OP as an alternative to the public option with the idea of creating a non-governmental alternative in the insurance market that could help increase competition of that market, especially in the individual and small group markets.

The idea is to foster the development of qualified non-profit insurance plans in those markets with an emphasis on integrated care and plan accountability. I think part of the interest in the CO-OP plan originally was to create better insurance value through integrated care and hopefully with greater price competition in that market.

The idea was in the legislation to have at least one CO-OP plan per state. The program's funding has been reduced, but it's at $3.8 billion to provide federal loans to help capitalize these CO-OP plans, both for start-up costs and to meet insurance solvency requirements.

And the - (Carrie) mentioned that Bill has served on the Advisory Board that advised HHS in the development of the regulations and rules around this program.

Those were issued in April and regulations came out in July and the first request for applications for loan funds has now been issued, and applications actually were due on the 17th.

Bill can provide a lot more detail on the interest that has been shown in the program. I think there was some sense that this might not be a particularly

viable alternative, but interestingly I think there is perhaps more interest than we previously thought.

So what is a CO-OP plan? The governance structure is that these plans are to be non-profit member corporations with governance subject to majority vote of members.

It's important to note that this is a little bit different than the governance structure from many CO-OPs out there which actually are ownership arrangements between members and the CO-OP.

This governance structure for CO-OPs, health CO-OP, health insurance CO-OPs really doesn't require membership, the membership ownership of the CO-OP.

CO-OPs offer at least one qualified health plan at the silver and gold level in every exchange that serves the geographic area in which it is licensed. The aim here really is to insurance that there are greater plan choices, larger - more plan choices available in rural markets and all the markets in which they are offered.

I'm thinking in terms of rural markets, of course. And that they encourage the CO-OP plans to sell inside of the exchanges as well as - choice they make - they may make a choice to sell outside the exchange as well. The law focuses on the CO-OP selling in the individual and small group market.

And many have thought that this was a bit of a restriction because these plans need to get up-to-scale, and so there has been a question about how much flexibility there would be in the ability of CO-OP plans to sell outside of the individual and small group market.

And there's a little bit of wiggle-room in the regulations that allows for that by saying that essentially two-thirds of the contracts must be in the individual, small group market, which as I'll say - as I'll explain later, might be important to the start-up feasibility of these plans.

So other features of the CO-OP plans include a loan priority of - for CO-OPs that offer plans on a statewide basis, use integrated care models and have substantial private support.

The idea of CO-OPs, of course, is that the assets and profits of the CO-OP can be inured to essentially the members and be used to lower premiums, improve benefits, or implement programs to improve quality.

It turns out in the regulations that adding to reserves to meet re-solvency requirements is interpreted to be in the interest of CO-OP members which will obviously be important to the start-up of these health plans.

There are explicit restrictions on the ability of current insurance issuers and governmental entities from offering CO-OP plans for purposes of keeping the current insurance market separate from these new CO-OP plans that are hopefully going to be developing.

And CO-OP plans can contract for administrative services recognizing that start-up health plans are after all, complicated business entities and that we will have problems in some cases obtaining the resources necessary - the expertise and resources necessary to build the infrastructure.

We have actually considerable experience in rural communities in the 1990s with the development of insurance plans, managed care plans in small rural

areas which didn't go so well, in part because the infrastructure was a problem.

The CO-OPs will be able to contract with entities that provide third-party services, including actuarial services, finance claims, administration, HR services and so forth that will really be necessary for the administration of the plan.

So in order to understand the fit that the CO-OP program might have for rural insurance markets, it's helpful I think to review some of the basic facts about these markets.

And that is, that rural areas are really at a disadvantage in accessing private insurance based on much of the work that we have done and others have done in studying those markets.

Employer-based insurance is less common in rural areas. We have a preponderance of small firms, self-employed, part-time and seasonal employment in rural areas.

And therefore, the focus of the CO-OP program on the individual and small group market is entirely consistent with the predominant private employer market that we see in rural areas. So that's on the upside in terms of opportunities for addressing the needs in rural communities.

On the other hand, we also know that the employment market is - private market is characterized by lower wages and incomes which could significantly make more difficult the start-up of these CO-OPs to the extent that we know that take-up rates in the small group market are always a challenge and the

economic capacity of small employers in rural communities and their employees, is going to be problematic.

So without the subsidies that are available through exchanges, there's going to be a challenge in terms of small group take-up in rural communities, in our view.

The other reality that we face in rural markets, and actually in all insurance markets based on the most recent work by the Kaiser Family Foundation, is that we have a very high concentration in insurance markets in many states, meaning that there are relatively few insurance plans that are servicing those markets.

And in the individual market, the Kaiser report noted that the median is about 54% market share in the individual market in more than - in the majority of states in the country and a similar pattern in the small group market.

So the lack of competition really in the market already, could break - could be helpful to the CO-OPs potentially, to the extent that they offer more competition.

But it also might mean that they are - these existing plans are really the dominant players and have well-established networks and provide a discount arrangements and so forth, that are going to be very difficult for CO-OP plans to break into those new markets.

So, how might CO-OP plans help in rural communities? And here, what we're really looking at is this strong history of cooperatives, local and regional cooperatives in rural areas of this country, largely in their cultural and other sectors not in the health sector.

And there's a strong sense I think among many, that the CO-OP plans might offer rural consumers expanded coverage options, improve affordability of those options and enhance quality of care in a substantive role in plan governance.

The need in rural communities is for better insurance value because on average rural purchasers of insurance tend to get less for the dollar that they spend in insurance than those who live in urban communities, based on research on that issue.

And the greater control that they would get through shared governance models in the CO-OP plan could very well benefit rural communities and health systems. CO-OP plans might be a vehicle for strengthening local and rural health systems.

This is a speculation and a hypothesis as to whether or not CO-OP plans could bring greater attention to the balance of interest between purchasers and providers to the extent that the health plans as a collaboration of provider organizations, could potentially deal with workforce and other issues in the health system more productively than truly competitive systems.

The challenges of building and sustaining rural CO-OPs are many. After all, these are complicated insurance arrangements. The financial and administrative capacity is certainly among those.

That includes the capitalization and solvency requirements which typically states require that plans have 10% of premiums as a solvency, as a reserve capacity to cover premiums. Of course the loan program is designed to provide early capitalization of those solvency reserves that will be needed.

Access to insurance expertise, actuarial being among those, but not exclusively. Marketing and so forth are obviously very big needs that these plans will have as they begin to develop their insurance products, their markets, and so forth.

The administrative services that they will need include marketing and enrollment, network development, contracting, claims payment. These are all important capacities that may or may not exist in rural markets.

The good thing which Bill can talk about is that we are seeing signs among the administrative services market providers that there is interest in servicing the development of these entities, which could be a good sign.

The challenge of building, sustaining rural CO-OPs really also is about enrolling and achieving financial stability through the establishment of a critical mass of enrollees.

There was mention in the lead up to the legislation that there might - envision - the policy makers envisioned about 25,000 people as necessary for purposes of, if you will, seeding the development of a CO-OP plan.

That's probably too low, based on the managed care experience that we - the managed care health plan experience that we've had in the past. And the question really is how do these CO-OP plans get to scale, given the limitation that they will have in terms of being able to get into the market.

And also, because of a provision that is in the regulations and in the law which prohibits their use of loan dollars for marketing. These are going to be difficult challenges for them to meet.

There are also competitive advantages that existing plans have based on existing provider discounts that are going to have to be addressed by plans as they build their provider networks.

It may be that if a plan - a CO-OP plan has rural roots as we might say, they might have a better chance of breaking into provider networks and obtaining discounts in return for this kind of support that the plan might be able to give to the rural healthcare provider community.

Governance, board experience, you know, recruiting a board with the experience and expertise in the areas of insurance is obviously hard to come by in rural states and rural communities.

So on the one hand, you know, that may mean that rural providers and rural community members just are not going to be able to have the capacity to develop an insurance plan.

And finally, network adequacy is certainly a major challenge. Primary care, workforce challenges in rural communities, how to deal with safety net providers such as FQHCs and any CO-OP plan that develops.

There're roughly two scenarios that I see here potentially. One is that CO-OP plans just might not seek to serve rural areas if they're urban-based for example, because they don't want to deal with the whole issue of network adequacy.

On the other hand, as I said earlier, there may be some interest especially if a plan does have an orientation - existing orientation toward rural communities

to want to work collaboratively with the health systems in rural communities to help build and support that rural health system.

So we think that there are some trade-offs here that might be met by having either rural or urban-based CO-OP plans developed.

Scale and sustainability are certainly likely to require that urban-based plans that serve rural areas develop more of an intention to the urban population, particularly at the outset, in order to get the kind of critical mass of an enrollment that they're going to be looking for.

So that could potentially mean that whatever rural engagement and control - control's probably too strong a word, engagement and involvement in governance might be diminished.

Premium affordability may require that value-based insurance designs be employed, such as tiered provider networks. That could be problematic for rural providers. We know very little about how they might - how these CO-OP plans might actually design the benefits that might be offered in the market.

And there's certainly no assumption here that tiering benefit providers would necessarily exclude rural providers, hospitals and physicians, just that it could. And it's something to pay attention to as these plans develop and unfold.

And finally, in conclusion, we think that there are, you know, some interesting, important opportunities for building, you know, rural cooperatives and health systems.

There are FQHC networks around the country that I know have discussed the possibility of developing a CO-OP plan. We have regional health systems that

are serving rural states that might serve as a basis for the development of such plans.

And we also have, at least in our state, some health reform entities that might be able to transition to become a CO-OP health plan for the state.

In all instances however, the governance issue could be potentially tricky to the extent that organizations such as a health system, or an FQHC network might want more control than the governance requirements in the CO-OP plan stipulate.

The CO-OP plans are going to need to be aggressive in pricing and cost management certainly, in order to be able to compete on a price basis with existing insurers and be successful in the marketplace. And there are reasons to believe that they could do so, given the fact that they don't have to generate a profit for shareholders and so forth.

But there's also a very small needle that they will have to thread in order to do so with respect to being - they have to be concerned, for example, about adverse risk selection and the population. If they price themselves inappropriately or too low, they're also not going to be able to sustain their cost and be successful.

And finally, the need to build a high-value provider network is certainly the essence of the ability of these plans to be successful to the extent that that's essentially what purchasers and employers are looking for.

And I think that will be a bit of a - I don't want to say challenge, it certainly won't be a challenge, but it's an opportunity for the provider community in

rural areas to work with emerging CO-OP plans to build that kind of high-value insurance product that rural communities need.

With that I'll turn the presentation over to Bill and he can flush this out with a little bit more on the ground, what's happening now.

Caroline Au-Yeung: Hi...

Dr. Andy Coburn: Thank you very much.

Caroline Au-Yeung: Sorry, this is (Carrie). If I can just interject for a minute, I just wanted to let people know - or remind people that they can submit questions at anytime using the chat function today.

We'll be doing a Q and A session after the presentations and we'll relay those chat questions to the speakers. And also if it's okay, I want to do a brief introduction of Bill before he talks.

Bill Oemichen is President and CEO of the Cooperative Network, a Minnesota and Wisconsin association of more than 600 cooperative businesses.

He also serves on the U.S. Department of Health and Human Services Consumer Oriented and Operated Planned Advisory Board, for which he chairs the Governance Committee. Before taking on his current role at the Cooperative Network, Mr. Oemichen held a number of positions in the area of rural health and human services.

Among others, his former titles includes Senior Vice President of the Wisconsin Federation of Cooperatives, the Minnesota Association of

Cooperatives, Administrator of the Wisconsin Trade - a division of Trade and Consumer Protection and Deputy Commissioner at the Minnesota Department of Agriculture.

And now I'll hand the call over to Bill. Sorry for the interruption.

Bill Oemichen: Okay, thank you (Carrie). Good afternoon to everyone on the East Coast and good morning to everyone else who's on the call. I greatly appreciate your participation in talking about what the possibility is for this federal CO-OP plan can mean for rural America.

And I'll go ahead and get started. And I'm going to be looking at a number of different things in the short time that I have with you. I'm not going to be able to cover everything probably to the degree that folks would like.

And I would just point out that you'll be receiving the slides after the presentation today. And we also have information available on our Web site at www.cooperativenetwork, that's one word, .coop C-O-O-P, and so there is more information available there.

So right now we really have a unique opportunity to develop new healthcare CO-OPs in rural America. And when I use the term CO-OP, I'm using the federal definition of CO-OP, which is basically the new types of entities that are created under this federal program.

For those of you who are familiar with cooperative businesses that exist somewhat principally in rural areas, but certainly in many urban areas of our country, those can be, and we'll talk a little bit about the differences here in a few minutes, those can be a little bit different because they're structured under state law.

What we're talking about today are these new entities that are really structured under federal law. So we have this unique opportunity. We have $3.8 billion that's available.

There is no discrimination, unlike other federal statutes between urban and rural areas, so this money is fully available to fund new projects in rural America as well as urban America.

And the background of my Association is we helped create a number of healthcare CO-OPs over history and some 30 years ago and 40 years ago, and some within the past 4 to 5 years.

So this has been certainly an area of concentration for us, particularly with our activities being focused in rural America. And as Andy already mentioned, there is an ability to partner with other cooperatives.

That's both existing cooperative businesses as well as other new federal healthcare CO-OPs that are getting underway to achieve efficiencies and economies of scale. And I don't mean those just as buzz-words.

But there are provisions in the federal CO-OP statute that allow for what we call federated purchasing groups that will help get you the expertise that you need so you don't have to dream it up all locally, that there is some assistance available at a more regional or national scale.

Moving on to the next slide. Why are we looking at CO-OP plans? And this is real briefly - because this is a unique opportunity to combine the interest of the consumer, the healthcare insurer and the healthcare practitioner together in one entity.

And I was privileged to testify several times in front of committees of the U.S. Congress and that was a question I frequently got asked is, "How can we combine all of these interests together?" And a healthcare cooperative is one way to do that.

And we believe that CO-OPs help create competition because CO-OPs, in our country's history, have generally stepped forward to fulfill a need that wasn't necessarily being met by other providers.

And we're in somewhat of a unique position because we already have healthcare cooperatives that are successful, that are already in business in Minnesota, Wisconsin, Washington State, and so we have some models to look at.

And these CO-OPs serve significant parts of rural America. And so it's not something that we're just necessarily creating from scratch, but we have some examples to look to.

Now I'd already briefly mentioned this, but the legal authority, and I'm an attorney, and I try not to get too bogged down in legality, but I think it's really important for all the participants on today's call to understand once again that we're talking about a new beast, if I can use that term, created under federal law that may or may not be a CO-OP under state law.

If you're going to form one of these new entities you have to be incorporated at the state level, but you've got several options. One, you could form under a non-profit statute.

And in many states that could be really your only option to form one of these new non-profit federal CO-OPs or some states like Wisconsin and Colorado, Minnesota have statutory authority to create non-profit healthcare cooperatives that separate, in some cases, from the insurance statues of that state.

And at least in my survey which is not exhaustive, but Wisconsin has I think by far the most comprehensive set of statues for healthcare cooperative. And that may be because that group health cooperative, Claire Group Cooperative South Central Wisconsin, which is based in Madison, formed a number of decades ago.

And so that legislation was put in place a long time ago and in the case of Wisconsin the legislature just modernized that statute just the past year. And one of the things I want to point out is, from a lawyer's perspective, you don't necessarily have to form your entity under your own state's laws, incorporation laws.

You can potentially chose another state's incorporation statute, but you have to be careful that that entity will be recognized by your state, excuse me, insurance statues and that you won't face any barriers.

And again, we don't have a lot of time to go through all these various things today, but I just want to at least leave that thought in your mind when you're talking to your attorneys, if you're looking at CO-OP formation, is you can potentially look to another state's law to help form your entity, again, as long as your own state insurance statutes where you're domiciled are going to recognize that.

And moving on to the next slide. We have many - and not moving up for me yet, but I'm going to try it again, here we go, and we have many, many CO-OPs in the United States, 47,000 in fact that have been measured by the federal government already serve 120 million out of 300 million Americans.

These aren't for sure all healthcare cooperative, these are CO-OPs of many, many different types. And I think the message is CO-OP businesses are already a significant part of the economy.

And this is one area you can turn to when you're looking at forming a new healthcare CO-OP, is you already have entities out there that are going to understand your model from a very, very early basis.

And just to give you a map, I will move back to a previous slide and hopefully that'll - yes, it's displayed there, and all those dots represent a headquarters of a cooperative, not all the facilities, but the headquarters of the CO-OP.

And I'll try to leave that up there for at least a couple of seconds so you can get a full breath of the country, but no matter where you are in the United States, it's most likely there's already going to be a fairly substantial cooperative business community in your state.

And again, the reason why I point that out is that's a ready-made community to start partnering with if you're looking a forming a rural health cooperative. Moving on to healthcare cooperatives.

We already have in the United States a number of different types, four different types in fact that currently serve 2.4 million lives. And we have one group that we call the staff model HMO and that's very predominant in the

Upper Midwest and we're not totally sure why but it seems to be predominant where Swedish Americans settled initially.

And HealthPartners, which is based in Bloomington, Minnesota in the Minneapolis, St. Paul, metropolitan area, Group Health Cooperative of Puget Sound, in Seattle, Group Health Cooperative of South Central Wisconsin, which I already mentioned in Madison, Wisconsin and Group Health Cooperative of Eau Claire in Wisconsin.

We have purchasing resellers and that's Healthy Lifestyles in Brown County, which is Green Bay, home of the Green Bay Packers, the Farmers Health Cooperative of Wisconsin, where they're banding people together and purchasing healthcare plan.

And actually the Farmers Health Cooperative of Wisconsin is one that we helped a number of CO-OPs form about seven years ago which has been very successful. And we're in the process of getting approval, hopefully from the State of Minnesota for a new healthcare cooperative for farmers in that state.

And then there's the direct purchasing, Alliance Employers Health Cooperative, which provides a network for self-insurance cooperative - or self-insured employers, excuse me.

And then specific products, like WisconsinRx/National Cooperative of Rx which is a drug buying cooperative. Rural Wisconsin Health Cooperative, which is actually a CO-OP of rural hospitals.

And so there's a number of different examples that are out there and some of these folks could potentially, depending on where you are, provide very useful information to help get your CO-OP off the ground.

So just a quick review of some of the CO-OPs to give you an idea of the breath that's already there. The largest by far is HealthPartners HMO. You can see a picture of their office building, corporate headquarters on the south end of the airport Minneapolis, St. Paul, formed back in 1957. They have 11,000 employees.

And I have to point out that HHS, at least from my understanding servicing on the advisory board, is not looking at you trying to create a Health Partners any time in next few years, but this is just meant to give you the idea that this is possible, it has been done by others and become very, very successful type of cooperative.

And HHS I think is really looking at an evolution of proposals. So they're not expecting all this work to have been accomplished right in the first few years, because nobody can do that.

Or at least, very rare person who can get all that work done, setting up a network that is totally within the cooperative and all that and so this really is intended to be an evolutionary process.

So that's HealthPartners. The next one is Group Health Cooperative of Eau Claire and that's - you see it formed in '74. Eighty-five thousand members growing very rapidly.

And I stepped over one and I'm going to that Group Health CO-OP of South Central Wisconsin, actually the CO-OP that I belong to and get my healthcare from. That's one of their clinics located near the state capital, Madison, 65,000 members.

And it will then finally end up with Group Health Cooperative of Puget Sound, founded in 1947. There they're into 501c(3) non-profit under Washington State law, 650,000 members.

I have a couple slides that follow after that, when you get the slide bank, and I'm not going to go through this material in any detail, but all it's intended to show is where healthcare cooperatives already exist.

They are considered the highest quality healthcare provider in those states. So in Minnesota the highest recognized or the highest quality healthcare provider is HealthPartners.

In Wisconsin it's Group Health Cooperative of South Central Wisconsin. In fact GHC of South Central Wisconsin is rated nationally as the seventh highest ranked healthcare plan in the United States, and so pretty significant honor.

Same thing for the Group Health Cooperative of Puget Sound, highest rated plan in Washington State.

Andy's already done a good of reviewing the - some of the HHS requirements and I'll just give you a few of the deadlines and Andy mentioned one of these which has already past, which is October 17.

For those interested in applying or planning and/or solvency loan, there's a series of deadlines for this application through grants.gov. And October 17, as we've mentioned, is the first one.

The next one is December 31 of this year and then they're followed-up by three different dates in 2012. And applicants can seek up to 100,000 initially

for planning loans, which is to help do the actuarial work at the plan design, do the legal work.

So that funding is available for that. And those are short term loans. There's a longer term loan up to - or 15-year loan for capitalization. And what's anticipated is a number of applicants who will apply first for the planning grant - planning loan, excuse me.

The statute uses the term grant, but they're not grants in the way that we think of them because you do have to pay them back, but I apologize if I accidentally use that term, because it is in the statute.

But, so number of applicants who will apply for that first planning loan and then we'll come back in and seek a capitalization loan. We expect about 15 to 20 applications from around the country at this point.

I know of at least 12 or so that were in the first group that were filed on or before October 17. HHS was expecting another five or more before December 31 and then expecting some additional ones to come in 2012.

But the stated goal within Section 1332 of the Affordable Care Act is for at least one application in each state. So no matter where you are the intention is to try to get some money out to each of the states.

And also the statute talked - talks in terms of statewide proposal and as the advisory board we said that priority should be given to a strong regional proposal within that state or within a grouping of states, over a weaker statewide proposal.

And that was the recommendation that HHS supports. So don't feel like you have to have a statewide network right from the start. If you can be a game changer, and one of the terms that we used at the advisory board, within your more regionalized area within your state, that that's going to be given very strong consideration by the HHS grant reviewers.

Moving on to the next slide. As I've already mentioned, don't feel like you have to do all the work of having the provider network and the front and back office activities all within your CO-OP from the start.

The grant process anticipates - or the loan process, once again, excuse me for that, anticipates that you'll - that you may be in the position of having to contract out.

Now there's some groups, one of the groups, Northern Community Health Cooperative in Duluth, Minnesota, which is looking to serve Minnesota statewide and Northwestern Wisconsin, they already have expertise in this area.

And so they have an advantage that they're going to be able to do some of this work upfront because they already have staff that are skilled in this area. But they may be, in my view, more of an anomaly based on other groups that we've been helping to advise across the country.

And so once again, don't feel like you have to have all this done upfront with in-house but you need to go and get quality providers and you're going to have to demonstrate that these are quality providers to HHS as part of the loan application.

As I already mentioned, there is private purchasing councils CO-OPs are seeking to shirt - seeking to share some services. A number of the CO-OPs - new CO-OPs have banded together with Milliman to do the actuarial study.

And Milliman has set a price and through a group called NASHCO, a brand new group, National Association of State Health Cooperative, they set a fixed price and there's kind of an attractive term there that if the CO-OP is unable to move forward, that that money will not actually be (mailed) to Milliman, and once again this is a very evolutionary process.

So very briefly how to get started, first of all you have to determine if there's a local need. Is your local market competitive or monopololistic? And so how do you fit into that?

And we've operated in two very different markets just in Wisconsin and Minnesota. Wisconsin's a very decentralized regional insurance market. Minnesota is a very centralized insurance market with really only three providers.

In the legal world we'd call that oligopolistic or an oligopoly and so you have to decide how you're going to function in that type of marketplace. What are the local rates of uninsured and underinsured?

The states - many states report high rates of insured and in some cases the regulators will say well there's really no role for a new insurer, but the fact is in many cases people are very underinsured.

And we have particularly found that with agricultural populations, farmers and (ager) businesses through (sir) farmers. You have to develop a formative leadership team, because there's really two boards of directors that you'll have,

a formative group up front and then a operational board once your CO-OP is operating.

So you need to seek out those who have a passion for healthcare. And I can't emphasize this enough, those CO-OPs that are successful in forming, have people who are truly committed to them and make it a priority to get the work done.

Because to do the application, HHS takes a substantial amount of work. You need the broad strategic thinkers as well as who'll focus best on task. And I - we'd been advising some CO-OPs that have one of - or have their board come from one group versus the other group, and they really need to have a balance of both of those.

You need to have expertise in the provider insurance markets and under the governance recommendations that - and that were adopted by HHS, it's permissible to have providers on your board of directors.

So that's something you can incorporate into your articles and bylaws. You could determine who can insure - or determine who can insure, excuse me, the tasks that have to be accomplished.

Someone has to get the grand application, or the loan application done. Again, it's no small feat. And so someone really needs to - or someone or some folks need to be appointed to make sure that gets done.

And it's difficult and we've seen this experience over and over again, if you're just relying on volunteers that's going to be a difficult row to hoe, to use an agricultural expression, and so that's where getting some local foundation support to provide a grant to - a grant writer or some other assistance with

expertise in the insurance markets would be very helpful to get your CO-OP off the ground.

Determine if there're local funding sources, already hit some of this, but you need that to get the legal work done. And actually were doing an annotative set of articles and bylaws for federal healthcare CO-OPs, which we hope to have on our Web site some time within the next several weeks to month.

And so that will be one resource and that's going to be made available publicly at no cost. You need to get the actuarial assistance, the plan development, the network development, the infrastructure and that's something that HHS has emphasized.

Making sure you have an IT system that's both helpful for the consumer as well as the cure for many type of threats, as well as the marketing. You need to make sure that you know what the market is and how you're going to fit into that marketplace.

And the final slide on how to get started, connect early with your state insurance regulators. It's very helpful to have letters like the Northern Community Health Cooperative, the Common Ground Cooperative in Milwaukee.

They provided letters from their insurance regulators documenting that they've already been discussions and how the surplus funds would be used under state law. And those are the types of things that HHS is going to see - want to see.

And so therefore it's very helpful to contact and get in touch with HHS staff at an early stage in your process and they're very helpful and they're very willing to provide information. Get on their radar screen.

Helpful to connect with your local elected officials to get some level support there, particularly to the extent you need that with regulators who are not familiar with this concept.

We have the benefit in the Upper Midwest that our legislators, our regulators, are quite familiar with cooperatives, but we know that that's not true elsewhere in the country necessarily.

And finally you can seek the assistance of local cooperative development centers. There's about 25 across the country. You can just Google them and see if there's one in your state and they can provide you assistance, particularly on the governance side, which is important in this grant process - excuse me, loan process.

I'll keep tripping over that. And finally, manage expectations. A lot of groups have the temptation to go out and publicly start talking about what they're doing and you really need to do the work behind the scenes first to get your formative board set up.

Get the participants you need from the agent - community, from the provider community, because I can tell you from experience, once you start talking about a new healthcare plan, you will get endless calls from people seeking health insurance. And that's great, you can put them on a list to contact later, but that will get in the way of your getting work done right from the start.

So if you have further questions, because again we don't have time to cover any of this in great detail, there's contact information listed on that slide and you'll get that slide.

So feel free to contact us and we'll try to provide whatever assistance we can and once again, thank you for your participation in today's conference.

Caroline Au-Yeung: Thank you, Bill and Andy, for your presentations. This is (Carrie) Au-Yeung speaking again and I just wanted to give (Loren) a heads-up, you can still submit chat questions.

We're just going to do a few moderated questions here based on what we've been receiving. And a good one to start with is, are CO-OPs within one state competing with each other for federal funds? Or can DHHS award more than one grant per state?

And I don't know if, Andy, do you want to start with that?

Dr. Andy Coburn: Well maybe I'll pass that to Bill, because he's more - he's closer to this.

Caroline Au-Yeung: Oh okay, sorry.

Bill Oemichen: Sure, there could potentially be more than one CO-OP in each state and I've heard of some that could very well be considered competing with each other on the margins, but typically what I've seen so far is CO-OPs that are forming in the rural parts of a state, and then other CO-OPs, or a CO-OP forming in the urban parts of the state, and so they're not really competing with each other.

The HHS - the statute in the HHS grant review process, or loan review process, anticipates that there could be more than one applicant from a state. So don't feel like you're in an intensely competitive world within your state.

I know some applicants have already thought that they're really competing against others, but really what you're trying to do is just demonstrate that you have the wherewithal in your local area to make a change in that marketplace that's going to be significant and by doing that you'll get the interest of the HHS grant reviewers

Caroline Au-Yeung: Great thanks, Bill. And actually I think I have another question that's probably best addressed by you, do you know if there is a list available of states that have applied since October 17 for funds and do you know - there's not - go ahead.

Bill Oemichen: No, there's no list that I'm aware of yet. I hoping one eventually will be published by HHS, but there is none that I'm aware of yet.

Caroline Au-Yeung: Okay and the follow-up to that is, if states, or whoever would want to start a CO-OP, has missed the October 17 deadline, is it too late to start?

Bill Oemichen: No. Absolutely not. There's a December 31 deadline yet this year and then there's several deadlines for next year. So it's when you can get your proposal in a condition that a HHS loan reviewer or grant reviewer's going to look at and say, "This makes sense."

So don't feel like you're too much of a rush. I know a number of groups wanted to get in right now because there is a subsidiary concern, and I think it's a valid concern, that the super committee that Congress created, when they have for 1.2 trillion cuts, and the Congress in the previous round made cuts to this program, there's some concern that additional cuts can be made.

But I don't think - I guess the only way to say this is I can never tell you what Congress is going to do, and I used to work for the U.S. House of

Representatives, but I would try to make sure that you have a very good proposal first.

And I don't think even if there are cuts, it's going to cut back to the point where a lot of projects that were worthy won't get funded.

Caroline Au-Yeung: Okay, sorry to hit you hard here, Bill. Another question that follows up on that one is our state official, for example, insurance departments, governor's offices required to sign off on applications to HHF?

Bill Oemichen: That's a very good question. No, they're not required to sign off. What HHS would like to see is a letter showing that there have been discussions between the cooperative organizers with the state.

And then there's going to have to be discussions about how and what the state solvency requirements are and whether the loans that are provided by HHS will help meet that.

But there's no requirement that you get an actual endorsement letter saying, from the state insurance regulator, saying we endorse this project. It's helpful if you can get that. And some cases groups have actually gotten that from their state insurance regulator.

Caroline Au-Yeung: Okay, good to know. And the next question is for Andy. We're wondering if you could speak to the extent with which - extent to which CO-OPs are going to be interfacing with the exchanges? I know that they have to offer plans on the exchange, is there concern about market share in the exchange, is the essence of the question.

Dr. Andy Coburn: Well, I certainly think that the law envisioned that the CO-OP plans would be offered through the exchanges and provides for some expectation that CO-OPs sell inside the exchange, if they are selling outside the exchange.

So I think the situation with the states and how they're moving forward with their exchange development efforts, you know, will be very important in terms of strategically for a CO-OP plan deciding where they're going to sell within or outside the exchange or both.

Caroline Au-Yeung: Gotcha. And the next question is while it is member owned as run, how does the state interface with the CO-OP? And I guess, Andy, if you want to start with this one, it's a little broader.

Dr. Andy Coburn: Well, I think in any number of potential ways, one of the things that - certainly they're going to have to interface, as we were just talking about a moment ago with a department of insurance with respect to solvency requirements and other aspects of insurance regulation.

There will also potentially be, in some states, interest in the CO-OP program such that states might want to look at, and we pointed this out in our policy brief, ways that they could seed, if you will, enrollment in a CO-OP plans by using their public insurance programs or potentially even Medicaid.

Although there is this restriction in the law to the individual and small group market, which could potentially be an impediment to that. But state policy makers could help, certainly provide some support in some states for the establishment and support of the the development of insurance CO-OPs.

Bill Oemichen: And I can offer some - at least one really good example, I think of that and that's in Illinois. A group of businesses in the Chicago land area are working to form a healthcare cooperative.

And they work very closely with the Illinois insurance department and so closely in fact that the Illinois insurance department took the lead on moving legislation forward in the Illinois General Assembly and Senate to create a new healthcare CO-OP statute in the state of Illinois.

And so that's one example of how closely you can work together. In a lot of states doing a new statute's not necessarily required, but in Illinois it appeared under their existing laws that they needed to do this and the Illinois department of insurance was very happy to help move forward on that.

Caroline Au-Yeung: Great, thanks. The next question is how have health insurers - private health insurers reacted to the CO-OP legislations, that they have not been known historically to support of CO-OP purchasing programs. And I guess that would be directed more to Bill who's on the ground with this stuff.

Bill Oemichen: Well during our advisory board meetings in Washington D.C., we had many - hundreds of people out in the audience and after I went out - I try to figure out who they were, and many of them were insurance industry representatives.

And initially I think they all thought well this is something that's interesting but doesn't represent any kind of threat to the marketplace. Now I'm starting to hear from a number of insurers that they view this as a potential threat.

And so among other things there's some lobbying going on with HHS right now to make the application requirements more restrictive to make it more difficult for people to successfully form healthcare CO-OPs.

I think HHS has been very resistant to that kind of pressure, as our advisory board was very - or has been very resistant to that pressure. But I think as you see more and more of these CO-OPs seek funding, it's going to get a lot more private insurance interest.

And I think as all the callers know, or all the listeners know, that the federal law prohibits insurance companies from getting involved in this and getting access to these funds. There's an absolute bar within the statute for them.

Caroline Au-Yeung: Okay. The next question is the extent to which profit sharing will be made available to members of the CO-OP as it is in other CO-OPs as just (electricity) CO-OPs?

Bill Oemichen: I can...

Dr. Andy Coburn: Okay then, Bill, you could..

Bill Oemichen: Yes, go ahead.

Dr. Andy Coburn: ...provide more detailed information. But certainly the expectation and requirement is that whatever quote unquote surplus or profits, however you want to think about it, are generated by the CO-OP plan, needs to inure to the benefit of the members.

How exactly they do that through a dividend arrangement, which I think would probably be unlikely, but it's certainly possible. Premium reductions - reductions in the rate of growth and premiums would certainly be a desirable thing to have happen.

Improvements in the way in which so - way in which care is delivered, in terms of care management capabilities, any number of possibilities are available for the CO-OP plans to use those surplus funds, should they exist.

Bill Oemichen: And I would agree with everything that Andy said, just add one caveat, in a number of states, insurance laws prohibit a rebate back to the insurance consumer.

And so on some cases what we would call a patronage distribution or a dividend, might be considered illegal under state law. And I think that's in part the reason why the federal government when the congress, when they wrote the statute said it's really the goal to reduce premiums and provide higher quality care to the members.

Caroline Au-Yeung: Great. Okay and this is the final question for the day, and there are plenty of questions that we haven't gotten to, and we appreciate those, and to the extent possible we'll try to address them in follow-up emails, but the final question that we're going to be able to do today on the call is, are federal exchange subsidies available for individuals purchasing a CO-OP plan and will joining a CO-OP meet the requirements of the individual mandate?

And I guess that one can go to Andy.

Dr. Andy Coburn: And correct me if I'm wrong, Bill, but I see no reason why the subsidies that would be available for the exchanges would not be available to CO-OP members who qualified. It's certainly, and I think it's - these are going to be insurance plans and as such, would certainly meet the individual mandate.

Bill Oemichen: Right, I agree with Andy and just say yes and yes to both questions.

Caroline Au-Yeung: Okay, thank you. And thank you, everyone, for attending today's webinar. Thank you, Andy and Bill, for presenting. A recording of today's event is going to be posted at www.shadac.org\2011-coop-webinar. And also Bill slides are now up there, there was some trouble with the link earlier, but they are available at that Web site.

The recording will be available on Friday, October 21, that's this Friday. We will also include a direct link to the recording and to today's flag in a follow-up email to all attendees today.

To stay updated on the workable share and our co-host Rural Assistance Center, we encourage you to signup for our respective mailing list and follow-up on Twitter and Facebook. Our Twitter handles are there as our Facebook URLs.

Finally thank you to the Robert Wood Johnson Foundation for supporting this webinar and thank you to the Rural Assistance Center for co-hosting with us today. Have a great afternoon, thanks.

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